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Quality of jobs and services in the Personal care and Household Services sector GENERAL REPORT

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INTRODUCTION

The compilation of this general report is based on 11 national reports directed by Pour la Solidarité – PLS (Belgium) and ORSEU (France) and elaborated in cooperation with the project consortium and, with the support of Advisory Board (AGE Platform, Eurofound) in the framework of “For quality! – European project for quality of jobs and services in personal care and household services”:

- Belgium, France, Spain, Italy, the United Kingdom (UK), Sweden, Finland, the Netherlands, Austria, the Czech Republic and Germany.

Implemented from 2014 to 2016, For quality! (<http://forquality.eu>) has carried out a research on qualifications and quality of work and services in personal care and household services (PHS) that are provided at home/at the household, not in institutions (such as "residential care"). By supporting a stakeholder dialogue between organisations active in PHS through a partnership of the variety of workers and services employers in PHS, For quality! aims to promote quality services and jobs in the PHS sector. The project focuses on specific PHS - *personal care* and *household services* – while skills and working conditions in other PHS services such as nursing services in elderly care are already currently discussed at the EU level. The project intends to contribute to making employment in PHS more attractive and creating more quality jobs and encourage the movement of workers from the black or grey economy to the formal economy, and better protecting vulnerable people. For quality! gathers 9 organisations or networks established in Belgium, France and the UK:

- European think & do tank Pour la Solidarité - [PLS](#) (project coordinator)
- Office Européen de Recherches Sociales ([ORSEU](#))
- European Federation for Services to Individuals ([EFSI](#))
- Social Services Europe ([SSE](#))
- European Research and Development Service for the Social Economy and Social Innovation ([DIESIS](#))
- European Social Network ([ESN](#))
- UNI Europa, the European Services Workers' Union ([UNI EUROPA](#))
- The European Federation of Food, Agriculture and Tourism Trade Unions ([EFFAT](#))
- The European Federation of Public Service Unions ([EPSU](#)).

This general report follows the same methodological grid as the 11 national reports that are also available, and contains: PHS policies, work and employment quality, and finally service quality in the PHS sector. The report presents a selection of main findings and comparisons on the 11 countries at stake.

1. PHS POLICIES IN THE COUNTRIES AT STAKE

1.1. Defining PHS sector

The terminology personal care and household services (PHS) includes many different services to persons and households, which may be provided by people with various employment statuses: employees working for care providers (organisations), self-employed, friends or relatives. Generally, PHS are perceived differently across Europe, including differences in the kind of PHS that are provided. Indeed, due to the wide range of activities these services are most often not seen as a coherent economic sector in the European Union (EU), and thus there is no one general legal definition for it.

In **Belgium**, the multitude of activities related to the PHS services sector falls under the commonly used expression of “proximity services” which first appeared in the 1980s. As there is no legal definition of the PHS sector in Belgium, Laville and Nyssen’s (2000) definition of proximity services seems to be more appropriate, as it reflects the 2 dimensions of this expression: PHS services are considered as “activities answering to individual and collective demands by either an objective proximity - limited to a restricted area - or either a subjective proximity, reflecting the relational aspect of the different services provided”. Despite the lack of a general legal definition, the sector is properly defined and structured.

In **France**, in 2005 the so-called “Borloo Plan” gives a legal definition to the “personal services” (*services à la personne*) sector, through the elaboration of a list of such (decree 29 December 2005). The list indicates which services open access to public support for consumers, mainly in the form of tax reduction. This list includes several services, such as childcare; care for the older people, disabled persons or persons needing a personalised help at their home or a mobility help in their close environment with an aim to foster their home support; as well as housework and family assistance. At present, more than 20 activities have been defined as belonging to the scope of personal services. A difficulty is that 2 types of services, which are different in their logic and history, have been pooled together in this new sector:

- Social services, including care services to the dependent persons, which mostly are located in the third not-for-profit sector;
- Services to private individuals, rather corresponding to comfort or lifestyle services, which are mostly located in the private sector or in the private direct employer system.

In **Italy**, there is no legal definition of PHS. The national institute for statistics ISTAT uses the following definition: "domestic workers maintain home environments of users clean and tidy, take care of older people, children or dependent persons, provide handling services in the house of users, wash their clothes, do the daily shopping, cook and serve meals"¹.

In **Spain**, it is very important to clearly distinguish between 2 different economic sectors, which relate to

¹ ISTAT, <http://nup2006.istat.it/scheda.php?id=8.4.2.1.0>

different social and economic mechanisms as well as rationales:

- On the one hand the sector of home-based social care and domestic services (*servicios sociales de atención domiciliaria de atención personal y doméstica*). These services are regulated by the Dependency Law.
- On the other hand there is the sector of households as employers of domestic personnel (*servicio del hogar familiar*). These activities are regulated by the Royal-Decree on domestic servants.

Both models are completely different and there is no common approach to these sectors. However, there is a Spanish Association for Personal Services (*Asociación española de servicios a la persona, AESP*) which promotes the creation of a national regulation, including financial incentives to consumers and companies, aimed at developing these services.

In the **United Kingdom**², at the difference of other European countries, until today only very little attention has been paid to the PHS sector. Not only has the sector not been legally defined, but this sector is also neither the subject of regular statistical exercises nor are there any public policies explicitly targeting this sector of activity. Consequently, there is very little data and research available on the PHS sector in the UK.

In Sweden, although there is no detailed legislation on PHS the sector is mentioned throughout several laws: the law on tax advantages RUT and ROT, the act on tax credit on domestic services signed in 2007 (Law SFS 2007:346, 31 May 2007), and the law LOV on the personal choice.

In **Finland**, household services (*Kotipalvelut*) and home care services (*Kotihoito*) were developed in the 1950s and were mostly organised by municipal social welfare authorities and targeting mostly elderly. PHS are included in a broad framework law: the Social Welfare Act from 1982 as well as the Social Welfare Decree from 1983. It does not provide any detailed regulation on PHS services but gives a least a definition³: “PHS mean performance of or assistance with functions and activities related to housing, personal care and attendance, child care and upbringing, and other conventional functions and activities in normal daily life”, and “PHS are organised in the following forms:

- Assistance, personal attendance and support provided at home by a trained home helper or house aid for an individual or a family;
- Auxiliary services such as meals on wheels, clothes maintenance, bathing, cleaning, transportation and escort services, and services promoting social interaction”.

In **the Netherlands**, due to the wide range of activities the PHS services are not seen as a coherent economic sector, and thus there is no general legal definition for it. Also within the statistical databases a

² The report separates as much as possible elements for the UK and elements regarding countries (England, Wales, Scotland, and Northern Ireland).

³ Social Welfare Act 710/1982, Section 9.

single figure to view the trends in this sector is absent.

In **Austria**, there is neither general legal definition of the PHS sector. There is first the long-term care (LTC) branch which corresponds to a diversity of PHS for dependent persons. As for the branch of household services, the country has a specific legislation on domestic work: the Law on home help and domestic workers (*Hausgehilfen und Hausangestelltengesetz - HGHAngG*).

Also in **the Czech Republic**, there is no PHS general legal definition. The sector is spread in two separate systems:

- Non-care system: corresponds to social home care, which contains the following activities: help with the activities of daily life, help with daily hygiene, providing food or help with meal preparing, household services, and enabling contact with social surroundings.
- Care system: corresponds to wide range of care services for dependent persons, aiming to provide care within the family in a home environment.

At last, no legal definition of PHS exists in **Germany**, although household-related employment contracts and services” (*haushaltsnahe Beschäftigungsverhältnisse und Dienstleistungen*) is a term used in German finance law. Instructions from the ministry of finance point to this lack of a legal definition and provide a description of what shall be treated as household related services: a job in the sector “household-related services” is a job, which has a strong relationship to the respective household. The activities include the preparation of meals, home cleaning, garden work, and care for elderly dependent persons, disabled people, or children. Remedial classes or recreational activities are not covered. In a household, it is often possible for one individual to provide both types of services.

The diversity of definitions presented in the 11 countries at stake shows and confirms the difficulty to consider the PHS sector as homogenous⁴. The definition chosen in our context is that PHS cover “a broad range of activities that contribute to well-being at home of families and individuals: child care, long term care (LTC) for the elderly and for persons with disabilities, cleaning, remedial classes, home repairs, gardening, ICT support, etc.”⁵ This definition embraces both care activities and non-care domestic activities. It is however important to note that the distinction between ‘domestic’ and ‘care’ work is difficult to maintain in practice, as tasks performed by the workers may include both household maintenance and personal care⁶.

⁴ Farvaque N., Thematic review on personal and household services, EEPO, European Commission, 2015.

⁵ European Commission, Staff Working Document on exploiting the employment potential of the personal and household services, SWD (2012) 95 final.

⁶ EFFAT, Promote industrial relations in the domestic work sector in Europe, report, 2015.

1.2. Overview of policies, actors and trends of the PHS sector

In the 11 countries at stake, different measures have been taken to regulate and develop the PHS sector. In this regard, policies and the financing role of public authorities and their influence on job quality in the PHS sector may be an element to compare between countries.

In view of improving the working conditions in the PHS sector, Italy was the first EU Member State to ratify the C189 ILO Domestic Workers Convention in 2011, which is entered into force in September 2013. Germany was the 2nd EU Member State to ratify the ILO Convention (also in 2011), now entered into force⁷. This ILO Convention enters into force for Belgium on 10 June 2016, and on 8 January 2016 for Finland. So far, 7 out of 11 countries covered by the project at stake have not ratified the Convention: France, Spain, the UK, Sweden, the Netherlands, Austria and the Czech Republic.

In **Belgium**, PHS is structured in two major axes. Firstly, there are support and assistance services to older or sick people, to disabled and to all individuals with limited autonomy who wish to live at home. These services are only provided by public or not-for-profit organisations. Secondly, there are domestic home services, governed mostly by the service voucher system launched in 2004 at the federal level, according to a "quasi-market" model.

Following the 6th reform of the Belgian State, the federal authorities no longer have any powers in the PHS-related area. The PHS services, mainly in terms of financing, are subject of Belgian Regions (Brussels, Wallonia, Flanders) and communities (French, Flemish, German), along with the local authorities (communes and Social public welfare centres CPAS) and the mutual societies.

PHS providers fall into the “protective” regulation (*Régulation tutélaire*) because the services provision is financed and supervised by public authority. This public regulation aims to ensure access to services through regional decrees to vulnerable people (families, elderly and/or disabled) while imposing managerial and professional standards.

France has been a pilot in the creation and promotion of a PHS sector. This sector includes a series of in-home services dedicated to individual persons. The development of such a sector has been given a strong public impetus since the early 1990s. In 1991 a tax deduction was introduced which is still in place. Alongside the diversity of PHS services, there is also a strong heterogeneity of providers and organisational models to deliver the service. Two types of providers may be distinguished:

- Providers who are employed by a service organisation either in the non-profit sector or in the profit sector. This is called the “provider organisation” model (modèle prestataire)
- Direct providers who are employed by the individual beneficiary. The direct employment system has existed for a long time and has been strongly supported by public policies. The trajectory is

⁷International Labour Organisation (ILO), Ratifications of C189, <http://www.ilo.org/>; <http://bit.ly/1Mm9kH2>.

rooted in the heritage of the servant jobs, directly employed by bourgeois families over the 20th century. In terms of employment relationship, the status of these workers is specific, as they are directly employed by the beneficiary of the service.

Since 2002 (Law on dependency), there is a public allowance for autonomy named APA (allocation personnalisée d'autonomie), which allows partial funding for human assistance, technical assistance and specific housing installations for dependent people. It is granted only to people over 60 years old, after individual medical and social assessment.

In **Italy**, no overarching policy has been put in place to regulate the provision of PHS. The significant variety of national and regional frameworks regulating care, the importance of the informal economy, in particular regarding care for the older persons, are to be put in the context where the family is put at the centre of the Italian welfare model: family is seen as the major responsible actor to deliver resources to its members.

The role of the State in the PHS has significantly evolved in the last decades, starting from a big government with a near-monopoly on social services, to a State which guarantees the creation of a network of services for all that enables the long tradition of social cooperatives to take over the running of these services at local level: they employ social care operators to provide beneficiaries with the services need on behalf of municipalities. As a matter of fact, social cooperatives of 'type A' are the first service providers in the PHS sector; the rest of the service providers being public institutions and private for-profit organisations. Recently, new private actors have entered the market, which is now much more competitive but also more unstable⁸. They have the same role, which is to manage and implement PHS on behalf of local authorities.

In 2003, the legislative decree 276/2003, has led to the creation of a national voucher system to promote legal employment and to regulate occasional work in the PHS sector - among other sectors - in the context of the labour market reform law 30/2003 (also known as the "Biagi Law")⁹. The measure turned out rather ineffective given that it only takes on board "occasional activities", in which PHS only constitutes a marginal share. From a worker's perspective, the use of vouchers being dedicated to occasional activities, it is not suited to standard work activities, but rather to occasional services that are limited in time. Therefore, vouchers cannot replace standard work contracts, and can be used only when standard contracts do not apply. Thus, it entitles to lower minimum social security and insurance entitlements for workers and explains why no collective agreements apply.

For long, **Spain** has relied on a "Mediterranean" model of social protection, relying a lot on families and

⁸ IWAK, Creating Formal Employment Relationships in the Domestic Services Sector: Successful Strategies? Insights from the Project "Labour Market Measures for Reducing Illegal Employment in Private Households of the Elderly" supported by DG Employment, Social Affairs and Inclusion, <http://www.iwak-frankfurt.de/documents/brochure/april2011.pdf>.

⁹ Circolare 17/2010. Lavoro occasionale di tipo accessorio. Legge Finanziaria 2010. Modifiche art. 70, decreto legislativo 10 settembre 2003, n. 276.

relatives. In December 2006, the Spanish government passed Law 39/2006 for the Promotion of Personal Autonomy and Care for People in a Situation of Dependency (*Promoción de la Autonomía Personal y Atención a las Personas en Situación de Dependencia*) – also known as the LAPAD or the Dependency Law. This law established the individual right of all citizens to access a broad range of services and support in situations of dependency. With the approval of this law at national level, autonomous communities had to include its provisions in their own social services structure. The model therefore still relies on decentralised levels, but it creates a common framework. According to the 2006 Dependency Law, the beneficiary may benefit from a catalogue of in-kind benefits and services including: dependency prevention services and the promotion of personal autonomy, personal alert system, home-help service (addressing the needs of the household), personal care, adult day-care centres and/or residential care service. The law distinguishes 3 degrees of dependency (1-moderate, 2-severe, and 3-major). If the competent administrations are unable to offer these services, the dependent person is entitled to receive financial benefits. There are 3 types of financial benefits: financial assistance to access certain care services, financial assistance for informal caregivers (non-professional care), and financial assistance to hire personal caregivers. The amount of these benefits depends on the degree of dependency and the economic situation of each individual. Available data show that more than 45% of the total financial aid offered for dependents relates to ‘family and non-professional care’. Thus, although financial support for family carers was supposed to be an exceptional measure, in practice it has turned out to be the most popular one.

The funding of the social services system as a whole is shared between 3 levels: the state, the autonomous communities and the local level (regional and municipal levels). In addition, the service user pays a part of the total costs, depending on their particular circumstances (“co-payment”). According to Eurofound, many authors claim that the funding provided to Spanish social services is low, especially compared with the European average. Although estimated public spending on social services has increased as a consequence of the new rights covered by the 2006 Dependency Law, the financial crisis is making it difficult to maintain initially planned budgets.

Two main drivers explain the important evolutions of the Spanish model, in the field of care policies. The first one is the increase of the share of 65+ old persons. It represents today 17.5% of the total population compared to 14% in 1990. Life expectancy in Spain is one of the highest in the world (second just after Japan). The second driver lies in the changes in family structures and institutions. Usually families were the first institution to care for relatives, but since the 2006 Law a specific sector tends to emerge.

In the **United Kingdom** not only has the sector not been legally defined, but this sector is also neither the subject of regular statistical exercises nor are there any public policies explicitly targeting this sector of activity. Consequently, there is very little data and research available. While the care sector is well regulated at national level, the sector of domestic personal services has not been the object of any specific public regulation.

There are no specific policies in place to foster this sector. Households hiring employees are treated as any other employment relationship (in contrast to other countries where employers of domestic staff

might be able to take advantage of measures such as tax reductions). Employees working in the PHS sector are not treated in a specific way, neither. For example, as long as an employee who occasionally works for a private household earns less than GBP 110 per week, this does not have to be declared for tax purposes by the private household. The current fiscal and social systems in the UK incentivise households and private employers to employ domestic staff occasionally rather than regularly, as this avoids any administrative burden. This therefore fosters informality in this sector. Nevertheless there also exists a formal sector – largely private – providing care and housework services to dependent people. There is a very large offer of private housework services.

In international comparisons, the LTC system of **Sweden** stands out as being very generous and as providing a high level of formal care which is financed primarily by public rather than private money. In the field of care policies, despite some downsizing, public service provisions still account for the overwhelming majority of all formal provisions (around 90% of formal care).

Although special housing and home care can be run by a municipality or by a private health and social care provider (such as companies, trusts or cooperatives), the local authorities remain the ultimate responsibility to supply and maintaining the level of care even when private organisations supplement some of their responsibilities. The governance of the model is hence much decentralised. Taxes and general allowances finance the bulk of expenditure on LTC, while fees finance only around 4%. Most LTC services are financed through local municipal taxes collected by 290 municipalities.

Since the 2009 law on System choice in the public sector (LOV reform), private providers can enter the market and marketisation is growing up. The assumption is made that municipalities and recipients will choose providers based on their performance. Municipalities have autonomy to grant licences for operation, set prices and monitor compliance. If they participate to this choice system, they have to provide quality information on providers. All providers receive the same reimbursement (according to the amount of help decided by the needs assessor), and are thus competing by service quality, not by prize.

Today, two parallel mechanisms co-exist, namely the RUT-reduction (for domestic services; applies to services conducted close to the house or apartment where the taxpayer lives.) and the ROT-reduction (stands for *Reparation, Ombyggnad, Tillbyggnad*; for renovation services of one's own home, launched in 2008). Together, these two schemes are known as “husavdrag”: the tax advantage allowed to anyone who buys “housework”. Taxpayers are entitled to deduct 50% of the expenditure up to SEK 100,000 on household services, including care services. The deduction, then, is up to SEK 50,000 (close to EUR 5,500) per person and year if the service company has a business tax certificate. The services may be carried out in their own home or in a parent’s home. Main objectives of these tax incentives were to increase formal employment and to combat undeclared work. A considerable amount of younger persons buy RUT-services for their elder parents, some of these parents having lower incomes. In the Swedish context still privately purchased services play a lesser role compared to both family care and publicly funded services.

In **Finland**, PHS services are under the control of municipal authorities, which are also the main provider.

Either each municipality provides services themselves or they are organised in federation of municipalities formed by one or more neighbouring municipalities for the provisions of such services. Municipalities can externalise by purchasing services from another local authorities or from private providers¹⁰. The Finish legislation does not strictly regulate provisions on the extent, content or arrangement of services, leading to differences between PHS services provision from one local authority to another. Thus, local authorities are untitled by the law to cover the essential basic services, which are specified by the legislation.

One of the specific features of Finland concerning PHS is the integration process between home help and home nursing. At first, home nursing services (*kotisairaanhoido*), provided by health care authorities, were clearly separated from home help services which were provided by the social welfare. Many local authorities created one new single provision form of services called 'home care' (*kotihoito*), integrating both services in one single system. In many cases, this process has been connected to administrative reforms, merging social and health care administrations in one single entity at the local level. This new model aims at combining home-help services and home health care services, offered by the same care worker.

The law on Health and Social care Voucher was introduced in 2009 in order to regulate more efficiently the diversity of local practices concerning home care services. With this system, personal care services production and provision are managed through a more market-based mechanism. Several municipalities started to give vouchers to home care users to pay for personal care services or to pay their informal carers. Through this system, the user can select different service providers from a list approved and subsidized by the municipality. This choice is rather made by big municipalities. In the private sector, the use of voucher system may have prevented the use of outsourcing services.

Local taxes for municipal home care services are income-related: people with higher income pay higher fees. This system led to the privatisation of the sector as private alternatives for home care can be less expensive than public care services for people with a good or modest pension. This shift from public provision to market provision underlines the pressures for an increasing erosion of the principle of the 'Nordic universalism', stipulating that any person, regardless of income levels, should have access to one and single service system (Kroger, Leinonen, 2011).

In the **Netherlands**, the Long-term Care Act (WLZ - *Wet langdurige zorg*) applies to people who need all day intensive care or require close supervision. WLZ has been introduced on 1st January 2015 and has replaced parts of the Exceptional Medical Expenses Act (AWBZ - *Algemene Wet Bijzondere Ziektekosten*)¹¹. Prior to the reform launched in 2014 the AWBZ was covering a broad package of services: personal care, nursing, assistance, treatment and stay in an institution. Assistance includes day care in groups as well as personal (one-on-one) assistance. A lot of LTC legislation has been changed in

¹⁰ OECD, Early childhood education and care policy in Finland, 2000. <http://bit.ly/1DXkMTj>

¹¹ Other parts that belonged to the AWBZ have become the responsibility of the municipality and are included in the "Wmo".

2014, moving to greater decentralisation of responsibilities from the central state to the municipal level. Since 1st January 2015 municipalities have become responsible for child welfare, employment and income and care for chronically ill and the older persons.

Another important law is the Law on Social Support (Wmo - *Wet Maatschappelijke Ondersteuning*), which is carried out by the local council. The Wmo law regulates the provision of support and household care for disabled, dependent and older persons and has transferred the responsibility from the State to the municipalities of providing household care and support whether in kind or in cash through the use of personal budgets (PGB - *persoonsgebonden budget*). The first step of decentralisation of the PHS sector took place in 2007, when domestic care was shifted from the AWBZ to Wmo. A new decentralisation step has been implemented since 1st January 2015 (Wmo 2015) when municipalities have become responsible for most of all youth care, Wmo (personal) care and welfare.

Since 1st January 2015 fewer people receive domestic help from the new Wmo 2015. In 2015 and 2016 therefore extra money is available to municipalities in the form of domestic help allowance (HHT - *Huishoudelijke Hulp Toelage*). The HHT helps to preserve jobs in the household. The HHT helps municipalities to facilitate Wmo-clients to contract domestic help at a lower contribution than the actual cost. The domestic helper is employed by a provider. In order to develop a strong workforce, objectives of the HHT plans and can best determine what is needed regionally or locally to maintain employment and further develop the market for domestic services.

The ongoing reforms try to decrease the public expenditure, but the decentralisation is combined with large budget cuts for municipalities to fund activities in the social domain¹².

In **Austria**, the role of the public authorities is divided in several levels of statutory power, and regulated by one federal and 9 different provincial (Länder) laws. Federal competencies are implemented uniformly in all Länder, while provincial competencies are different among themselves.

The Austrian system benefits include: benefits in cash (federal cash benefits, respite care benefits, 24-hour care), benefits in kind (a variety of services which may be bought with the cash benefits: mobile services, outreach services, semi-institutional services, in-patient/institutional services, and services for persons with disabilities), and benefits for carers (paid and unpaid leave, working arrangements and pension credits, respite care, training and education)¹³. The key component of care provision is the care allowance, which provides users with the freedom of choice of care. As regards the benefits in kind, they are voluntary and often require income and asset dependent co-payments, in accordance with the care needs. To cover the costs, some Länder also involve the family members by asking them to provide contributions. Estimates show a wide disparity between Länder in terms of the private co-payments share for home care and residential care. One specific characteristic is that around 65,000 caregivers are

¹² EEPO, 2015.

¹³ Typology and description have been taken from the OECD report Austria long-term care, 2011.

migrants mainly from the eastern-European neighbouring countries, with greater attention on recruitment of workers from further east¹⁴. These caregivers are essentially employed in the framework of the 24-hour care system. The objective of this system is to provide assurance of nursing and care around the clock¹⁵: the assistance is given to the person under care at the household and certain tasks relating to the personal care and eating. In addition to these tasks, under a doctor's order a caregiver may perform certain defined medical tasks for example the administration of drugs, bandaging and subcutaneous injections. To benefit from this grant additionally to the cash benefit, the dependent person has to be recognised at least level 3. The amount of this grant depends on whom the dependent person has hired: an employee (EUR 1,100) or an independent worker (EUR 550).

The importance of the informal care provision (about 80%) has led the Austrian authorities to set up the 2007 Home Care Law, which aims at creating better regulation of informal care provision.

With regard to the projected trends in age-related expenditure, Austria has notably put on track the health system reform, on basis of the reform plan 2013-2016 to stabilise healthcare spending as a share of GDP as of 2016¹⁶. Some doubts are however expressed whether this reform can bring about decisive action to reorganise the healthcare and LTC systems in a cost-effective and sustainable manner.

In the **Czech Republic**, there is neither a unified legal background nor any authority responsible for the regulation of the 2 sub-systems (care and non-care) that represent the PHS sector. The Ministry of Health is responsible for home health-care and care provided in health institutions, the Ministry of Labour and Social Affairs is responsible for social services, and municipalities/regions are responsible for the planning of social services and for the availability of social PHS¹⁷. The Czech policy supports the development of PHS services at local level, as well as allocates the care allowance, thus giving its dependent citizens the freedom of choice.

The total cost of cash benefits amounts about EUR 650 million per year (about 0.6 % of the GDP), paid to about 300,000 recipients. However it is important to mention that, compared to the Western European EU Member States, Czech citizens may afford more hours with these amounts of benefits.

Services in-kind include personal assistance and home care for persons that are dependent as a result of their age, disability or chronic illness. Personal assistance is provided to the clients of social services at home, without time limitation. This can include shopping, meal preparation, washing, paying bills, taking medications, etc. The service provided is determined on the basis of individual requests.

In **Germany**, the Home and Institutional Care act (*Pflege-Versicherungsgesetz*), from 1994, stands as the

¹⁴ For quality! project, Third Regional seminar, Vienna, 22.09.2015, report.

¹⁵ For quality! project, Third regional seminar, Vienna, 22.09.2015, report.

¹⁶ http://www.bmg.gv.at/home/EN/Topics/Health_reform

¹⁷ OECD, Czech Republic long term care, in Help Wanted? Providing and Paying for Long-Term Care, 2011.

starting point for the last major reform initiated by the German Federal government to enlarge and improve the national health and LTC system¹⁸. Along with pensions, health, accident and unemployment, it introduced a fifth branch to the social insurance scheme - the main framework for social security in Germany – which covers LTC¹⁹ needs, as they were previously leading to pressure on the costs of health insurance. This is why the Social Long-term Insurance (*Pflegeversicherung*, LTCI) was put in place²⁰. Through LTCI funds, the German legislation provides for various forms of LTC services such as benefits for care giving at home in cash and in kind (for community care), in day or night care institutions as well as in nursing homes according to the level of dependency of beneficiaries²¹. So far, the dominant type of benefit of the LTCI is the cash allowance. Funding of the LTCI is ensured by a system of salary deductions (by means of social contributions to be paid by employers and workers/employees at an equal share), the amount of which is calculated based on citizens' income.

The 2009 Employee Sending Act sets minimum standards for the working conditions of employees providing services in Germany through companies set in one of the other EU countries.

The 2011 Law of Family Care Time encourages family members to provide LTC for their families. This law enables employees to reduce their working hours to care for their relatives for a maximum of 2 years. Half of the deducted hours are paid to the employee by their employer. The other half is at the expense of the employee themselves: when returning to their job, employees make up for the expense imputed to the employer by receiving a salary reduced for as much as it has costed them. The Federal Office of Family Affairs and Civil Society Foundation offers employers interest-free loans in order to finance this measure.

As for household services, the rise in PHS in Germany was strengthened during the 1990's by the appearance of 'mini-jobs' and then by the Hartz IV reform (2003), which made 'mini-jobs' more flexible and created 'midi-jobs'. Mini-jobs are those from which the monthly revenue does not exceed EUR 450²²; they provide employees the right to full exemption from social security contributions, whereas employers pay higher social security contributions. Midi-jobs are those that provide a monthly salary of between EUR 400 and EUR 800; these provide workers the right to a sliding-scale reduction in social security contributions. These employment schemes were initially created to encourage wives to take up part-time work, while already covered by the health insurance of the spouses²³. Nonetheless, many mini-jobbers do not choose to pay extra pension contributions, which results in greater precariousness on the long term.

¹⁸ Eurofound, More and better jobs in Home-care work, 2013

¹⁹ Long-term care corresponds to a diversity of personal and household services (PHS) for dependent persons.

²⁰ Cools, F., Stokkink, D. (dir.), Maarten, G., Valsamis, D., February 2013

²¹ Schulz, E., 2010

²² Conseil Central de l'Économie, Lettre mensuelle socio-économique, N°190, 30/04/2013, p.10

²³ European Commission, European Employment Policy Observatory, Personal and household services - Germany, June 2015

2. WORK AND EMPLOYMENT QUALITY

2.1. Career and employment security

Overall, career and employment security in the PHS sector varies from one country to another as a function of the content of collective agreements, as well as the existence of specific regulations on employment²⁴. Yet all observations in the 11 countries converge and confirm an observation that workers in the PHS are mostly women, mainly working part time, with relatively low skills and often from migrant background. Besides, in many cases migrant workers are also undeclared workers.

The PHS sector relies on a variety of employment models, which can be merged in 2 main types: direct employment model (2 parties), and provider organisation model (intermediated or triangular form of employment, between 3 parties)²⁵. Other forms of ‘contract’ between 2 and 3 parties exist, too.

	Two parties	Three parties
Employment contract	Model 1: Direct employment model (by the household)	Model 2: provider organisation model (different organisations - public, NGO, private - can provide the service)
Other form of ‘contract’	Self-employment Undeclared employment Informal help/care	Combination of direct employment and intermediation form a provider organisation

Source: Farvaque N., 2015.

The indicators chosen to give a picture of the working conditions in the countries at stake are gathered in 3 data sets: employment status (overview on the nature of employers and/or on the contractual relation employer/employee, on existence of collective agreements, on undeclared and on migrant work), amounts of wages, and access to social protection and/or worker’s rights.

2.1.1. Employment status

The employment status in the PSH sector is strongly depending on specific regulations on employment, and the countries at stake show a variety of settings.

²⁴ Farvaque N., 2015.

²⁵ Farvaque N., 2015.

Nature of employers and/or contractual relation employer/employee

In **Belgium**, voucher contracts - signed with a PHS company - are an interesting practice to be mentioned, in terms of improvement of employees' working conditions. While there are fixed-term contracts lasting a day, a week or a month, since September 2009 workers automatically obtain a permanent contract once they have been working for the same company for 3 months²⁶.

In **France**, about 90% of workers in PHS have permanent working contracts: service provider organisations mainly offer permanent contracts in order to attract new workers²⁷.

In **Italy**, a written contract is required. Yet a specificity of the collective agreement concerns dismissal: employers do not have to comply with the possible reasons for dismissal as defined by the Italian law, nor they are obliged to provide a written dismissal statement, although it is a precondition for workers to be entitled to unemployment benefits.

In **Spain**, in terms of type of work contract, recent data²⁸ show that 34.3% of people working in non-residential social work activities for elderly persons and people with disabilities have had temporary employment contracts (in contrast with 23.6% for the whole economy). In addition, 41.8% of workers work part time, compared with 14.7% for the whole Spanish economy. When it relates to the field of domestic employment, the regulation is defined by the 2011 Royal Decree, which regulates the specific relationship between domestic employees and employers.

Alongside these "official" occupations, it is crucial to highlight the importance of non-professional workers caring for relatives. Since a 2007 decree, these non-professional carers may benefit from a specific in cash allowance, in case when there is no local social service available. According to the evaluation of the Dependency law, more than 400,000 persons benefited from this aid in 2013.

In the **United Kingdom**, the PHS sector is characterised by a high level of part-time jobs, which seems to be increasing. Furthermore, the introduction of direct payments and the extension of cash-based personal budgets encourage informality and occasional employment and more generally bad working conditions. There are no requirements for personal budget holders to provide contracts or formal conditions of employment to the personal assistants they employ, or for such workers to have any minimum qualifications.

Household employing housework staff is submitted to the same rules than any other private employer. In *England* there is no obligation to declare occasional workers under a certain threshold and there are social exemptions for occasional workers paid less than GBP 111 per week (around EUR 140) this being the

²⁶ Farvaque N., 2015.

²⁷ Farvaque N., 2015.

²⁸ Active Population Survey 2012.

threshold for liability to social security contributions. This particularity of the British model leads many households to recruit for very short working times, without neither administrative duty to undertake nor social contributions to pay.

Sweden has for particularity the high share of public employment and the importance of municipal employees. Globally speaking, the care sector shows relatively good working conditions, because in this mainly tax-financed system with predominantly public providers the employment relationships are regulated, subject to scale salaries. They are not as much characterised by atypical employment relationships and low wages as in other EU Member States. Care work for older or disabled persons is mainly a female occupation; over 90% of the employees in the care sector are women (SALAR, 2009).

Part-time work is much more common among care workers than it is amongst the female workforce overall. Holding more than one job is also an indication of the involuntary nature of part-time work. Some surveys report a figure around 7% of the workforce holding more than one job²⁹.

In **Finland**, as municipalities are the first providers of PHS, the largest group of employment in the field is in the various municipalities' social work departments (about 80% in total). Workers hired by municipalities cover an extensive range of tasks from medical operations to PHS, some workers being entitled to perform medical task and household services. The remaining 20% represents the share of private entrepreneurs (5%) and employees working for the private sector (15%). In most of cases, they are providing non-care services. Their employment status can be arranged by municipalities via outsourcing agreements, rental work or part-time entrepreneurships or via an employment relationship with a private company or a NGO. Entrepreneurs work mostly directly for the household, under the tax deduction system. Domestic workers, which tasks are usually limited to cleaning activities are most of the time employed by service companies operating in the cleaning sector.

In the **Netherlands**, when older or disabled people hire employees to do household care for a maximum of 3 days per week, the contract is then subject to the Domestic Work regulation of 2007³⁰. Consequently, people hiring employees under these conditions are exempt from any social contributions and taxation, layoff authorisation or administrative obligation. They can use their personal budget (PGB) attributed by the municipality to pay the employee's wage.

At present, it is actually more interesting for the individual to employ a person without declaring him-her. The employee will also find its interest because the wage is higher than the net wage after declaration to the tax authority. Another Dutch particularity is the lower proportion of informal PSH workers, in comparison to the other EU countries, which is due to its dense networks of available services.

In **Austria**, in most cases PHS are provided informally (over 80%) by family members, mostly women.

²⁹ http://www.cccg.umontreal.ca/rc19/pdf/szebehely-m_rc192009.pdf

³⁰ EFSI, 2013.

The cash allowance alone usually is not sufficient to cover the total cost of PHS if the need is high. This could be interpreted as an indicator that informal - less costly - care support is preferred by the Austrian authorities.

The Austrian specific legislation on domestic work - the Law on home help and domestic workers (*HGHAngG*)³¹ - makes provisions for remuneration, working time, daily and weekly rest, holidays, notice period and social security insurance of domestic workers. Also, general employment law includes areas which apply to domestic workers, such as maternity leave, health insurance, and protection against violence and abuse.

In the **Czech Republic**, while healthcare services are provided by home care agencies contractually linked to health insurers, social services are provided either by informal carers and/or by professional providers. About 80% of care to the dependent persons is provided informally. Informal caregivers are registered only when they get a care allowance from the dependent person so that the State pays their social and health insurance. The relatives provide this predominant type of care at home. However, most informal care providers also work: 80% of them have a full-time job³². Thus a decision upon informal care is strongly dependent on the flexibility of a caretaker's job.

As the current legislation guarantees equal conditions for all workers, thus including domestic workers, and creates sufficient room for balancing personal, family and work life, KZPS³³ suggests that emphasis should be placed on ensuring the proper application and enforcement of current legislative framework rather than on creating new ones.

In **Germany**, informal care activities are often shared among some members of the beneficiaries' families. They tend to be unemployed, reduce their working hours or leave their job to take care of their relatives. A direct consequence is an indubitable lack of professional perspectives for women with a dependent relative: with sons providing help mostly with financial tasks, spouses, daughters and daughters in law are mostly responsible for personal care of their relatives.

Although the measure of formal provision of domestic services has gone with significant impact on employment, in particular in the PHS sector, an increase in low pay and precarious forms of employment have been monitored, including the rise of "working-poor"³⁴. According to Prognos, 40% of households having recourse to PHS (care and non-care taken together) formally provided employed persons through the "mini-job" scheme (direct employment relationship), 32% contracted with self-employed persons (direct employment relationship) and 28% contacted other PHS providers ("triangular relationship")

³¹ EFFAT, Promote industrial relations in the domestic work sector in Europe, final report, 2015.

³² Sowa A., 2010.

³³ KZPS, Decent work for domestic workers, International Labour Conference, 99th Session, report, 2010.

³⁴ Farvaque, N., Developing personal and household services in the EU - A focus on housework activities, Report for the DG Employment, ORSEU, 2013.

between service provider, payer and user). Yet within PSH, it is important to specify that the mini job scheme most often does not apply to care work, and that the most common types of mini-jobs are in the field of domestic work. As of the “contracted care providers” in the format of a “triangular relationship” (*sozialrechtliches Dreiecksverhältnis*) it only applies to the care work/sector. At last, regarding elderly care provided at home/at the household, it involves primary self-employment, undeclared labour and work contracts that combine pay with accommodation arrangements (for the workers, as a rule migrant women, with “live-in-employment”).

Existence of collective agreements

Regulations may put PHS workers on equal footing with other workers, or may bring them a specific status leading to inferior conditions. The influence of collective agreements in improvement of working conditions and quality of PHS is important.

In **Belgium**, the working and pay conditions are set within Joint Committees (*Commissions paritaires*) which are the negotiation scene between trade unions and employers in the same industry of the private sector. Each Joint Committee sets its own agreements in terms of pay, work conditions and training opportunities. For household services to families and dependent persons in both Brussels and Wallonia regions, PHS are regulated by the Joint committee 318 (*Commission paritaire 318*) competent for workers in general and their employers. There are 2 joint sub-committees (*sous-commissions paritaires*): 318.01 for the French community, the Walloon region and for the German-speaking community; and the 318.02 for the Flemish community. The collective labour agreement of 16 September 2002, concluded for an indefinite period, fixes working conditions, remuneration and wage-indexation for support services staff to families and to older persons subsidised by the Walloon Region. As for service voucher workers, minimum wages are set through collective agreements joint committees within associated with the licensed company or even within the company, and it is prohibited to derogate.

In **France**, the status of PHS workers is not different and is regulated by binding collective agreements³⁵.

In **Italy**, the collective agreement for *collaboratori domestici* regulates working conditions and stipulates different rights if the worker is cohabitant or not, particularly with regard to the maximum weekly working time.

In **Spain**, the working conditions of workers in the social services sector are regulated by common regulations (Estatuto de los Trabajadores) and by collective agreements. There are 2 main collective agreements that influence professional profiles, training programmes and pay mechanisms

- Collective Agreement XIV on Care Centres and Services for People with Disabilities (August 2012), which has notably defined guidelines to improve professional qualifications and training.

³⁵ Farvaque N., 2015.

- Collective Agreement VI on Care Services for Dependent People and Development of Personal Autonomy (April 2012), which applies to companies and workplaces that provide services for dependent people and promote personal autonomy. This collective agreement seeks to regularise and maintain employment.

In the **United Kingdom**, collective agreements are only likely to be found where the work is carried out by directly employed staff of Local Authorities or the NHS.

In **Sweden**³⁶ almost all collective agreements concerning wages and working conditions are negotiated at the sectoral, multi-employer level under bipartite conditions. Unorganised employers can, and usually do, sign application agreements (*hängavtal*) with the trade unions. These agreements set wages, working conditions, as well as equality at the work place. The part of workers in the health care sector covered by collective agreements is nearly 100%, due to the fact that an overwhelming majority of the employees in the sector are employed in public sector institutions.

In **Finland**, as in Belgium and in France, the status of PHS workers is not different and is regulated by binding collective agreements³⁷. Most PHS sector workers are either depending on General agreement in the municipal sector (KVTES), Private social service sector collective agreement or Real estate service sector collective agreement, which are all generally mandatory.

In the **Netherlands**, employees of care businesses or of maintenance/housekeeping businesses benefit of a collective agreement for their sector that can offer them more favourable working conditions than the Dutch common law. The trade unions FNV and CNV Vakmensen negotiated a collective agreement for the cleaning sector, including private homes, with the employer organisation OSB in 2014³⁸. This agreement only covers cleaning personnel who are employed through agencies, though; workers employed directly by private households are not part of the agreement. As for home care sector and the child care sector, workers fall within the scope of a collective labour agreement³⁹.

Austria does not have a full collective agreement on domestic work; however, there is an agreement on the minimum wage for domestic workers, graded according to qualifications and work experience. In addition, collective bargaining agreements exist for care work, including care workers who provide “low skilled” assistance with everyday activities and household tasks. 24-hour care workers who provide care to the elderly in their private homes are mostly self-employed and therefore do not benefit from the minimum wage agreement⁴⁰. The employers’ associations with whom the unions negotiate are large

³⁶ Eurofound, European Observatory of working life EurWORK, Sweden: Industrial Relations in the Health Care Sector, 2011.

³⁷ Farvaque N., 2015.

³⁸ EFFAT, Promote industrial relations in the domestic work sector in Europe, final report, 2015.

³⁹ EEPO, 2015.

⁴⁰ EFFAT, 2015.

organisations, involving many sectors including domestic care/cleaning⁴¹.

In the **Czech Republic** the collective agreements take place at the sector and company level⁴². They are regulated by the Collective bargaining Act. In social services about 200 providers have a collective agreement or are negotiating⁴³.

In **Germany**⁴⁴ some collective agreements are extended in certain sub-sectors (like eldercare or gardening) but a majority of workers in the non-care sector are not covered by a collective agreement. Yet all workers are covered by the statutory minimum wage set at EUR 8.50 per hour since January 2015, with a transitional period up to 2017. Until the end of the transition period minimum amounts in sectors that are currently still lower than EUR 8.50 (e.g. EUR 8.00 in elderly care in Eastern Germany; in Western Germany the current amount is EUR 9.00) need to go up to the level of the statutory minimum wage.

Undeclared work

In the countries at stake, the PHS sector represents one of the most frequently undeclared services purchased by households. Workers employed illegally in the PHS sector do not benefit from any welfare, statutory minimum wage, sickness or accident insurance, holiday, sick days, unemployment or pension allowance. Furthermore undeclared working arrangements inevitably result in a loss of revenue for the State through forgone taxation and benefits. In accordance with their particularities, countries at stake experience diverse measures to regularise undeclared work, the main ones observed being the introduction of the voucher system and the creation of specific institutions combating undeclared work, or the introduction of the specific regulation for a country-predominant PHS workers' profiles and backgrounds.

In **Belgium**, the undeclared work reduction was one of the first objectives of the service voucher system. Looking at the positive development in the number of workers entered into the system and the increasing number of active users of the device since its creation, it can be deduced that the introduction of service vouchers has contributed in the regulation the undeclared work in Belgium. The device has prompted some workers to regularise for the benefits of the system. The device also urged to encourage beneficiaries to make use of approved service providers to benefit from tax deductions. The reduction of the tax deduction service voucher to only 10% in Wallonia since 1 January 2015 has led to higher prices.

⁴¹ EFFAT, Decent work for domestic workers! booklet, 2015, <http://www.effat.org/en/node/13931>.

⁴² Eurofound, Czech Republic, On wage bargaining. <http://bit.ly/1MudNHJ>

⁴³ Horecky J., Project PESSIS 2 “Promoting employers’ social services organizations in social dialogue”, Country-case study: Czech Republic, UZS, 2013. <http://bit.ly/1LfYy3A>

⁴⁴ Farvaque N., 2015.

Unitis (the union of the service voucher businesses) is afraid to see the PHS sector to slip into the shadow economy in the region.

In **France** undeclared work has significantly diminished in 1990s and 2000s, following the public policy (strong tax incentives). However, in recent years, these tax incentives were scaled down under the weight of pressure on public budgets. Direct employment has decreased and it is very likely that undeclared work is rising again. This trend would affect undeclared work both migrant workers (25% of the workforce in 2012) and non-migrant ones.

In **Italy**, quantitative evaluations of undeclared PHS employment range from 40% (National Institute for Statistics - ISTAT) to 70%. This can be explained by the fact that a personal assistant would cost 30% to 40% less on the irregular market than on the regular one.

In **Spain**, according to some surveys the black market represents up to 70% of the PHS sector.

In the **United Kingdom**, undeclared working arrangements prevail, which not only make it difficult to measure the actual extent of the sector but also risk having an adverse effect on working conditions.

In **Sweden**, no global estimates are available. The conversion of undeclared work can be assessed in the case of cleaning. According to the results of the 2012 survey estimate a drop of 10% of the black market since 2005⁴⁵.

In **Finland**, no recent data have been found. According to the evaluation done in 2006 (Niilola and Valtakari, 2006), the tax deduction for household services allowed to considerably reduce the proportion of undeclared work from 60% to 25% between 2001 and 2004. This shift mostly occurred in the renovation sector.

The share of undeclared work in the **Dutch** PHS sector is estimated around 28 to 40%. Indications are that this type of work seems to be work via which people earn some pocket money⁴⁶. The main institution combating undeclared work is the Inspectorate SZW⁴⁷. Since January 2013, the new law (WAHS) targets to shift more cases from criminal law to administrative law (by use of fines, warnings). On this new legal basis, undeclared work combined with unemployment benefit leads to very high fines (up to EUR 36,000 per illegal worker and/or closing down the business), possible reduction and/or repayment of the benefit.

Since the beginning of 2010, voucher systems are being experimented under the name of “Alfachèques”⁴⁸, with “alpha-workers” (*alphahulpen*) as the home helpers who work for the care recipient. Instead of providing care in kind, municipalities distribute these vouchers to people entitled to

⁴⁵ Farvaque N., Structural frame - Overview of the personal and household services in the EU – Sweden, EC, 2013.

⁴⁶ EEPO, 2015.

⁴⁷ Renooy P., Labour inspection strategies for combating undeclared work in Europe: the Netherlands, REGIOPLAN, 2013.

⁴⁸ EFSI, White book on personal and household services in ten EU Member States, 2013.

Who benefits. According to the personal situation of the beneficiary, the municipality determines the amount of hours and vouchers that the beneficiary is entitled to. The personal budget granted is directly transferred to the beneficiary's bank account. With these vouchers, beneficiaries are supposed to receive the service from worker of their choice. However, the fact that its beneficiaries must prove afterwards how they spent their personal budget, leads to more administrative burden for both users and public authorities. In addition, Alpha workers do not benefit from regular rights and benefits. Last but certainly not the least, the use of Alpha workers is the way to reduce the LTC budgets.

In **Austria**, in 2007 the country implemented a legal framework to reduce an important undeclared immigrant employment in the PHS sector. The country has introduced the household services vouchers (*Dienstleistungsschecks*) in 2006⁴⁹. The user and the worker agree together on the wage while respecting a minimum wage set by the Act governing Domestic Help and Domestic Employees (*Hausgehilfen-und Hausangestelltengesetz*). By using the voucher, users fulfil all social insurance obligations on behalf of the worker. Since 2006, the household services voucher system has increasingly developed, and its introduction has contributed to formalise the contractual relation between employer and employee. Yet the impact of the voucher system should be nuanced⁵⁰. The reason would lie in their price: while the voucher nominal value amounts EUR 10, the undeclared black market of a domestic worker amounts EUR 7. Consequently the voucher is financially not interesting.

In the **Czech Republic**, it is estimated that 90% of activities (none-care activities) are done in the grey economy. As it is a grey economy, there is no relevant/official data. The workers have basically no rights as all agreements are oral and wage is paid in cash only⁵¹. In order to reduce undeclared work in the PHS sector, in 2004 the country has introduced the Law that establishes the definition of the illegal work, strengthens control mechanisms in the area, as well as introduces penalties against offenders⁵². In 2013 the country has also introduced a new system of undeclared work inspections.

In **Germany**, the direct employment relationship model results in a large percentage of PHS supplied by individuals, including undeclared workers. However, their number can only be estimated: according to various sources, informal employment in private households may reach 90-95% in Germany, which is particularly high when compared to other European countries⁵³. Workers from abroad illegally employed in the PHS sector are estimated to be 100,000. Several instruments have been developed to support the creation of formal employment in the PHS sector. The most important is the so-called "mini-job"⁵⁴ indicated above (see 2.1.1. Employment status). Yet, the fact that the home of beneficiaries/clients is

⁴⁹ EFSI, 2013.

⁵⁰ Farvaque N., Developing personal and household services in the EU - A focus on housework activities, Report for the DG Employment, ORSEU, 2013.

⁵¹ For quality! project, Third regional seminar Vienna, 22 September 2015.

⁵² European monitoring centre on change (EMCC), Tackling undeclared work, <http://bit.ly/1UPgwyp>

⁵³ POUR LA SOLIDARITÉ, 2012.

⁵⁴ Cools, F., Stokkink, D. (dir.), Maarten, G., Valsamis, D., 2013.

protected by law prevents the competent authority (i.e. customs administration) to control if the minimum wage and working hours are applied by households/employers or if a legal contract applies.

Migrant work

Migrant PHS workers are generally considered as foreign-born people, first-generation immigrants. They are often poorly paid and subject to undeclared work, social security premiums and taxes evasions. PHS sector in the countries at stake is undertaken to a significant extent by workers from migrant background. The number of migrants who provide care to elderly people in their own home is increasing. Also, many migrant domestic workers report cases of both psychological and physical abuse, including sexual abuse. With this growing phenomenon, it comes out more than ever as crucial to provide more support, including training, for migrants who find themselves in these often challenging roles.

In **Belgium**, migrant workers have a disadvantage even when they are regularly employed, such as under the voucher system. These workers, particularly the non-EU workers, have a higher turnover and need more time to find a job, and also hold more fixed term contracts⁵⁵.

In **Italy**, the legal status of migrant workers makes them very vulnerable. According to the current immigration law, the duration of the residence permit for employment is usually linked to the duration of the job contract and even in case of open-ended contracts the duration of permits cannot exceed 2 years⁵⁶. In 2012, 76.7% of domestic workers were foreigners (42% of which coming from Romania, Ukraine and Philippines)⁵⁷. According to the ILO, in 2011, more than 80 % of the registered 881,702 domestic workers were foreigners⁵⁸. The recent decrease can be explained by the fact that the crisis has hit harder the professional situation of migrants (mostly women), as well as that of Italian women, some of whom were somehow forced to return to the activity of paid domestic workers.

In **Spain**, nowadays the domestic sector “is not just highly *feminised* but also remarkably *foreignised*”⁵⁹. In recent years, the PHS sector has benefited from immigration policies, which have permitted the development of a regular supply-side. The situation was that, as some immigrants are illegal, some have to accept poor conditions in order to obtain legal employment that will allow them to obtain a residence permit. This is an obstacle because they tend to accept any type of employment relationship in order to obtain to survive and regularise their situation. In 2005, a massive regularisation of immigration was decided by the Spanish government that resulted among other things to a limitation of this kind of

⁵⁵ Farvaque N., 2015.

⁵⁶ Farvaque N., 2015.

⁵⁷ Istituto Nazionale Previdenza Sociale, Bilancio Sociale 2012, 2013

⁵⁸ ILO: Promoting integration for migrant domestic workers in Italy, International Migration Paper, 2013.

⁵⁹ León M., Migration and Care Work in Spain: the domestic sector revisited, 2010.

“strategy” (accept any job so as to obtain a residence permit). Almost 200,000 people, mainly women, were granted work permits in the household sector.

In **Finland**, according to statistics from 2009, the proportion of foreign citizen working in the social and health care sector is relatively small (3.4%), which is representative of the number of foreign people in the country. The type of jobs with the highest percentage of foreign people are cleaning (13%), kitchen helpers (4.9%) and hospital/nurses’ aides (4%). Foreign people are over represented in the lower echelons of jobs within the social and health care services sector⁶⁰.

So far, **the Netherlands** has been the case of exception in Europe: presence of migrant care work within both organisations and households is limited. However, the recent emergence of a market for migrant live-in care workers is the phenomenon increasingly considered as a possible future development of migrant care work⁶¹.

Migrant work is of particular importance in the **United Kingdom**. Every year around 17,000 non-EU residents enter the UK as domestic workers accompanying their employers (Gallotti 2009). The issue of migrant domestic workers is closely related to that of the informal employment of foreign workers. In April 2012 the immigration rules for domestic workers in the UK changed, and now only allow domestic workers to accompany their employers for a maximum of 6 months. Moreover, it is only possible to apply for a domestic worker’s visa if an individual has been working for the same employer for at least 1 year. This visa is non-renewable and domestic workers are not allowed to bring along family members. In addition, once in the UK, domestic workers are not allowed to change employers, as they were previously able to do. Organisations concerned with domestic and migrant worker rights as well as trade union organisations criticised this change in legislation move as a step back in terms of migrant workers’ rights.

In **Sweden**, an increasing proportion of the care workers in care of older or disabled people are foreign-born; in 2008, 18% were born outside Sweden (3% were born in other Nordic countries, 6% in Europe or North America and 9% in Africa, Asia or Latin America). In the metropolitan areas like Stockholm, more than 40% of the care workers are foreign born (Statistics Sweden, 2010). There is no active recruitment of care workers from other countries; the vast majority of workers born in other countries have migrated for other reasons, many as refugees.

In **Austria**, it is nowadays estimated that 80% of 24-hour care is carried out legally⁶². The data estimate the number of caregivers at 50,158⁶³, most of them residing in eastern-neighbouring countries (mainly

⁶⁰ Näre L., Ideal workers and suspects: Employers’ politics of recognition and the migrant division of care labour in Finland, *Nordic journal of immigration research*, 2013. <http://bit.ly/1ItjK7h>

⁶¹ Da Roit B., van Bochove M., *Migrant workers in long-term care in the Netherlands from a comparative perspective: a literature review*, Centre of expertise for Informal Care, 2014.

⁶² Farvaque N., 2013.

⁶³ VIDA, 2015.

Slovakia, Romania and Hungary) and working under the Austrian 24-hour care statutory regime for care. However, in order to perform tasks required by the 24-hour system caregivers must first undergo, at minimum 200 hours of training or have performed at least 6 months of lasting care for the user⁶⁴. Despite high levels of satisfaction, workers receive no vacations or sick pay, must be available for 24 hours to provide care, and often must leave their families behind for 2 weeks while they provide care.

For the **Czech Republic**, it was estimated in 2009 that 12% of irregular migrants (23,400 out of 195,000) work in the domestic sector⁶⁵. Besides, a lot of locals are employed as domestic workers.

In **Germany**, east-middle European carers are usually preferred because of their lower wage⁶⁶. The number of undeclared workers from Central and Eastern Europe are estimated at between 100,000 and 150,000⁶⁷. Other estimations are even higher: between 150,000 and 200,000⁶⁸, and up to 300,000⁶⁹.

2.1.2. Wages

Wage levels are directly dependent on working times, even though minimum hourly wages may be fixed by collective agreements or should stick to the national law⁷⁰.

In **Belgium**, the voucher workers' wage is fixed on basis of the collective agreement (EUR 11 gross hourly wage). These workers are entitled to full social protection: health, unemployment, family benefits, etc.

In **France**, there are 3 collective agreements in the PHS sector: one for non-profit associations, one for for-profit companies and one applying to direct employment. All these agreements apply and respect the national minimum wage: EUR 9.61 gross hourly wage, EUR 7.32 net hourly wage (January 2015). This amount corresponds to the first wage level in the collective agreement.

In **Italy**, there is no national scheme that guarantees a minimum income. At regional level, 8 Italian regions currently have a minimum income scheme. However, the national collective agreement for domestic workers is forethought in this regard: it classifies 8 levels of profiles, each one having a specific wage, ranging from A (domestic workers) to super D (trained and skilled family assistants taking care of dependent persons). The minimum monthly wage for personal assistants in cohabitation regime varies

⁶⁴ For quality! project, Third regional seminar, Vienna, 22 September 2015, report.

⁶⁵ Hamburg Institute of International Economics, 2009.

⁶⁶ Schulz, E., 2010

⁶⁷ Pennekamp, J., Geschäfte in der Grauzone. Faz-online: <http://www.faz.net/>: <http://bit.ly/1JsKLJp>.

⁶⁸ Caritas, <http://www.caritas.de/fuerprofis/fachthemen/migration/pflege-und-migration-in-europa>

⁶⁹ ver.di, ...raus aus der Schwarzarbeit, Gute Arbeit in Privathaushalten, p. 22., 2015.

⁷⁰ Farvaque N., 2015.

from EUR 789.81 (level B) to EUR 958.58 (level C-super), while in the case of non-cohabitation the minimum hourly wage is EUR 5.64 and EUR 6.64 respectively (figures 2015)⁷¹. The minimum wage levels indicated in the collective labour agreement are on average lower than the minimum levels in other sectors (for instance, minimum monthly wage in construction is EUR 833.21 for the cooperative sector).

In **Spain**, a new regulation (Real Decreto 1620/2011, de 14 de noviembre) covering working conditions for domestic staff in Spain entered into force on 1 January 2012. It affects approximately 700,000 workers, most of whom are women. The new regulation puts household workers on the same level as normal employees in many respects, such as wages and working time. With regard to the wage, the Minimum Interprofessional Wage, fixed annually by the government at EUR 641.40 in 2012, now applies to household workers and must be paid in currency rather than in kind.

In **the United Kingdom**, the wage in the PHS sector is not complying with the National Minimum Wage (NMW). The Living Wage (LW) is an hourly rate that is set independently and calculated annually. The current rate is GBP 7.85 per hour⁷². There have been a number of economic and social arguments made in favour of the living wage. For example, the LW has been shown to improve psychological health and wellbeing among employees and increase life expectancy (Public Health England, 2014). The Low Pay Commission has indicated that employers should (where possible) aim to pay the LW.

In *England*, the mean hourly pay rate for a senior care worker in adult domiciliary care is £8.36 and for a care worker the rate is £7.36. The national minimum wage is £6.50. There are wide spread concerns that through practices such as not paying for travel time, travel expenses, training or uniforms; some employers are in effect paying less than the national minimum wage.

In **Sweden**, there is no legal minimal wage. A collective agreement sets a minimum for each sector depending on qualification. For instance, municipal care employee with basic qualification earns EUR 1,820/month on average; municipal care employee with nurse qualification earns EUR 2,455/month on average⁷³; the collective agreement for personal service sector fixed a minimum EUR 1,778/month in April 2011⁷⁴.

In **Finland**, there is no minimum wage. However, the collective agreement in most of the employment branches determines the minimum wage and other minimum employment terms. According to the Statistic Finland and Association of Local and Regional authorities, the average pay level in the PHS public sector is EUR 2,534 euros per month (should be link with the Finnish high cost of living), with 200 working days per year, 2.5 visits per day and 7.25 working hours per day .

⁷¹ Lavoro e Diritti, CCNL Lavoro Domestico, minimi retributivi 2015, www.lavoroediritti.com/.

⁷² Rate from May 2015. In London the living wage rate is GBP 9.15 per hour.

⁷³ Figures from 2009. Source: report DG Justice.

⁷⁴ DGCIS. Étude sur les services à la personne dans sept pays européens, rapport final, 2011.

In the **Netherlands**, the Minimum Wage and Minimum Holiday Allowance Act (*WML*) requires payment of a minimum legal wage and of a minimum holiday allowance to every legally hired person. The law does not specify the number of working hours in a week. The usual working week consists of 36, 38 or 40 hours. In 2015, based on 40 working hours per week, the minimum wage has amounted EUR 1,501.80 per month, EUR 346.55 per week, EUR 69.31 per day, EUR 8.66 an hour⁷⁵. The minimum wage is lower if the worker is under the age of 23. A tax is included in these wages - approximately 30% of the wage - so the worker receives about 2/3 of the given wages⁷⁶. As concerns the PHS sector, the wages amount from EUR 2.200 to EUR 2.600⁷⁷. In terms of the social protection, the Dutch law subordinates every inhabitant to social insurance. Also those who work and pay income tax are insured. Employed persons have employee insurance by law (unemployment benefit, disability benefit).

In **Austria**, minimum wages are set in sector-specific collective agreements. These collective bargaining agreements set minimum wages by job classification for each industry and provide almost in each applicable agreement for a minimum wage of EUR 1,500 per month for 38 hours a week. The agreement *Mindestlohtarif für Hausgehilfen und Hausangestellte* set up minimum wages for domestic workers. With regards to occupations where no such collective agreements exist, wages are regulated by the pertinent law and are generally lower than those covered by collective bargaining. As regards the access to social protection, in the service voucher scheme, workers are not entitled to unemployment benefits, sickness benefits or future pension benefits. Workers whose monthly income does not exceed the threshold of EUR 512.36 (in 2011) are only insured against accidents. Workers may opt for voluntary health and pension insurance with a comparatively low monthly flat rate of EUR 52.78 (in 2011) per month. Workers whose monthly pay exceeds this threshold (only when the worker has at least 2 employers) need to pay social security contributions at the regular rates.

In the **Czech Republic**, workers in the social services are all bound to the §109 of Labour Act or wage. Their way of remuneration can be found in the register of social services providers, and their wage most often does not reach the average wage⁷⁸. In January 2015, the Czech minimum netto wage has amounted EUR 332 per month⁷⁹. In June 2015 the average gross wage has amounted CZK 25,306 (EUR 933)⁸⁰.

In **Germany**, as of January 2015, a cross-sectorial minimum wage of EUR 8.50 per hour came into force. Although the total number of mini-jobs fell by -3.6 % from December 2014 to March 2015, it seems to have affected minor employment in the commercial sector to a greater extent than that in private households⁸¹. However, as mentioned above, PHS being implemented inside the beneficiaries' homes, it

⁷⁵ Government of the Netherlands, <http://www.government.nl/>

⁷⁶ Wage Indicator, Netherlands 2015, <http://www.wageindicator.org/main/salary/minimum-wage/netherlands>.

⁷⁷ <http://www.wageindicator.org/main>

⁷⁸ Horecky J., PESSIS 2, 2013.

⁷⁹ Eurostat, 2015.

⁸⁰ Czech Statistical Office (CZSO), <http://bit.ly/1D2AxqR>

⁸¹ European Commission, EEPO, 2015.

makes it difficult for customs administration (responsible for the monitoring of the compliance with the minimum wage) to ensure that working hours of directly employed workers comply with their actual wage. In the care sector, a sectoral minimum wage applies. It is valid for outpatient nursing service companies and excludes activities of the non-care sector such as cooking, house cleaning, domestic economy or gardening. This is why, in 2015, the minimum wage in the care sector exceeds the general minimum wage by EUR 0.90 in old Länder and by EUR 0.15 in new Länder⁸². Employed care givers with (free) board and lodging earn on average between EUR 800 and EUR 1200.

2.1.3. Social protection and worker's rights

In **Belgium**, every worker is protected by the Belgian social security system in the following branches: sickness benefits and maternity benefits for accidents at work and occupational diseases, disability, old age benefits, unemployment benefits and family benefits.

In **France**, the workers in the PHS sector enjoy the same social protection than workers in other sectors. However, the low hours worked have led many of PHS workers to benefit from the Couverture Maladie Universelle (CMU) which is the safety net of the French social security system. Workers directly employed by users benefit of a system of relatively good social protection (pension rights, mutual insurance, etc.) managed by a specific branch organization (IRCEM).

In **Italy**, for personal assistants covered by the collective labour agreement, it is foreseen that, in case of illness, personal assistants keep their position for 10, 45 to 180 calendar days (+ 50% in case of oncological diseases) by length of service from 6 months – 2 years to minimum 2 years. During these amounts of time, remuneration is ensured - with a maximum of respectively 8, 10 and 15 days per year - as follows: 50% of the remuneration is foreseen until the third consecutive day; 100% of the worker's remuneration is provided from the fourth day on. Social care operators being usually employed the public administration or by cooperatives enjoy better employment conditions, which can be assimilated to that of public workers or social workers, depending on whether they are employed by municipalities directly or through cooperatives.

In **Spain**, a new regulation (Real Decreto 1620/2011, de 14 de noviembre) covering working conditions for domestic staff in Spain entered into force on 1 January 2012⁸³, affecting approximately 700,000 workers, mostly women. The new Royal Decree puts household workers on the same level as normal employees in many respects, such as wages and working time.

In the **United Kingdom**, if care workers are employed by local authorities, the NHS, national charities or

⁸² European Commission, EEPO, 2015.

⁸³ Eurofound, New regulation improves rights of domestic workers, 2012, <http://bit.ly/1LlhsTs>.

some of the larger Care home providers they will be covered by collective bargaining arrangements, whether nationally or locally. However outside of these it is unlikely whether there will be collective bargaining even if there is a trade union presence within the workforce. In *England*, in 2012 the government introduced new pensions legislation. One of the requirements of this legislation is that all employers automatically enrol certain employees into a workplace pension. People who are Individual Employers employing Personal Assistants will have to consider whether their Personal Assistants qualify to be automatically enrolled into a workplace pension. Each employer will have a staging date which is the date that the new duties first apply to them and these begin coming into effect on 1 June 2015.

In **Sweden**, one particularity is the high share of public employment and the importance of municipal employees in the care sector. Working conditions are relatively good, with employment and social protection relationships.

In **Finland**, any legal employee is entitled to social protection. Furthermore, Finland has a well-developed social dialogue system. In the personal care sector, workers are represented by the Union of Health & Social Care Services (Tehyry) and the Finnish Union of Practical Nurses (Superry). Domestic workers are organised by the Service Union United, PAM. In most cases, private client would buy cleaning services from companies which will send a worker to their house. This employment relationship has been covered by collective agreements since a long time. The current agreement, which will be valid until January 2017, has been negotiated by PAM and the Association of real estate employers. According to the trade union PAM, it is unusual for a private household to hire directly a domestic worker. Therefore, this kind of employment relationship is not covered by any collective bargaining agreement.

In the **Netherlands**, the Collective Agreements Act (the AVV Act) states that the Minister of Social Affairs and Employment is allowed to declare collective agreement provisions agreed in a sector between employers and employees, provided that the Minister considers the rules essential for the majority of persons employed in the concerned sector⁸⁴. This is illustrated by the collective labour agreement for temporary agency workers, which was negotiated and agreed for the 2012-2017 period.

Regulations on “services in the home” (*Regeling Dienstverlening aan huis*) contain provisions excluding employers from the duty to pay social security contributions and taxes if the domestic worker is employed for only 3 days a week or less. It is the worker’s responsibility to pay social security and declare taxes (domestic workers are not automatically included in the social security system)⁸⁵. The regulations also provide for a maximum of 6 weeks of sick leave whereas the norm in the Netherlands is two years.

Elderly and disabled persons can employ so-called “alpha workers” (*alfahulpen*) to assist them with domestic tasks, who are exempted from social security coverage and do not benefit from the same labour rights as regularly employed persons.

⁸⁴ Regioplan, 2013, *ibid*.

⁸⁵ EFFAT, 2015.

The different domestic worker groups are represented within the “cleaners’ committee” of FNV and have formed a domestic workers “organising committee”. They run a campaign for the ratification of ILO Convention 189 by the Dutch Government, which would entail a reform of the domestic work sector in the Netherlands to allow domestic workers the same rights as other workers.

In **Austria**, the Equal Treatment Acts (*Gleichbehandlungsgesetz*) prohibit discrimination on the basis of “ethnicity” in the areas of employment, social protection, social benefits, education, access to goods and services and the provision of goods and services available to the public, including housing, and, in the field of employment, discrimination on the grounds of beliefs or religion⁸⁶.

Furthermore, Austrian trade unions have been actively organising domestic workers, improving their working conditions and defending their interests and rights. In Austria domestic workers are represented by the trade union Vida (trade union for transport, social, personal and health care services, and private services)⁸⁷. 24-hour care workers are organised in the trade union GPA-djp (union of private employees, and employees of the print and journalism sectors)⁸⁸.

Regularly employed workers automatically become members of the Chamber of Labour (*Arbeiterkammer*); the membership includes approximately 11,800 domestic workers. Since the Chamber of Labour only represents employees, 24-hour care workers who are typically self-employed in Austria, do not belong to the membership.

Ensuring compliance with laws and regulations in the domestic work sector is a major challenge as the workplace is a private home, which often places limitations on inspection visits to households. Labour inspectors in Austria only have a mandate if an agency or institution employs the domestic worker, not if the private household employs them directly⁸⁹.

In **Germany**, all active people (defined as people who work more than 15 hours a week, e.g. *geringfügige Beschäftigung*) are legally obliged to subscribe to social insurance schemes; this makes coverage almost universal. Membership of a care insurance scheme is compulsory for people with sickness insurance coverage. All support for carers in Germany is provided through the long-term care insurance scheme. Thus informal carers’ access to support is entirely dependent on the insurance entitlement of the person receiving care. The benefits provided to informal carers include: respite, holiday or stand-in care, technical aids (such as home nursing equipment), or insurance cover (retirement pension and accident insurance for informal carers)⁹⁰. The LTCI funds may even pay their pension contributions; the conditions are to provide care at least 14 hours per week and to be unemployed or to work less than 30

⁸⁶ European Commission against Racism and Intolerance (ECRI), ECRI Report on Austria, 2010.

⁸⁷ Trade Union VIDA, www.vida.at

⁸⁸ EFFAT, 2015.

⁸⁹ EFFAT, 2015.

⁹⁰ Cools, F., Stokkink, D. (dir.), Maarten, G., Valsamis, D., 2013.

hours per week. As for self-employed carers or carers employed by a company or non-for-profit organisations, they pay social and pension contributions and therefore benefit from it.

When it comes to people employed under a mini-job contract, social contributions, although they are reduced or null for the employee (thanks to a higher contribution from employers), remain compulsory under the mini-job scheme. Nonetheless, this status alone does not entitle workers to the social security; another job can entitle mini-jobbers to social security, where contribution from their mini-jobs can be aggregated. Yet, at the end of 2011, the major part of mini-jobbers (i.e. 5 million workers) only had a mini-job. Some of them received other revenues such as retirement or unemployment benefits. Besides, workers have the possibility to pay the complement for their pension contribution (13.9% in the case of PHS), but this is not compulsory. One can easily conclude that the structure offered by the mini-jobs does not constitute a solid safety net for PHS workers in terms of social protection and retirement pension. As a consequence, a significant share of mini-jobbers shall lack pension entitlements in the future⁹¹.

In the non-care sector, collective agreements are traditionally set between the employee representatives (*Gewerkschaft Nahrung Genuss Gaststätten* or Trade Union Food Pleasure Restaurants) and the employer representative DHB (*Netzwerk Haushalt* or DHB, Network Household). They would be binding if 50% of employers were members of the DHB, but this is not the case. Even if those collective agreements, originally set by sub-sector, have been extended to the whole sector, most workers in the non-care sector are not covered by a collective agreement. Thankfully, the new 2015 legislation ensures that all workers are now covered by the EUR 8.50 statutory wage⁹².

2.2. Skills development and professionalisation

As observed by Nicolas Farvaque (2015), measures to improve working conditions cannot but go hand in hand with measures to improve the professionalisation of workers, in order to create and insure a better quality of service. In the present context, the term ‘professionalisation’ should be understood as improvement of skills in the PHS sector, in both descriptive and normative senses⁹³: the term can be used to describe the state of play of the supply and the demand for training, the skills needed, the recognition of qualifications, etc. but also to point out the fact that PHS activities are provided more ‘professionally’; from a normative perspective, professionalisation also refers to initiatives and measures taken to ensure that workers are better qualified, in order to improve employment and services qualities.

The rising trend of PHS workers is expected to continue in the coming years, in all the countries at stake. The sector provides opportunities for a greater number of jobs, especially for the better-qualified workers,

⁹¹ European Commission, European Employment Policy Observatory (EEPO), June 2015.

⁹² European Commission, EEPO, June 2015

⁹³ Farvaque N., 2015.

and all countries clearly share a common consciousness of the importance of qualifications. A large majority of the labour force is female and there is a common opinion that being employed in domestic services is not a serious profession. The offer of jobs in the PHS sector is generally insufficient relative to demand, particularly due to the lack of skilled labour, a high turnover, and still too low use of new technologies for the development of new services and for matching supply and demand. Yet, it also comes clearly out that the PHS jobs require specific skills, technical and/or relational, that are underestimated.

In **Belgium**, if certain professions such as household or senior aid are framed legally, others such as home help or polyvalent workers are much less. The service voucher workers must not have a specific qualification in order to work. The training, however, has shown its importance and therefore steps have been taken since 2007 to facilitate access to training for service voucher workers.

- Regional training funds (*Fonds de formation régionaux*) which replaces the Federal training funds (6th State reform) and aims at increasing the training level of service voucher workers. Enterprise may organise internal or external trainings for their workers, in relation to the tasks that they have to perform.
- Sectoral training fund (*Fonds de formation sectoriel, Form TS*), created in 2009 by the social partners of the sector. Any company under the Joint Subcommittee 322.01 must provide a collective training of 12 hours per full-time equivalent contract. The trainings focus on the following themes: ergonomics, customer relations, ironing, work organisation at the user's place, product knowledge, health and safety.

For care and assistance to families and dependent persons, caregivers must be holders of a recognized diploma (regular or social advancement education) or in Authorised Training Centres. Confirmed caregivers have the opportunity to become mentors for new workers.

In **France**, a huge majority of PHS workers has low qualifications. A challenge is therefore to develop trainings. Many service provider organisations have adopted a strategy of professionalisation, promoting the training of some of their workers. The major degree used in home services currently, the auxiliary social state diploma (DEAVS) can be obtained through vocational training and validation of acquired experience. This professionalisation has an impact on the wage structure. In the area of health care provided in the home of dependent people, intervention prices are fixed by public conventions. These rates do not necessarily include the cost of training and professionalisation; also many structures face budgetary pressures. This is why many organisations do not encourage training since it represents an important expenditure. It also to be mentioned that access to training is more difficult for employees directly employed by private employers.

In **Italy**, although social care operators (level super D) must be trained to be employed as such, there is no specific compulsory training for personal assistants (unqualified generic caregivers) working in the household services and long-term care sector. The 328/2000 law has led to the creation of various professions. Social care operators now have a national regulation, whereas their training is regulated at

regional level. This implies differences in terms of training, and thus the quality of jobs and services.

In 2007, the collective agreement for domestic workers introduces the possibility for a specific category of workers to follow training: it enables domestic professionals working fulltime with an open-ended contract and having worked for more than 12 months for the same employer to enjoy 40 hours per year to access specific trainings. The latest collective agreement (2013) includes trainings that are necessary for foreign workers to renew their residence permit.

In **Spain**, the 2006 Dependency Law has put the emphasis on the importance of qualification and professionalisation of the workforce, as a means of developing employment in the sector. It is expected that the number of medium-qualified jobs will grow in the fields of social services, home care, cleaning and care services for children and for elderly people. However, according to the actors participating to the workshop organised in the context of this project, an important step will be to better define and delimitate the different jobs and occupations in the care sector. This will help to better define the necessary conditions to occupy the job, as well as the content in terms of training. Several regulations and programmes have been approved in recent years in order to develop qualification and training:

- New Vocational Education and Training programmes have been approved.
- After 2009, a new procedure has been set up for evaluating and accrediting competencies acquired through work experience or non-formal methods of training. Workers who accredit their work experience receive a professional certificate (*certificado de profesionalidad*). Workers in the community care services sector can obtain a professionalism certificate in ‘social and health support for dependent persons in households’, based on their particular work experience.

Professional certificates, regulated by Royal Decree 34/2008 of 18 January, are nowadays the instrument of formal accreditation of professional qualifications in the National Catalogue of Professional Qualifications in the field of labour administration.

In the field of domestic jobs, currently there exists one professional certificate, but it is not compulsory for the moment to occupy a job, it only depends on the employer’s will. However, from January 2016, it will be required for domestic workers to have this professional certificate.

The development of lifelong learning and the use of “professionalism certificates” i.e. recognition of prior work experience are seen as new tools for solving the problem of lack of professionals in the sector. Employers have difficulty finding professionals with broad knowledge and experience and feel that these certificates could help to improve workers’ qualifications (Eurofound, 2013).

In **Finland**, the Act and Decree on Qualification Requirements for Social Services Professionals (272/2005) regulates qualification. Within the home care services sector, qualification requirements can be considered as quite strict and high level and usually vocational training last 3 years. However, as these

restrictions can be considered as an obstacle for the development of the sector. Therefore, current Government negotiations have been suggested that the three mandatory years of Vocational education should be shortened to 2 years⁹⁴.

Concerning the household services sector, several efforts and initiatives have been done to develop the professionalisation of the sector. In 2000, a 3-year competence-based basic vocational qualification in household and consumer services was established as part of tourism, catering and home economics sector (ISCED 3), meaning that the qualification can be archived through the validation of acquired experience and with skills demonstrations. In 2010, this qualification was integrated with Cleaning Service Qualification (200 people were qualified people in 210-2012). It is also possible to follow a further Qualification in Household Work Services (240 people were qualified in 2012)⁹⁵. These qualifications are strictly differentiated from social and health care qualifications.

Concerning personal care services, training programmes for home helpers and assistant nurses were merged in 1993, resulting in a new 3 years vocational training programme (or a 2 year programme for secondary school graduates) and a new occupational title called 'practical nurse' (*lähihoitaja*). Practical nurses have the goal to help, guide and support the users to cope with their daily life. In this integrated home care system, it is now often the same person that performs both the home-help activities and the home nursing tasks. However, this system creates disagreement between health care professionals and social care professionals. Health care professionals are reproaching to social care professionals a lack of adequate medical expertise and social care professionals regret the focus made on medical treatment⁹⁶.

In **Sweden**, for home-care workers, publicly or privately employed, there are no mandatory qualifications, other than what is stated in the Social Services Act: that staff have 'suitable training and experience'. Of all eldercare workers (those employed by the hour excluded), 73% had some kind of vocational training in 2007; slightly more in residential care and less in home care (NBHW, 2009b). The relatively low training level is an issue for policy makers. In recent years, several State subsidies have been offered to the municipalities in order to encourage them to provide training for already employed care workers and thus raise their vocational skills. However, for the moment there are no plans to introduce minimum standards for formal training.

Just over three-quarters (76%) of Swedish care workers have at least one year of formal training. This is a partial reflection of the fact that the majority (70%) of the Swedish care workers are assistant nurses (AN). However other figures mentioned in the ENEPRI report indicate that 70 – 75 % of the total labour force has specific occupational training in LTC today. This is an increase with 10% compared to 10 years ago. The proportion of staff with post-secondary school education has not changed in the last 10 years and is about 13 – 15 % of the labour force.

⁹⁴ Jokin E., *op.cit.* p11.

⁹⁵ *Ibid.*

⁹⁶ Kröger T and Leinomen A., *op.cit.* p134.

All in all, the lack of targeted qualifications for LTC staff can pose challenges to the quality of services according to OECD. There are no requirements or qualifications for LTC workers, nor are there national standards for workforce qualifications. It is often up to the municipality to establish a training programme. Many workers therefore may face constraints at work when lacking a minimal training.

There are some initiatives to develop and upgrade employees' skills. In 2012, the National Board of Health and Welfare (NBHW) provided recommendations on staff qualifications for basic elderly care (to be equivalent to a 3-year secondary school health care programme) and for specialised tasks such as dementia care, mental illness etc. Participation by municipalities remains on a voluntary basis. In 2011 the Swedish government began the Omvårdnadslyftet, a 4-year education initiative to improve LTC staff competencies. The focus was put on workers with no formal education. The municipalities were given monetary incentives to participate (reward given to those that have raised competence levels to a certain degree). 10,000 employees have been trained under this initiative since its launching.

In terms of professions, the vast majority of the employees are care workers (assistant nurses, nurse's aides or personal assistants). The 2 largest occupational groups in home care are assistant nurses (*undersköterskor*) and nurse's aides (*vårdbiträden*). They are supervised by home care supervisors (often social workers with university training) and registered nurses, supplemented by occupational therapists and physiotherapists on a more consultative basis. Assistant nurses typically have 2 or 3 years of upper-secondary nursing training which they may have acquired before starting to work as care workers or they may have received the training as part of their job, paid by the employer (the municipality). Nurse's aides have a shorter education, often provided by the municipality. In comparison to the other Nordic countries, the Swedish home-care workers have much less contact with a supervisor – only one third of the Swedish workers have a meeting with their supervisor at least weekly, compared to two thirds in the other Nordic countries taken together.

In the **United Kingdom**, the skill levels of the homecare workforce are generally low. However, employing agencies are now required to have specified levels of qualified staff. National Care Standard 20, relating to the competency and training of staff, specified that by 1 April 2008 50% of all personal care was to be delivered by workers with National Vocational Qualifications (NVQ) or equivalent. Skills and qualification levels are therefore slowly increasing, with most staff having or working towards NVQ qualifications acquired through on-the-job learning and assessment. Newly appointed home care workers without relevant qualifications must register for NVQ training within 6 months of starting employment. However, up to the end of March 2007, between a fifth and a quarter of registered home care agencies had not met this qualifications standard. In 2008, only 32% of care assistants or home care workers had gained NVQ level 2 and a further 27% level 3 (the 2 lowest levels) or above. From January 2011, NVQs have been incorporated into a Qualifications and Credit Framework (QCF) that enables people to gain qualifications at their own pace along flexible routes and allow a 'mix and match' approach to meeting the different development needs of the workforce.

There are few workers in domiciliary care with professional (e.g. nursing) qualifications. Three-quarters of the domiciliary care workforce work as care/senior care workers providing direct, hands-on personal

care and only 3% have professional roles (the rest being managerial or supervisory positions). A Care Certificate has been introduced into this sector in England during 2014.

In *England*, professional roles accounted for 6% of all jobs in adult social care jobs. This group includes several rather different jobs, which have in common the requirement for a professional qualification. The jobs included in this category are social workers, occupational therapists, registered nurses, allied health professionals and teachers. There is evidence that employers may be filling (either now or in the recent past) a skills shortage of registered nurses in England by recruiting from abroad.

In *Northern Ireland*, the NISCC 2014 report on the Qualification Profile of the Social Care Workforce in the Independent and Voluntary Sectors in Northern Ireland showed that 5.6% of staff in conventional domiciliary services holds a social work, nursing or allied health professional qualification.

In the **Netherlands**, the community-based care is a sector with increasing demands for quality and skills. The skills that will be relevant for the future are influenced by several phenomena, especially: shifting care from institutions to people's homes, the use of new technologies and the use of different diagnostic techniques.

The new health professional works in various care areas and in varying settings, and he-she works as a generalist. The most important skill is to "deescalate": professional attention is always focused on functioning of citizens in their own environment as independently as possible. Thus after treatment, surgery or temporary takeover of function the concern is focused on return of citizens to their own home or environment.

Regarding the qualifications of care and domestic workers, the Netherlands has educational requirements for nurses. Their training takes 3 to 4 years. Nurses require continuous recertification that involves additional training or passing a test every few years. Specialisation (or postgraduate education) is possible for nurse specialists.

With regard to training, here is no national training or upgrading policy for PHS in general. However, there are few local development initiatives in the supply of personal services. For instance, in Tilburg, people over 55 years old may use the home care service area "WoonZorgService in Wijk" (WZSW⁹⁷ using "service vouchers"). This initiative combines assistance to seniors with a tool for reintegration of the unemployed into the labour market. After training, the latter can establish themselves as self-employed in the PHS sector. For this type of local initiative, municipalities are free to use the financial resources of benefits (social and unemployment) they have. The Ministry of Labour and Social Affairs has shown interest in developing these initiatives by commercial enterprises at the national level.

Furthermore, high unemployment rates are making the sector more attractive to work in, while the increasing emphasis on labour market measures may succeed in boosting recruitment. In this regard, it is

⁹⁷ Woonzorgservice in de wijk (WZSW), <http://www.wzsw.nl>

worth to mention the Dutch innovative strategy to recruit and retain employees: *the use of telecare*. Video networks enable home-care clients and home-care providers to contact each other by use of a camera and a screen. A home-care provider can be contacted at any time, day or night. This was expected to heighten clients' sense of safety and independence and intended to substitute in part for home visits by home-care providers⁹⁸.

As in most European countries, **Austria** is subject to a general shortage of staff in the PHS sector. The demand is mainly rising for elderly care workers, home helps and social workers. Career advancement prospects in care for persons with disabilities are very good for qualified workers.

In the long term, it is expected that the shortage of home care workers increases, especially in the group of qualified workers⁹⁹. With regard to the household services, it is likely that the demand for domestic workers will continue or even increase, yet public provision of services is reduced¹⁰⁰.

The demand for nurses will increase with upcoming retirements in the coming years. Therefore, training in the PHS sector needs to be promoted and made more attractive. A professional transition in the nursing field or promotion to a higher nursing profession often requires qualifications which cannot be acquired while working as a majority of the interested persons cannot afford a vacation due to the associated loss of income¹⁰¹.

In **the Czech Republic**, the PHS sector is a sector with increasing demands for quality and skills. Shifting care from institutions to people's homes and the use of new technologies influence the skills that will be relevant for the future. There a need for general high quality workforce in the sector¹⁰².

In terms of qualifications, Jiri Horecky portrays four professions with their qualifications requirements¹⁰³: nurses (compulsory university degree), social workers and ergotherapists (secondary upper school and higher education in the field, combined with 200 hours expert course), workers in the basic social care provision (basic education combined with 150 hours expert course), and management/technical staff (qualification requirements given by special laws).

In **Germany**, according to the Federal Statistical Office (2015), most outpatient nursing service companies employed trained nurses or nurse assistants in 2013. For PHS services, the high training costs keeps outpatient nursing companies from training their employees, who usually get trained by inpatient care companies before changing for outpatient care services.

⁹⁸ European Observatory on Health Systems and Policies, 2012, *ibid*.

⁹⁹ Eurofound, *More and better jobs in home-care services*, 2013.

¹⁰⁰ EFFAT, 2015.

¹⁰¹ VIDA (Trade Union, Die Gewerkschaft), 2015.

¹⁰² For quality! project, Third regional seminar Vienna, 22 September 2015, <http://forquality.eu/>

¹⁰³ Horecky J., PESSIS 2, 2013.

In the case of non-care services, the skills required are often under-estimated: language, manners, thoroughness, flexibility, ability to work independently and to adapt to increased physical burdens, etc. A 3-year training exists (for ‘trained housekeeper’ or *Hauswirtschaftler*) that, according to experts, does not correspond to the soft skills needed for such a position. Less than 8,700 persons were trained as housekeepers by such companies in 2013. It has to be noted that, in Germany, unemployment strikes trained housekeepers more heavily than other professions in average.

Regarding informal care givers, they are entitled by LTCI funds to receiving free training courses. Landers are in charge for training the workforce engaged with vulnerable people. In 2003, the country standardised the vocational training for older workers by federal law. Thus, Länder no longer regulate the training themselves. As of now, they are only responsible for the implementation of training.

2.3. Health and well-being

Countries at stake converge with the observation that many PHS workers do not feel well at their work and are not satisfied with their working conditions: PHS workers frequently stipulate that they ‘usually have too much to do’, that they are ‘unable to respond to the needs of the users’, as well as that they ‘consider seriously leaving their work’. Also, some initiatives to promote health and well-being in the sector have been detected in the countries observed.

In **Belgium**, the Royal Decree of 28 May 2003 on the monitoring of workers’health regulates in general the tasks and duties of the employer and the occupational prevention consultant/labour doctor concerning medical mandatory examinations in the context of occupational medicine. The regulations concerning the welfare of employees in the performance of their works are explicitly set out in Article 9 of the Royal Decree of 12 December 2001 on the voucher-services system: the licensed company must always, as the employer, comply with obligations related to the well-being of workers, including the safety and health of workers during the execution of their work, and avoid the risks associated with it. This means that the licensed company, as the employer, bears the ultimate criminal liability concerning the application of the regulations on the well-being at work. However, when the work is done at the particular user’s home, it is the user who first determines working conditions. Yet there is no direct legal relationship between the two parties.

In **France**, the PHS jobs are highly exposed to psychosocial risks and emotional factors. The work organisation can hardly intervene in the prevention of such risks but often offers places for exchanges where workers can express their difficulties or their concerns. It can also combine highly demanding activities (e.g. with highly dependent persons) with less demanding activities (such as cleaning) to offer workers a lifeline. Employees hired by private employers are often more isolated. Since 2011, they should have access to occupational medicine. However, only full-time workers are concerned. Employees of service provider organisations are nevertheless better monitored by the occupational medicine. Another problem is that the occupational health and safety inspection cannot control the current job at user’s

home.

The harshness of PHS jobs is also linked to the fact that employees work from multiple employers to achieve a full-time work. The combination of these contracts creates risk situations for the health of employees.

In **Italy**, in average, domestic work involves 6 thousand injuries per year. However, in 2008, 35,763 work-related injuries have been registered by domestic workers, 2 of which were mortal. This shows a deficit in terms of prevention.

The isolation of worker can be very important when co-habitation arrangements are made between the employer and the employee, in particular in the case of immigrant women moving alone to Italy to find domestic work. The chronic emotional pressure that the very nature of long term care work implies as well as the lack of instrument compared to residential institutions for long term care - can result in a reduction in the quality of personal assistants' work and easily lead to a deterioration of their health. The fact that personal assistants rarely attend training courses about safety at work contributes all the more to this result.

In **Finland**, all employers are required by law to arrange occupational health services for their employees. Self-employed people can arrange access to occupational health care on a voluntary basis. Employers, as well as self-employed people can purchase occupational health services from a local authority health centre or private service supplier¹⁰⁴. Employers have to provide documentation of the work schedule, listing rest periods and overtime hours to the health and safety authority. This information has to be reachable by workers or their representatives, who can ask for a report based on these records¹⁰⁵.

In the **Netherlands**, the Inspectorate SZW works for fair, healthy and safe working conditions and socio-economic security for workers¹⁰⁶. Studies show there are reasons to consider work in the Dutch private care sector as precarious work. Private domestic work remains often undeclared¹⁰⁷. For instance¹⁰⁸, for household services anyone outsourcing any form of work in the home for 3 days a week or less is exempt from paying social premiums and deducting taxes and from dismissal permit requirement.

In **Austria**, some recent studies showed that a huge majority of informal carers feel that caring represents a heavy burden. The most important stress factors confessed are responsibility, hopelessness and feeling overtaxed¹⁰⁹. It comes out from the recent trends that at least a third of carers feel unable to quantify their

¹⁰⁴ Ministry of Social Affairs and Health, characteristic of the social security system in Finland, Brochure 8ng, 2013.

¹⁰⁵ EFFAT, *op.cit.*, p19.

¹⁰⁶ Inspectorate SZW, <http://www.inspectieszw.nl/>

¹⁰⁷ European monitoring centre on change (EMCC), Regulation of domestic work, Netherlands, 2009.

¹⁰⁸ Van Walsum S., The (Non)regulation of Domestic Work in the Netherlands, International seminar from 29 March 2010.

¹⁰⁹ Riedel M., Kraus M., ENEPRI research report n°69, 2010.

working time¹¹⁰: it is particularly difficult to determine when both user and carer live in the same house (24-hour care) or when the user needs more supervision than care.

In the **Czech Republic**, results of a study on 'Stress, depression and life style in the Czech Republic' conducted in 2015 indicate that signs of depression, burnout and stress are relatively common among the Czech workers¹¹¹. It is notably the case in the PHS sector, and there are reasons to consider work in the private care sector as the precarious one. Furthermore, the practice of multiple job holding is widespread and usually perceived as an additional source of income. As most of the informal PHS workers already work full-time, they face the problem of availability, in order to be able to provide home care for their older persons.

In **Germany**, the jobs of home care giver/domestic worker are known for their high physical and emotional demands and control is made difficult in particular by the high level of informality of the sector. Working conditions vary greatly from one patient to another; the facilities (lift aids, special beds, etc.) provided in the users' houses are not all equal. It is also reported that the nature of the job gives few possibilities for home care givers to discuss job matters. This can somehow create a feeling of isolation.

3. SERVICE QUALITY

Quality is a, if not the, key element of PHS. Despite the efforts of the social partners to professionalise the PHS workforce, the review of the situation in 11 countries at stake shows that the issue of quality is still much alive today, and that it is an essential ingredient for further development of the PHS sector.

3.1. Availability, affordability and comprehensiveness of services

The principle of universal access to PHS services for people in need of care and assistance may be inspired on basis of the one stated by AGE Platform towards older persons in the need of care: they should be provided either free of charge or at a price which is affordable to the individual without undue compromise to their quality of life, dignity and freedom of choice¹¹². Also on basis the AGE Platform statement, such services and assistance should be easy to access by all those who may require them¹¹³.

In **Belgium**, to ensure high availability and accessibility, support services for families and dependent

¹¹⁰ Riedel M., Kraus M., 2010.

¹¹¹ Eurofound, European Observatory of working life, Czech Republic: new study investigates causes of stress among Czech workers, 2015, <http://bit.ly/1hjFDuR>

¹¹² AGE Platform Europe, WeDo quality principles, 2010-2012.

¹¹³ AGE Platform, *ibid.*

persons are subsidised on a flat-rate basis by delegating powers. For each authorised service, an annual quota of hours of activity (*le contingent*) is fixed, on basis of which grants are awarded. The grant covers staff costs, operating costs, meeting and training time. Access to these services depends on user's needs, which are valued at an annual social survey and following several criteria: family composition, degree of dependence, frequency and mode of intervention, income, resources, expenses) and should be given priority to those in the highest physical, psychological, social and financial need. The recipient must contribute to the aid which is calculated according to a schedule established by the Ministry, according to its financial condition and family burden.

For housecleaning services, all residents in Belgium may access the service voucher system, if these needs do not exceed the regulatory framework of the system.

As regards the comprehensiveness of services, in general, the 3 Belgian regions have set up support services networks and home assistance for families and dependents at local and regional level through centres that coordinate these services. This coordination tends to bring added value in relation to a series of home services performed separately by different professionals to meet comprehensively the beneficiary's needs. It is the role of the coordination centres of care and home help (CASD) or home care services (DSS).

In **France**, there are 2 main components regarding services quality:

- The tariff system chosen by the organisation or unit distinguishes the conditions relating to quality. If the fee is controlled by the government, the organisations and units must be authorised; if it is set freely (but with monitored development), the organisations and units must be accredited.
- In parallel with these obligations, the organisations or units voluntarily and increasingly have recourse to certification procedures. The government links these voluntary steps to a quality policy that it defines, since certification can replace compulsory accreditation procedures.

In **Italy**, the regulation of personal care services is embedded in the national legislative framework and, at the same time, is divided on a legislative level depending on local areas. This raises questions of equal access to such services from one region to another. Indeed the main problem with decentralisation is the relation between expenditure and the financing of the services; the poorest regions have more difficulties in financing the services¹¹⁴. The differences among regions in terms of funding levels also imply differences in terms of structure and quality and comprehensiveness of the services provided. Besides, the high increase in the number of personal assistants is due to the growing number of older people who need help and care, to household's reduced resources and limited public intervention responding only to the most severe situations.

In **Finland**, since 2005, home care has become more and more selective and directed toward "*the oldest*

¹¹⁴ Réseau européen des Services à la personne à finalité sociale, Personal Care Services in Europe – Synthesis, 2009

of the old and the frailest of the frail". Most of the people under 85 years old are often excluded from the access to publicly provided services, informal care excluded, if the elderly have a family member to lie on¹¹⁵. As informal care has been institutionalized, it has become the prevailing alternative for older people who do not need intensive help. It is creating disparities between users as older people who are not entitled to public care services have to find alternative solutions (either services depending on market-based mechanisms or informal care provided by family members). From the point of view of family carers, the recognition of informal care is perceived as a positive development. However, it is not efficient for the moment as the coverage allowance is still limited, the benefits are low and the days-off system is complicated to put in place in practice.

In the **Netherlands**, in terms of availability of services, geographically, the country offers a dense network of home care. Thanks to benefits in service or personal budgets, the Dutch people can choose the providers and even the type of care, unless there is a shortage or even absence of providers. Clients also have the opportunity to influence the quality of care, as they are given the chance to complain.

The European Observatory on Health Systems and Policies points out many initiatives launched in order to raise clients' awareness on the home-care services availability. For instance, special info centres in municipalities and a national-level website were set up to inform people where and how they can apply for care¹¹⁶.

It is worth mentioning that the LOC Voice in Healthcare¹¹⁷ represent the interests of an important number of people in need of care. This organisation gives the say and participation in healthcare as well as in general life to about 600,000 clients.

In order to defend fair competition among PHS providers, the country has created the Healthcare Authority (NZA). This organisation ensures the positive effects of competition through the prevention of monopolies or abuse of market power by providers or insurers. A strategy is now in place to systematically communicate information about the quality of available services and providers to service users and informal carers¹¹⁸. Transparent comparison aims at helping the service user to make informed choices for care, as well as stimulating care providers to provide quality care. Organisations are required by the NZa to compile their data on quality and on efficiency and make reports available.

Transparency is one major aspect, but comprehensiveness of services also includes how far the government supports a varied range of services and the development of integrated services (health and social), with comprehensive assessment of needs and adaptation to the needs (for a person centred care). The Dutch government does not provide this kind of support, but the support is increasingly being

¹¹⁵ Kröger T. and Leinomen A., *op.cit.* p130.

¹¹⁶ European Observatory on Health Systems and Policies, 2012, *ibid.*

¹¹⁷ LOC Voice in Healthcare, www.loc.nl

¹¹⁸ INTERLINKS, Quality management and quality assurance in LTC, European project INTERLINKS, 2010.

provided by municipalities. For instance, Eindhoven uses the system with "ranking stars"¹¹⁹.

In **Austria**, with regard to availability of PHS services, the country offers a wide range of services in order to provide persons with an appropriate response to their needs. It is especially possible thanks to both federal and Länder care allowance programmes, which are designed to enable the free choice among different options. One of them is the informal care: this kind of care traditionally plays a very important role in the PHS provision, and it can be financed by care allowances.

However, some regional disparities have emerged between 9 Austrian Länder. Indeed, formal care sector is still growing and this has resulted by tangible differences between Länder in terms of availability of services. This is especially the case of services to support informal care-giving, such as counselling and respite care¹²⁰.

The Article 15a B-VG of agreement for dependent people from 1993¹²¹ states that Länder are required to develop demand and development plans (*Bedarfs- und Entwicklungspläne, BEP*) for an adequate and comprehensive system of institutional, semi-institutional, and home-based care services with full geographical coverage, observing minimum standards¹²². Yet, the binding force of this agreement is rather limited as there is no specific penalty in case of non-compliance with the agreement¹²³. This agreement contains a basic framework, while most details have to be regulated on the provincial level and differ accordingly. Therefore in reality there is a broad variation between and within Länder, regarding availability and quality of services. This regional divergence is found in settings of formal care, institutional and home-based care.

When it comes to affordability, are covered by the federal and Länder care allowance programmes. Persons not entitled to receive the cash benefit at federal level are entitled to receive the same amount of cash benefit at Länder level. If the dependent person's income does not allow him/her to finance his/her care, then social services can provide complements.

Although the majority of caregivers in the PHS sector are now mediated by organisations that organise the workers, measures for quality assurance within organisations are often missing¹²⁴. There has been a recent and increasing competition on the prices of services and not the quality of services. As such, many organisations have difficulties finding qualified nursing staff.

In the **Czech Republic**, the State authorities support the development of easily accessible social services

¹¹⁹ <http://eindhoven.werksite.nl/loopbaanbegeleiding>

¹²⁰ The Austrian system for long-term care, Peer review "Achieving quality long-term care in residential facilities", 18-19 October 2010.

¹²¹ The text of the agreement (in German) is available at <http://bit.ly/1Hafv59>

¹²² Riedel M., Kraus M., ENEPRI report n°69, 2010.

¹²³ Riedel M., Kraus M., The Austrian long-term care system, project ANCIEN, report, 2010.

¹²⁴ For quality! project, Third regional seminar, Vienna, 22.09.2015, report.

at local level (especially out-services) and provide support (care allowances) for families to insure care of their older persons. The current network of PHS services is not sufficient across the country. Czech media regularly bring testimonies on the insufficient care provision across the country, as well as on a need for stricter rules with respect to quality control in the entire PHS system¹²⁵. Among 14 Czech regions, the accessibility and availability of PHS services is low and insufficient in the regions with lower population density. In parallel, regions with higher population density have more competing PHS providers¹²⁶.

When it comes to comprehensiveness, PHS services should be easy to access by all those who may require them¹²⁷. Overall, the accessibility of PHS across the country is not sufficient¹²⁸. Besides, some specific target groups (persons with disabilities) are specifically affiliated.

In **Germany**, the LTCI funds cover a fix amount of the costs of users who choose to be treated from their home, on the basis of their need of care and regardless of their age, income, wealth or the price for the actual service. Thus, the difference is left at the expense of users. When the latter cannot afford to co-finance the services, their families must contribute financially - within limits defined by the law: thankfully, the need of care is wider in the social assistance law and the difference can be covered by social assistance scheme if recipients or their children or near relatives cannot pay for it. Additional private insurances exist that users – and/or their families - can subscribe to cover these expenses¹²⁹. It is reported that 3 million persons are in substantial need of care and yet are not classified as care-dependent.

When users cannot afford - even if only partially - the cost for receiving long-term care services, they can apply for means-tested social assistance¹³⁰. In another vein, a family care giver can take up to 4 week vacation with the LTCI covering the expenses for a professional carer. However, a ceiling applies which is fixed at EUR 1,470.

When medical boards conduct in-home assessments to assess the need of individuals for care PHS, they used to focus largely on physical needs for personal care, nutrition, and mobility. The needs for assistance or supervision were de facto overlooked. Yet, persons with dementia or learning disabilities often need such services. Persons having difficulties to cope with daily activities are now assessed differently and will be entitled to receive benefits with Care level 0. Since January 2013, when fulfilling superior care levels, beneficiaries receive enhanced benefits and services. Nonetheless, in the case of users diagnosed with dementia, a problem lies with the lack of consideration for the users' gradual loss of independence.

¹²⁵ Sowa A., 2010.

¹²⁶ Horecky J., PESSIS 2, 2013.

¹²⁷ AGE Platform, 2010-2012.

¹²⁸ For quality! project, Third regional seminar Vienna, 22 September 2015, <http://forquality.eu/>

¹²⁹ European Commission, 2014

¹³⁰ Schulz, E., 2010

3.2. Quality of regulation, management and organisational level

In **Belgium**, although complementary, assistance/support services to families and dependent persons and household services via the voucher system do not comply with uniform regulations.

The support services to families and dependents are engineered by the regional governments. Providers can only be public and must be approved by the regions. Through this procedure - which imposes a number of standards in terms of qualifications, coaching and training of workers or of structural organisation - the different service providers are required to meet a regulatory framework that ensures the quality of services provided and filled. Services production is thus controlled by the government.

The service voucher system also has a regulatory framework in which the regions are now the guarantors. The law establishing the system requires an annual evaluation of the system, which examines the effect of the system on employment, the overall gross and net cost of the measure, the pay and employment conditions of beneficiaries and workers. Each company has the obligation to provide feedback. This feature also allows making compliance checks, which may lead to withdrawal of licenses if companies do not meet the obligations and criteria required. The service voucher companies are licensed by the federal government. With the 6th reform of the Belgian state, these competences will be transferred to regional authorities); meanwhile, the application has yet to be submitted to the Commission for accreditation which depends on the National Employment Office (ONEM).

In **France**, since the law n°2002-2 of 2 January 2002, which reformed social and health care activities, all organisations or units providing LTC and coming within social and health care sectors are subject to an authorisation process for their establishment, transformation and expansion. For LTC, this authorisation is issued by the president of the departmental general council when the services provided by the organisations and units are liable to be funded by departmental social aid, or when their operations fall within the scope of competency devolved by law to the department. This authorisation, granted for 15 years, sets out the basic conditions for quality that are necessary when setting up an organisation or unit. Conformity with these minimum quality requirements is then evaluated over the course of the authorisation period, either by the organisation or unit itself (internal or self-evaluation), or by an external body (external evaluation). The request for authorisation must demonstrate the ability of the organisation to guarantee users' rights and carry out the evaluations planned. To ensure that the user's rights are effective, the law expects a certain number of tools to be put in place by the organisations or services; these are compulsory for them to function.

Accreditation is granted for 5 years by the departmental prefect after deliberation by the general council. This procedure essentially concerns associations and businesses whose activities apply to home-based care for older and disabled persons or others who need personal help in the home or with mobility in their immediate environment, favouring their capacity to stay at home. Accreditation is granted with regard to the quality criteria of the unit as detailed in the specifications of 24 November 2005 concerning the quality accreditation planned in the first paragraph of Art. L.129-1 of the Labour Code.

Accredited organisations and units must be subject to external evaluation. The results of this evaluation are passed on to the prefect in charge of granting accreditation, at least 6 months before the approval is due to be renewed. As this is valid for 5 years, accredited organisations or units are evaluated far more often than those that are authorised. On the other hand, internal evaluation is not compulsory for accredited organisations and services.

When it comes to certification, it is a voluntary procedure that can replace the quality control used by public authorities for accredited or authorised organisations or units. The certifications currently recognised by public authorities meet the French NF standard X 50-056 for home-based care service standards (AFNOR, French Agency of Standardisation), the certificate registered by Qualicert under “Human services”(SGS-International Certification Service) and the certificate registered by Qualisap under “Quality of service organisations engaged in human services”(a Bureau Veritas Certification).

In **Italy**, central State has established the implementation of local integrated system for social services, for which municipalities are responsible. Therefore, municipalities are in charge of certifying public and private organisations that intend to provide their services to users, through municipalities. This concerns essentially the care sector. The responsibility for quality assessment is therefore in the hands of municipalities and results in obvious variations across countries.

For LTC services, the challenge is such that, when audits of the service are actually carried out, they are executed by the municipalities’ social services and by the regional health service managers of integrated health services (ADI) involved in the home¹³¹. Anyhow, experts often identify “the absence of any monitoring body of what happens in the house between the care-receiver and the care worker” as the main problematic area. It is common that care workers and care receivers do not know who to address for advice when problems arise, which can hamper the quality of services.

In **Spain**, one important regulation on service quality comes from the 2008 ‘Agreement on the accreditation of common criteria for the quality of autonomy and dependency care centres and services’ establishes several criteria for ensuring quality. The rationale behind this agreement lies in the 2006 Dependency Law and supports the idea that all dependent persons have the right to access quality care services. The official accreditation of centres, resources and services means that they must fulfil the requisites set by competent administrations. The accreditation of centres and services is compulsory for entering the System for Personal Autonomy and Dependency Care (SAAD). This agreement aims to promote the professionalisation and training of the workforce. Quality standards are directly linked to human resources and it is established that the quality of the service depends on the number of professionals available and on their training. Staff ratios have been defined (minimum number of professional workers per dependent person) as well as minimum qualification levels (by the year 2015, all workers offering accredited services must hold an officially recognised qualification related to their

¹³¹ Genet, N., Boerma, W., Kroneman, M., Hutchinson, A., B. Saltman, R., Home Care accross Europe - Current structure and future challenges, EOHSP, 2012.

working post). Some autonomous communities or regions have gone further and have developed proper regulation concerning occupational profiles, staff ratios, etc. As a matter of fact, this agreement is a good driver for the development of lifelong learning policies and in particular in the use of “professionalism certificates” (recognition of prior experience).

Regarding inspection of providers, it seems that autonomous community controls and monitors the mechanisms. As of the use of IT, it may prove as very relevant when considering the issue of service quality. In this context, a recent initiative from the Ministry of Health and social services may appear as a good practice. In April 2015 the Ministry presented the first mobile application in the field of dependency (App Dependencia). This application is directed for older people or people with disabilities. It facilitates the relations between them and their relatives and carers. The application includes testimonials, more than 60 videos with technical tips addressed to carers, information on services and benefits, and on the relation with relevant management bodies.

In the **United Kingdom**, the Care Quality Commission (CQC) regulates a range of care providers across *England* who are involved in delivering personal care. This includes residential care, nursing homes and care agencies. The CQC expects all regulated providers to comply with their new Fundamental Standards (which replaced the earlier Essential Standards on 1 April 2015). The CQC then regularly inspects providers to ensure the service they deliver is safe, effective, caring, responsive to people's needs and well-led.

In order to register, a home care service provider must complete an application form and provide appropriate financial references, a statement of purpose, a business plan, and a set of written policies and procedures making clear how the organisation intends to comply with the Domiciliary Care Regulations 2002 and the National Minimum Standards. Providers must also nominate a ‘responsible individual’, a senior member of the organisation responsible for supervising the management of the service. Although the responsible individual is not registered, they represent the organisation and must be able to show that both they and the organisation meet the fitness requirements for registration. In addition, upon registration, domiciliary care agencies are required to provide an outline of the training programme for the next 6 months for all staff, including managers.

In addition, regular inspections (announced and unannounced) of each provider organisation encourage compliance with a set of National Minimum Standards (NMS). There are 3 types of inspections: key inspection, and random and thematic inspections. A key inspection is a major assessment of the quality of the service and any risk it might present and is usually unannounced. Newly-established agencies have a key inspection in the first 6 months. Shorter inspections focus on specific issues and supplement the key inspection. They may follow up a previous concern or complaint, a change of manager, or a change in the service. Thematic inspections focus on a theme, for example how staff manages users’ medication. The NMS cover all aspects of management and care practice, but have been criticised for having an undue focus on processes and paperwork, rather than on outcomes and practice.

In *Scotland*, the Care Inspectorate is the independent scrutiny and improvement body for care services in

Scotland. The Care Inspectorate makes sure that people receive high quality care and ensure that services promote and protect their rights. In 2013 the Care Inspectorate published a report highlighting the quality of care at home services in Scotland, where over 80% of all services receive good, very good or excellent for all themes.

In *Northern Ireland*, the Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services, and encouraging improvements in the quality of those services. It aims at ensuring that health and social care services in Northern Ireland are accessible, well managed and that they meet the required standards. RQIA also has a role in assuring the quality of services provided by Health and Social Care (HSC) Board, HSC trusts and agencies, to ensure that every aspect of care reaches the standards laid down by the Department of Health, Social Services and Public Safety.

In *Wales*, providers are regulated by the Care and Social Services Inspectorate Wales (CSSIW) against certain standards. In 2008-2009 CSSIW found that there had been significant improvements in the quality of homecare services and that homecare providers were performing well in a number of areas, including care planning, quality assurance and medication.

In **Sweden**, the government guideline is to ensure that care receivers along with relatives should be able to trust the care offered in Sweden is both dignified and high in quality. From 2010 to 2014, quality of services has been reinforced through a top-down system “Better Life Initiative”, relied on a framework agreement between SKL (Swedish Association of Local Authorities and Regions) and the Swedish government (SALAR, 2015). The initiative covered 5 areas: preventative approach, good care for dementia, good care in the final stages of life, good drug treatment, and coordinated health and social care, with objectives connected to each. Regions, municipalities and counties that achieved the set objectives were awarded performance bonuses. This approach was aimed at all those involved in health and social care for sick elderly people and it resulted in a real cultural change, i.e. shifting perspective from the organisation to the person. The approach very much relied on the use of metrics and quantitative benchmarks. The evaluation report shows real improvement in terms of the quality of the service. It includes several quantitative data witnessing for instance an improved care in the final stages of life or a decrease in appropriate medication.

Since the 2009 reform on System choice in the public sector, opening the access to private providers, the assessment of quality is an important element of the functioning of the system. People need to base their choices on measures of quality and municipalities base their purchasing decisions on indicators of providers’ performance. A system with free choice of providers indeed requires better information on quality and efficiency.

The National Board of Health and Welfare cooperates with municipalities and county councils to develop open comparison and public performance reports on health care and social services. Surveys of service providers and users together with official statistics are used to build a wide range of indicators of quality which can be used to illustrate how municipalities and county councils are performing in different

aspects. This provides useful information for prospective service users as well as for politicians seeking to improve the quality of local services and it can raise the awareness of staff about quality of care. Additionally, two quality registers for elderly care have been developed building on modern IT solutions and enabling participating providers to compare their own results over time and with those of others. But for the time being, registers concentrate more on health care indicators than on social care. The introduction of a performance-based grant system has increased the input to registers dramatically and improved the coverage and quality of data. The next step is to promote the use of the registers for local improvements in quality by strengthening analytical capacity at the local level.

There is today no general guidance for assessment of need in Sweden. Instead, the assessment is much down the evaluator and is performed on a discretionary basis. Although there is no general guidance, the most commonly used tests when assessing the need of the elderly in Sweden is drawn from the National Board of Health and Welfare. The absence of standardisation may permit to more easily tailor the help to individual needs. The Swedish model is built on trust in the care managers' professional discretion.

In **Finland**, municipalities must have a social ombudsman in order to give advices and information to social services users and to evaluate how the rights of users are met within the municipality. Local authorities also conduct surveys toward their residents who used social and care services in order to evaluate the quality of the services provided and the degree of satisfaction of the users¹³².

The Act on the Status and Right of Social Welfare Clients (812/2000) formalized the right to good service for users. According to this piece of legislation, the user has the right to complain concerning the way s/he is treated to the responsible managers. S/he has different ways to do it, at different levels. When it concerns a decision taken by a municipal employee, the user have to make a 'demand for rectification', addressed to the social welfare board of the local authorities. If this first request is not taken into account, the person can do an 'administrative appeal' to an administrative court. The user can also directly complain about local authority actions by making a 'municipal appeal' to Regional state Administrative Agency, the Parliamentary Ombudsman or the Chancellor of Justice in Finland.

The national Supervisory authority Valvira provides licensing for social and health care providers which want to be part of the voucher system.

In the **Netherlands**, 2 accreditation bodies have been set up by the Dutch health care field: one for accreditation of hospitals (NIAZ) and the other for harmonisation of quality reviews in health care and social services (HKZ). The latter produces certification schemes and is an initiative of care providers, insurers and clients. With regard to the inspections, in case of HKZ certification an external organisation assesses if the quality management of the organisation meets predetermined HKZ standards. An institution designated by the Accreditation Council (RvA) executes it. The assessment is subject to strict rules. If the organisation meets the standards, it shall issue a Certificate HKZ. The certificate is valid for 3

¹³² *Ibid.* p.132

years, subject to a mid-retest. A recertification takes place after 3 years.

Labour inspectorates have a general mandate to ensure compliance with laws and regulations in the domestic work sector. As of the quality assessment of home care, the Health Care Inspectorate (IGZ)¹³³ holds responsibility for the quality of services supervision. Home care agencies are legally committed to thoroughly monitor and improve the quality of their services and staff working conditions and to provide annual reports to the IGZ. The Inspectorate can also do audits. Furthermore, service providers, professionals and service users mutually agreed to use common indicators which compose the Dutch Quality Framework for Responsible Care (QFRC). It contains measurable indicators that show if the organisation provides quality and responsible care. QFRC is important if one pretends to become member of the Dutch Organisation of Care providers (ACTiZ)¹³⁴.

At present, most services in LTC for older people take part in a national benchmark. Interlinks indicates¹³⁵ that it covers issues such as staff (quality of work), financial performance, clients indicators (Responsible Care Standards), services delivery, satisfaction of employees and quality outcomes. Some methodological questions remain however to be answered, notably the difficulty to operationalise quality. At last, it should also be noted that evaluation of client satisfaction with the service quality is increasing. Client satisfaction surveys for measuring quality have become mandatory.

In **Austria**, the fragmented PHS system relies on 9 different Länder legislations, as well as on several manners to designate, manage and finance the PHS services at municipal level. This heterogeneity makes notably hard the follow up of the quality of the regulation. To handle this problem, the working group for provision of care (*Arbeitskreis für Pflegevorsorge*) has started to collect some basic national data on care on a yearly basis, in an effort to make them comparable between for all Länder, with the ultimate goal to improve forward-looking capacity planning and steering.

In the **Czech Republic**, The quality regulation of PHS services is carried out separately within the health care and the social services systems¹³⁶. Provision of health care services is monitored and controlled by the health insurance company concerned. The Ministry of health issues accreditations for hospitals and LTC homes, stating that they fulfil quality standards. The system of monitoring and control of social services “National Quality Standards of Social Services” is included into the Social services law and supported by the Ministry of Labour and Social Affairs. Yet, the system is not very much regulated. The provision of high quality social services can be monitored by the Ministry, regional governments, municipalities and labour offices, as stated in the Social Services Act of 2006. Although the Ministry has offered a set of social care quality standards, they are rather general recommendations for social care providers.

¹³³ De Inspectie voor de Gezondheidszorg (IGZ), www.igz.nl

¹³⁴ ACTiZ, www.actiz.nl

¹³⁵ INTERLINKS, 2010, *ibid.*

¹³⁶ Sowa A., 2010.

Municipalities and regional governments are the principal institutions responsible for accreditations, the monitoring and control of the PHS services. PHS services may be provided on basis of licences issued by regional governments. The PHS provider is subject to an authorisation procedure in order to assess whether or not the provider is able to meeting all the conditions prescribed by the Social services Act, including the quality standards as well as the compliance with human rights¹³⁷. The control procedure is done by an inspection. If conditions are not met, then the license can be withdrawn.

At the state level, the Ministry of labour and social affairs produces a Report on Social Quality Standards, focusing on quality control of social services workers, and on training best practices guides.

The quality of PHS is monitored according to the dimension they include:

- The quality of health care system is monitored by inspection of insurance companies
- The quality of social services: the Ministry monitors 15 quality standards that represent the basic frame for PHS services provision¹³⁸: 8 “process standards” on quality level and users’ life, 2 “personal standards” on the conditions of employees (development, education), and 5 standards on operational activities (information, accessibility, quality measurements,..). With the introduction of these standards, the role of the user changed from being an object to being a subject of the care and influencing the quality of the provided care.

In **Germany**, the Medical Advisory Board of the Health Insurance funds set up guidelines for quality control, be it in institutions or for home care services. Quality audits are conducted by the Medical Advisory Service.

Concerning LTC, one of the first quality measures of personal care and housekeeping services to people who receive cash benefits is for a professional caregiver to review their situation and report it to the LTCI. The responsibility of calling such professional falls under the beneficiary’s. Depending on their care level, beneficiaries receive the visit of a professional caregiver from 2 to 4 times per year.

Besides, a significant number of good practices have been identified. We can mention the German Charter of Rights for People in Need of Assistance¹³⁹, which gives a detailed list of the rights of people living in Germany who are in need of long-term care and assistance. Several dissemination and quality tools were developed on the basis of the Charter, such as wide awareness-raising activities, charter-oriented quality management tools (e.g. self-evaluations, quality circles, mission statements, target agreements) and training material. The Charter is also used to develop external quality control tools and

¹³⁷ Horecky J., PESSIS 2, 2013.

¹³⁸ Horecky J., PESSIS 2, 2013.

¹³⁹ German Federal Ministry of Family Affairs, Senior Citizens, Women, and Youth and the German Federal Ministry of Health, Charter of Rights for People in Need of Long Term Care and Assistance, 2007: www.pflege-charta.de: bit.ly/INCpIlp.

legislation^{140 141}. Also, the DIN SPEC 77003 standards procedure for information, advice and placement of PHS was published in April 2015.

Although the public sector does not provide PHS it latter plays an important role in regulating the quality for personal care with the availability of quality criteria at federal level.

¹⁴⁰ For more information: <http://wedo.ttp.eu/>: <http://bit.ly/MeIgYL>.

¹⁴¹ AGE Platform Europe, European Quality Framework for long-term care services, Principles and guidelines for the wellbeing and dignity of older people in need of care and assistance, European project WeDO, 2010-2012.

4. CONCLUSION

The variety of definitions and situations of PHS shows that it is not possible to speak about this sector in a generalised manner, as otherwise it does not allow taking into account the particularities of each type of work and profession regarding the quality of jobs or the quality of service. It therefore appears that the PHS sector could be better developed by building one more specific definition of PHS.

Major PHS-related policy objectives in most countries at stake aim at creating formal jobs and/or formalising undeclared jobs. Some experiences presented demonstrate that policy settings may create formal jobs in PHS, offering entry positions and stable employment perspectives for service workers as well as migrants, women and low-skilled people. Experiences show and confirm that regular jobs in the PHS sector can be created with appropriate regulation and organisation, while the quality of jobs can be improved to some extent, also via training (although this potential is limited)¹⁴².

The rising trend of PHS workers is expected to continue in the coming years, in all the countries at stake. The sector records increasing employment levels (see annex) and provides opportunities for a greater number of jobs. All countries clearly share a common consciousness of the importance of qualifications. The offer of jobs in the PHS sector is generally insufficient relative to demand, particularly due to the lack of skilled labour, a high turnover, and still too low use of new technologies for the development of new services and for matching supply and demand. Yet, it also comes clearly out that the PHS jobs require specific skills, technical and/or relational, that are underestimated.

The financing role of PHS services acted by public authorities may positively influence working conditions, as well as increase the job quality. The impact of economic crisis forecast a further decrease of the public expenditures, which might be challenging for the future of the PHS sector.

Yet, it is more than ever essential to provide sufficient funding to the PHS sector to ensure quality services and working conditions. For indeed, the future development of the PHS sector will depend on the effective improvement of working conditions and quality of services¹⁴³.

¹⁴² Angermann A., Eichhorst W., Who cares for you at home? Personal and Household Services in Europe, IZA Policy Paper No. 71, 2013, <http://ftp.iza.org/pp71.pdf>.

¹⁴³ Farvaque N., 2015.

Annex: Comparative employment figures of the countries at stake

SOCIAL WORK ACTIVITIES WITHOUT ACCOMMODATION

Evolution of social work activities without accommodation (in thousands) since 2008:

	2008	2009	2010	2011	2012	2013	2014	2008/2014
UE 28	4.527,2	4.591,4	4.771,2	4.808,3	4.875,0	4.933,6	5.064,6	12%
UE 15	4.239,5	4.296,8	4.476,5	4.513,7	4.568,5	4.604,2	4.731,9	12%
BE	150,3	153,9	154,1	165,8	171,7	173,0	166,7	11%
CZ	42,6	36,0	31,5	26,5	30,7	31,8	29,8	-30%
DE	759,6	796,7	860,0	861,7	878,0	846,0	915,0	20%
SP	154,9	173,7	210,3	216,5	213,6	201,2	191,7	24%
FR	966,6	975,5	1.025,4	1.023,9	1.071,6	1.187,7	1.256,0	30%
IT	196,6	184,6	200,9	200,6	222,4	217,1	233,4	19%
NL	340,3	360,1	361,4	354,8	360,7	346,7	324,3	-5%
AT	42,2	56,1	61,0	54,3	50,9	51,7	56,5	34%
FI	125,9	123,4	120,5	125,4	128,4	125,5	125,3	0%
SE	163,1	167,3	164,1	175,8	175,2	182,3	194,7	19%
UK	1.006,0	955,9	966,4	995,1	949,9	933,5	927,5	-8%

Source : Eurostat, NACE rév. 2 niveau division (1000)

Growth rate of social activity without accommodation since 2009:

	2009	2010	2011	2012	2013	2014
UE 28	1,4%	3,9%	0,8%	1,4%	1,2%	2,7%
UE 15	1,4%	4,2%	0,8%	1,2%	0,8%	2,8%
BE	2,4%	0,1%	7,6%	3,6%	0,8%	-3,6%
CZ	-15,5%	-12,5%	-15,9%	15,8%	3,6%	-6,3%
DE	4,9%	7,9%	0,2%	1,9%	-3,6%	8,2%
SP	12,1%	21,1%	2,9%	-1,3%	-5,8%	-4,7%
FR	0,9%	5,1%	-0,1%	4,7%	10,8%	5,8%
IT	-6,1%	8,8%	-0,1%	10,9%	-2,4%	7,5%
NL	5,8%	0,4%	-1,8%	1,7%	-3,9%	-6,5%
AT	32,9%	8,7%	-11,0%	-6,3%	1,6%	9,3%
FI	-2,0%	-2,4%	4,1%	2,4%	-2,3%	-0,2%
SE	2,6%	-1,9%	7,1%	-0,3%	4,1%	6,8%
UK	-5,0%	1,1%	3,0%	-4,5%	-1,7%	-0,6%

Source: Eurostat, NACE rév. 2 niveau division (1000)

Evolution of the share in total employment of social activity without accommodation since 2008:

	2008	2009	2010	2011	2012	2013	2014
UE 28	2,1%	2,1%	2,2%	2,3%	2,3%	2,3%	2,4%
UE 15	2,4%	2,5%	2,6%	2,7%	2,7%	2,7%	2,8%
BE	3,4%	3,5%	3,5%	3,7%	3,8%	3,9%	3,7%
CZ	0,9%	0,7%	0,7%	0,6%	0,6%	0,7%	0,6%
DE	2,0%	2,1%	2,3%	2,3%	2,3%	2,2%	2,4%
SP	0,8%	0,9%	1,1%	1,2%	1,2%	1,2%	1,1%
FR	3,8%	3,8%	4,0%	4,0%	4,2%	4,7%	4,9%
IT	0,9%	0,8%	0,9%	0,9%	1,0%	1,0%	1,1%
NL	4,0%	4,3%	4,4%	4,3%	4,4%	4,2%	4,0%
AT	1,1%	1,4%	1,5%	1,4%	1,3%	1,3%	1,4%
FI	5,0%	5,1%	5,0%	5,2%	5,3%	5,2%	5,3%
SE	3,6%	3,8%	3,7%	3,9%	3,9%	4,0%	4,2%
UK	3,5%	3,4%	3,4%	3,5%	3,3%	3,2%	3,1%

Source: Eurostat, NACE rév. 2 niveau division (1000)

ACTIVITIES OF HOUSEHOLDS AS EMPLOYER OF DOMESTIC STAFF:

Activities of households as domestic staff of the employer, in thousands:

	2008	2009	2010	2011	2012	2013	2014	2014/2008
UE 28	2.451,4	2.367,2	2.465,9	2.513,5	2.489,7	2.399,9	2.323,6	-5%
UE 15	2.370,8	2.283,5	2.369,3	2.410,6	2.378,4	2.288,5	2.212,6	-7%
BE	25,9	32,8	35,2	35,7	16,9	21,3	9,0	-65%
CZ	1,9	1,8	2,1	2,0	1,5	1,2	1,7	-11%
DE	203,6	191,2	195,4	205,7	201,5	218,7	214,0	5%
SP	735,9	709,2	722,7	678,0	645,4	661,2	648,2	-12%
FR	589,6	585,0	585,4	595,9	573,8	431,7	321,8	-45%
IT	405,7	452,4	517,1	605,8	674,2	692,9	756,2	86%
NL						5,8	7,7	
AT	11,3	9,6	10,4	8,9	10,3	9,8	8,8	-22%
FI	8,4	8,3	7,8	7,7	7,6	8,2	10,2	21%
SE								
UK	131,5	46,6	47,1	53,0	46,8	48,4	65,4	-50%

Source: Eurostat, NACE rév. 2 niveau division (1000)

Growth rate of households as employers of domestic personnel:

	2009	2010	2011	2012	2013	2014
UE 28	-3,4%	4,2%	1,9%	-0,9%	-3,6%	-3,2%
UE 15	-3,7%	3,8%	1,7%	-1,3%	-3,8%	-3,3%
BE	26,6%	7,3%	1,4%	-52,7%	26,0%	-57,7%
CZ	-5,3%	16,7%	-4,8%	-25,0%	-20,0%	41,7%
DE	-6,1%	2,2%	5,3%	-2,0%	8,5%	-2,1%
SP	-3,6%	1,9%	-6,2%	-4,8%	2,4%	-2,0%
FR	-0,8%	0,1%	1,8%	-3,7%	-24,8%	-25,5%
IT	11,5%	14,3%	17,2%	11,3%	2,8%	9,1%
NL						32,8%
AT	-15,0%	8,3%	-14,4%	15,7%	-4,9%	-10,2%
FI	-1,2%	-6,0%	-1,3%	-1,3%	7,9%	24,4%
SE						
UK	-64,6%	1,1%	12,5%	-11,7%	3,4%	35,1%

Source : Eurostat, NACE rév. 2 niveau division (1000)

Share in total employment of households as employers of domestic personnel:

	2008	2009	2010	2011	2012	2013	2014
UE 28	1,1%	1,1%	1,2%	1,2%	1,2%	1,1%	1,1%
UE 15	1,4%	1,3%	1,4%	1,4%	1,4%	1,4%	1,3%
BE	0,6%	0,7%	0,8%	0,8%	0,4%	0,5%	0,2%
CZ	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%
DE	0,5%	0,5%	0,5%	0,5%	0,5%	0,6%	0,5%
SP	3,6%	3,7%	3,9%	3,7%	3,7%	3,9%	3,8%
FR	2,3%	2,3%	2,3%	2,3%	2,2%	1,7%	1,3%
IT	1,8%	2,0%	2,3%	2,7%	3,0%	3,2%	3,5%
NL	0,0%	0,0%	0,0%	0,0%	0,0%	0,1%	0,1%
AT	0,3%	0,2%	0,3%	0,2%	0,3%	0,2%	0,2%
FI	0,3%	0,3%	0,3%	0,3%	0,3%	0,3%	0,4%
SE	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%
UK	0,5%	0,2%	0,2%	0,2%	0,2%	0,2%	0,2%

Source: Eurostat, NACE rév. 2 niveau division (1000)

TOTAL EMPLOYMENT

Total employment (in thousands)

	2008	2009	2010	2011	2012	2013	2014	2014/2008
UE 28	218.884,5	214.942,2	212.759,8	212.105,4	211.377,5	210.829,7	212.866,4	-3%
UE 15	173.696,7	170.440,3	169.657,3	169.204,6	168.335,8	167.785,5	169.076,1	-3%
BE	4.413,7	4.389,4	4.450,6	4.470,5	4.479,0	4.484,5	4.497,3	2%
CZ	4.933,5	4.857,2	4.809,6	4.796,4	4.810,3	4.845,9	4.883,5	-1%
DE	37.902,3	37.807,8	38.072,7	38.045,4	38.320,6	38.640,0	38.915,4	3%
SP	20.316,5	18.957,5	18.573,7	18.270,9	17.476,8	17.001,6	17.210,5	-15%
FR	25.752,9	25.505,4	25.542,0	25.556,8	25.514,5	25.512,1	25.510,7	-1%
IT	22.698,6	22.324,2	22.151,6	22.214,9	22.149,2	21.755,3	21.809,5	-4%
NL	8.467,6	8.443,4	8.226,9	8.231,7	8.254,1	8.184,4	8.111,0	-4%
AT	3.928,7	3.909,3	3.943,9	3.982,3	4.013,4	4.030,0	4.034,2	3%
FI	2.497,2	2.423,3	2.410,1	2.428,5	2.431,0	2.403,2	2.385,9	-4%
SE	4.493,8	4.391,4	4.403,2	4.498,1	4.509,6	4.554,3	4.597,5	2%
UK	28.827,3	28.318,6	28.289,6	28.404,2	28.650,6	28.916,7	29.530,8	2%

Source: Eurostat, NACE rév. 2 niveau division (1000)

Growth rate of total employment since 2009:

	2009	2010	2011	2012	2013	2014
UE 28	-1,8%	-1,0%	-0,3%	-0,3%	-0,3%	1,0%
UE 15	-1,9%	-0,5%	-0,3%	-0,5%	-0,3%	0,8%
BE	-0,6%	1,4%	0,4%	0,2%	0,1%	0,3%
CZ	-1,5%	-1,0%	-0,3%	0,3%	0,7%	0,8%
DE	-0,2%	0,7%	-0,1%	0,7%	0,8%	0,7%
SP	-6,7%	-2,0%	-1,6%	-4,3%	-2,7%	1,2%
FR	-1,0%	0,1%	0,1%	-0,2%	0,0%	0,0%
IT	-1,6%	-0,8%	0,3%	-0,3%	-1,8%	0,2%
NL	-0,3%	-2,6%	0,1%	0,3%	-0,8%	-0,9%
AT	-0,5%	0,9%	1,0%	0,8%	0,4%	0,1%
FI	-3,0%	-0,5%	0,8%	0,1%	-1,1%	-0,7%
SE	-2,3%	0,3%	2,2%	0,3%	1,0%	0,9%
UK	-1,8%	-0,1%	0,4%	0,9%	0,9%	2,1%

Source: Eurostat, NACE rév. 2 niveau division (1000)

Share of total employment of households as employers of domestic personnel and social work activities without accommodation (comparison 2014/2008)

2014		2008		
	Activities of households as employers of domestic staff	Social activity without accommodation	Activities of households as employers of domestic staff	Social activity without accommodation
UE 28	1,1%	2,4%	1,1%	2,1%
BE	0,2%	3,7%	0,6%	3,4%
CZ	0,0%	0,6%	0,0%	0,9%
DE	0,5%	2,4%	0,5%	2,0%
SP	3,8%	1,1%	3,6%	0,8%
FR	1,3%	4,9%	2,3%	3,8%
IT	3,5%	1,1%	1,8%	0,9%
NL	0,1%	4,0%	0,0%	4,0%
AT	0,2%	1,4%	0,3%	1,1%
FI	0,4%	5,3%	0,3%	5,0%
SE	0,0%	4,2%	0,0%	3,6%
UK	0,2%	3,1%	0,5%	3,5%

— Source: Eurostat, NACE rév. 2 niveau division (1000)

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