Chapter 5

Long-Term Care Workers: Needed but Often Undervalued

This chapter describes the size and the composition of the long-term care (LTC) workforce, in terms of gender and skill mix, working hours and work pressures. The analysis focuses on the two major parts of the LTC workforce: those working in home care and those working in institutional care. Developments in the mix of qualifications in nursing LTC are considered. The chapter then examines the relative importance of factors behind the difficulties in matching demand for, with the supply of, LTC workers, such as salary levels and working conditions. The analysis seeks to answer the following questions: does the workforce meet current (and potential) demand? How many people work in the different components of LTC sector and what is their background? What are the working conditions in the LTC sector? What can be said about developments over time?

5.1. How many long-term care workers are there?

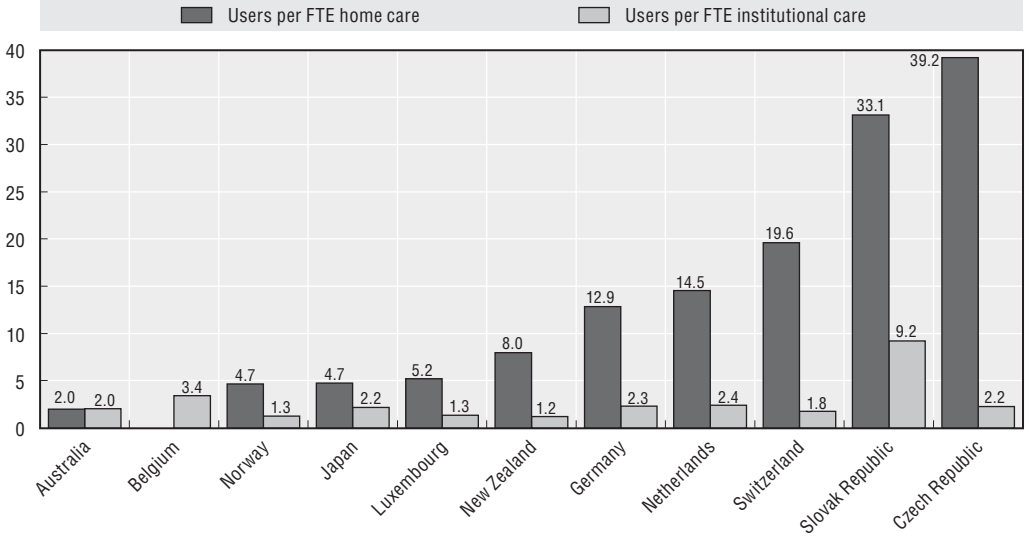
Is there a long-term care (LTC) workforce "crisis"? Reports from the United States suggest so (Stone and Wiener, 2001; Harmuth, 2002; IFAS, 2007). Yet, the answer to this question may be more complex across the OECD. What *is* the crisis: in the workforce itself, or in the tension between demand and supply? In order to answer this question, it is first of all important to review available statistics on the LTC workforce. Despite data limitations, many OECD countries have stepped up their LTC-workforce data collections.

More care recipients per worker in home care but most care workers are in institutional settings

While in Australia there is one full-time equivalent (FTE) LTC worker for each two LTC care recipients, in many countries a full-time worker serves more clients, with lower ratios in institutional care than in home care (Figure 5.1). Especially in the Czech Republic and in the Slovak Republic, the user/FTE ratio is very high, representing large workloads. The differentiation in workload in institutional care shows less variety than in home care.[1]

Figure 5.1. **Higher ratio of LTC users per full-time equivalent worker in home care than in institutions**

Selected OECD countries, 2008



Note: The definition of full-time equivalent (FTE) varies across countries. Available years for home care: Australia and Germany: 2005; Luxembourg, New Zealand and the Netherlands: 2006. Other countries: 2008. Available years for residential care: Luxembourg, New Zealand and the Netherlands: 2006; Australia, Belgium, Germany and the Slovak Republic: 2007. Data for the Netherlands consider nurses and ADL workers in employment only. Australian data exclude allied health workers (home care). German data exclude elderly care nurses (170 000 estimated in 2007).

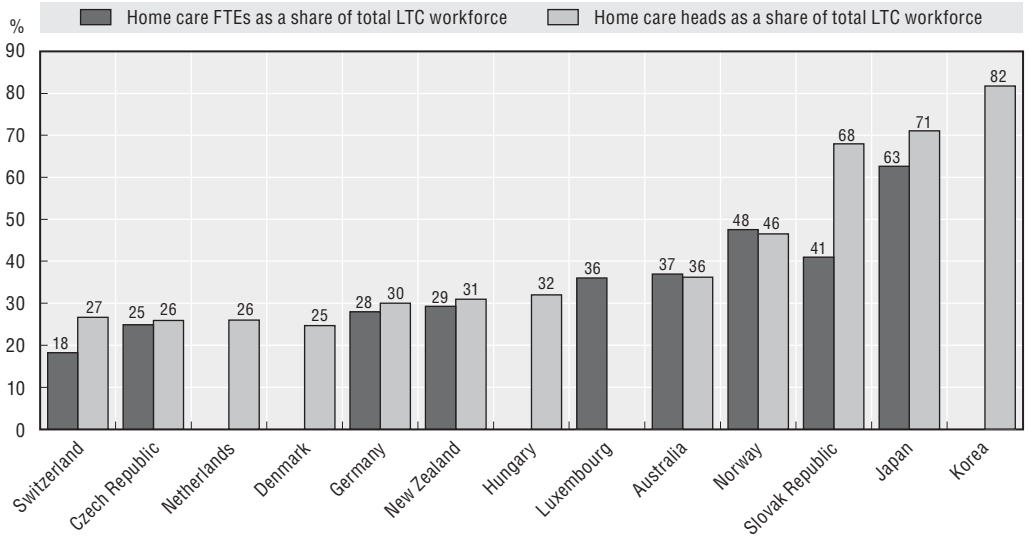
Source: OECD Health Data 2010.

StatLink http://dx.doi.org/10.1787/888932401463

Even though most care recipients receive care at home, most LTC workers practise in residential care – although Japan and Korea are exceptions (Figure 5.2).

Figure 5.2. **Less than half of LTC workers are in home care in most OECD countries**

Selected OECD countries, 2008



Note: Data for Luxembourg refer to 2005. Data for the United States, Canada, New Zealand refer to 2006. Data for Denmark, Germany, Australia and the Slovak Republic refer to 2007. For Australia, home-care data do not include allied health workers. German data exclude elderly care nurses (170 000 estimated in 2007). Data for the Netherlands reflect nurses and ADL workers in employment only.

Source: OECD Health Data 2010.

StatLink http://dx.doi.org/10.1787/888932401482

The size of the LTC workforce seems to keep up with population developments

In most countries for which data are available, the number of LTC workers is growing in line with the share of the population aged over 80 years, although in Luxembourg, Germany and Japan the size of the LTC workforce outgrew the increasing share of people aged over 80 years. The opposite occurred in the Slovak Republic, where worker density (number of workers per 100 people aged 80 or over) decreased from 1.6 in 2004 to 0.7 in 2008.

5.2. Who are the LTC workers?

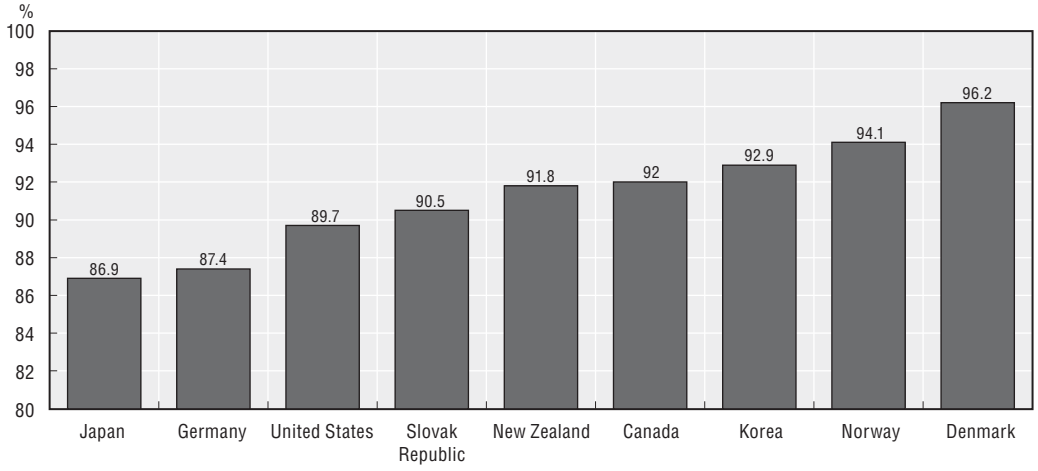
Most LTC workers are women and work part-time

The LTC sector is a major source for female employment in many OECD countries (Fujisawa and Colombo, 2009; Figure 5.3). In the Netherlands, one in every seven working women is employed in the care and welfare sector (van der Windt *et al.*, 2009). In most countries there is little change in the gendered character of the LTC workforce. Only in the Slovak Republic, the share of women in the LTC workforce has quickly increased to a level similar to that of other OECD countries, from 61% in 2004 to 90.5% in 2006. Cangiano *et al.* (2009a) report that female employment in care is mostly restricted to direct care work in the United Kingdom, while managerial jobs tend to be held by men.

Based on the number of care workers per full-time equivalent it can be calculated that many LTC workers work part-time, and slightly more so in home-care settings (Figure 5.4). In Japan, for example, 84% of home-care workers work part time. Moreover, five in every six home-care workers face monthly adjustments in their hours and working days per week.

Figure 5.3. **Most LTC workers are women**

Share of women in the LTC workers, selected OECD countries, latest available year



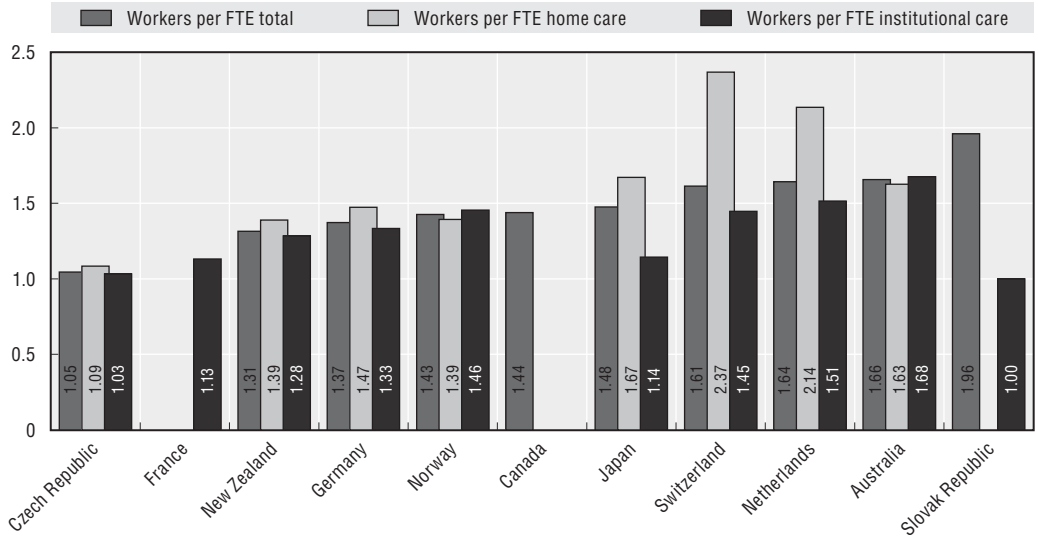
Note: Data for Japan refer to 2003. Data for the United States, New Zealand, Canada refer to 2006. Data for Denmark refer to 2007. Data for the Slovak Republic and Norway refer to 2008. Data for Korea refer to 2009. German data do not include elderly care nurses (170 000 in 2007).

Source: OECD Health Data 2010.

StatLink http://dx.doi.org/10.1787/888932401501

Figure 5.4. **Part-time work is more frequent in home-care settings**

Number of LTC workers per full-time equivalent (FTE), selected OECD countries, 2008



Note: The definition of FTE varies across countries. Data for New Zealand, Canada, and the Netherlands refer to 2006; data for France, Germany. Australia and the Slovak Republic refer to 2007. German data exclude elderly care nurses (170 000 estimated in 2007). Australian data exclude allied health workers. Data for the Netherlands reflect nurses and ADL workers in employment only.

Source: OECD Secretariat calculations based on *OECD Health Data 2010.*

StatLink http://dx.doi.org/10.1787/888932401520

A Japanese survey of institutional care employers suggests that 40% of the institutional care workers work on a part-time basis (Hotta, 2010). On the other hand, part-time working hardly exists in the Czech Republic. The same goes for those working in institutional care in the Slovak Republic (Figure 5.4). In most countries for which data are available,workers in institutional care settings work more paid hours than those in home care. In the United States, 43% of "direct care workers" were employed less than full-time all year

round in 2007 (PHI, 2007; PHI, 2010). Over half of personal and home-care aides (54%) worked part-time, or worked full-time only for part of the year (PHI, 2007). Although the LTC workforce in German nursing homes increased by 29% between 1999 and 2007, the share of full-time workers decreased from 46 to 35%. And while the share of *male* full-time workers in nursing homes increased by 92%, the share of *female* full-time workers decreased by 8%, even though the total share of female workers in German nursing homes remained at 87% (see *Drei-Verdi.de* in the list of web pages at the end of the chapter).

For five countries, developments in working time could be analysed through time series – mostly showing reductions in average weekly working hours. Data for Norway suggest that workers increased their working hours between 2003 and 2008, while fewer hours were worked per week in the Czech Republic (2005-08), Germany (2003-07) and the Netherlands (home care, 2004-07). Since 2000, Japanese home-care workers decreased their hours per week, while institutional care workers have increased their working hours (Hotta, 2010). German sources confirm decreased working hours (Oschmiansky, 2010; Rothgang *et al.*, 2009). The Australian institutional care sector shows a 10% reduction in working hours per week since 2002. Generally, a reduction in working hours reflects aggregate trends in OECD labour markets, with an increase in part-time work across the OECD from 12% in 2000 to 16% in 2009,[2] together with an associated 4% decrease in annual hours worked in the same period.[3]

LTC workers, especially the less qualified, sometimes hold multiple jobs. In New Zealand, 17% have multiple jobs – typically LTC-related or IADL-type activities (cleaning, private support work, and cooking) (Ministry of Health/University of Auckland, 2004). Cangiano *et al.* (2009a) and Martin *et al.* (2009) report similar results for migrant care workers in the United Kingdom and the United States, while Eborall *et al.* (2010) report that each social-care worker in England has on average 1.6 jobs.

With populations ageing, so is the workforce in general and the LTC workforce in particular. A major and increasing proportion of LTC workers is middle aged (Table 5.1).

There are different age patterns of entry in the LTC sector for different qualification levels. For example, Australian nurses start working in long-term care at an earlier age than other LTC workers, but still a quarter of the Australian LTC nurses starts their long-term care career at the age of 40 years. More than half of the community care workers start their LTC job when older than 40 years, and one in five when aged at least 50 years (Martin and King, 2008).

Entering the long-term care workforce may follow a period of economic inactivity. Between 16 and 29% of the Dutch low-level LTC workers were economically inactive before entering the current employment (van der Velde *et al.*, 2010). Similarly, about one third of the support workers in New Zealand was economically inactive prior to taking the job, of which 40% were housewives, and 46% were unemployed (Ministry of Health/University of Auckland, 2004).

LTC workers generally have low qualifications but requirements for institutional care are higher

LTC workers typically include nurses and lower-level care workers. The division of labour, the scope and type of activities, and LTC workers' regulation vary markedly across countries. This translates into different qualification mixes and ratios between nurses and lower-skilled workers across the OECD.[4] In most countries for which data exist, less than

Table 5.1. **Evidence on ageing of the LTC workforce**

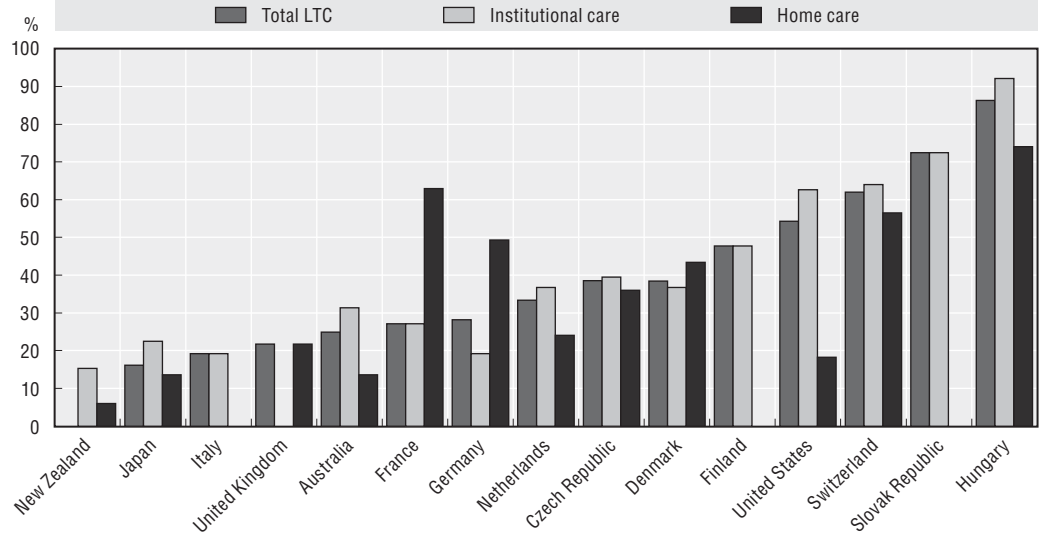
	Ageing workforce indicator	Type of workers	Trend	Source
Australia	70% of community care workers are over 45 years; and 60% of institutional care workers are over 45 years (female workforce age: 36% is over 45 years)		1997-2005: Average age of nurses moved from 40 to 45 years; the share of workers aged over 55 years increases	Martin and King (2008)
	Average age of employed nurses 44.1 years		Share of nurses aged 50 or over: 1998: 18.9; 2008: 34.9	AIHW (2008b)
Canada	Canadian LTC registered nurses are older than in Canadian health care			O'Brien-Pallas *et al.* (2003)
Germany			1995-2005: Nursing care workers aged 50+ increased from 18 to 23%	BGW (2007)
Japan	60% older than 50 years	Home-visit helpers		Hotta (2010)
Netherlands	2003 and later: > 50% older than 40 years		2002-06: Average age of workers in institutional care moved from 38.9 to 40.2 years. Share of those aged over 45 years: from 31 to 41%	*www.azwinfo.nl*
New Zealand	> 50% are 40-60 years old; 16% is 60 or over	56% provides IADL and ADL; 21% provides IADL only		Ministry of Health/University of Auckland (2004)
United Kingdom	No signs of ageing of the LTC workforce			Cangiano *et al.* (2009a)
United States	Average age: – all direct care workers: 41 years – institutional care workers: 38 years – home-care workers: 45 years (2009). – self-employed or working directly for private households: 49 years		Average age of home-care workers in 2007: 43	PHI (2007; 2010)

Source: OECD Secretariat compilation.

half of the nursing LTC workforce consists of nurses, ranging from 12% in New Zealand to 85% in Hungary (Figure 5.5).

Figure 5.5. **In most OECD countries, less than half of the LTC workforce consists of nurses, mostly employed in institutional settings**

Share of nurses in the LTC workforce (head counts), selected OECD countries, 2008



Note: Data for the United States and New Zealand refer to 2006; for Italy and Finland, to 2005; data for France (institutional care and total) refer to 2003, while home-care data refer to 2002; data for Australia, Germany and Denmark refer to 2007. Data for Australia do not include *allied health workers*. Data for Germany exclude elderly care nurses (170 000 estimated in 2007). Data for the Netherlands reflect nurses and ADL workers in employment only.

Source: OECD Health Data 2010.

StatLink http://dx.doi.org/10.1787/888932401539

Qualification patterns across care settings tend to follow the overall pattern within a country, but there are exceptions. So, while New Zealand has low shares of nurses in both home as well as in institutional care, and Switzerland has high shares of nurses in the subsectors, patterns are different in France and Germany, with high shares of nurses in home care and fewer in institutional care. The United States shows a different pattern: relatively few nurses in home care and relatively many in institutional care. Nurses, however, may work more hours than other direct care workers, so data based on headcounts can under estimate the actual input by nurses as compared to that of other lower-level care workers. Australian data, for instance, point to lower shares working part-time and higher numbers of weekly working hours, the higher the qualification and working level of nurses (AIHW, 2008a).

National or regional regulations set minimum requirements to qualify as a LTC worker, although other training schemes – often short-term training programmes provided by employers – also play a role, the latter in more on-the-job training programmes. Nurses typically qualify in a targeted – and possibly certified or accredited – vocational education, although there may be different work categories, for instance, registered nurses (RNs) and licensed practice nurses (LPNs) in the United States.[5] Nursing education generally requires at least three years of targeted education, but here, too, a practice component may form a major share of the education. While some countries have no targeted education for LTC workers (such as Hungary and Poland), many countries – especially for lower-level workers – have educational programmes that combine some theory with practice training. Japan is among the countries reporting several training levels for LTC workers. Training is available to enable qualification as a care worker or as home helper. The duration of such (initial) vocational education is highly variable across OECD countries (Table 5.2).

In most countries, initial vocational training for LTC is publicly financed, although in some, there is a mix of public programmes with national certification, and private funding. For instance, in New Zealand, the industry's own training organisation provides for – mostly on site – training. However, although the demand for long-term care services is changing, curricula for the LTC sector show little development. This is especially the case for lower-level care workers. For instance, in the United States, the minimum federal training requirements of 75 hours training for nursing aides/home-health aides (with 12 hours per year of continued education) have not changed in 20 years (IOM, 2008). Many states have, however, installed additional requirements.

For lower-skilled care workers, standardisation of qualification is often lacking and many LTC workers will not have such qualifications. In the Netherlands, between 17 and 60% of the LTC employees do not have relevant LTC-related qualification (van der Velde *et al.*, 2010, p. 15). In Australia 30% of the community care workers have no relevant qualifications, with those in community based care less likely to hold a relevant certificate than their colleagues in institutional care (Martin and King, 2008). Data for the United Kingdom point to an overall low qualification level of social care workers (Cangiano *et al.*, 2009a). In the United States, 59% of the direct care workers have a maximum qualification level of high school or less (PHI, 2010) and in Germany, fewer than half of the workers in home care have a relevant qualification. Across Germany, some 300 different qualifications for "care assistant" existed in 2007 (Oschmiansky, 2010).

But over qualification is also not uncommon: 20% of the Dutch "helpers" have higher care-related qualifications (van der Velde *et al.*, 2010). The Canadian Home Care Resources Study (2003) reports generally high educational levels of Canadian LTC workers, with a

Table 5.2. **Initial training levels for the lower-level LTC workforce across the OECD**

	Nationwide training programmes available for LTC workers	Job title or category	Training scheme	Training content and duration	National minimum requirements in curriculum?	Remarks
Australia	Yes	Ancillary Worker	Community Service Training CHC20108	430 hours, 5 weeks in practical and theoretical training	Yes	
	Yes	Residential Aged Care Worker	Personal Care Worker Certificate III in Aged Care	555 hours/8 to 16 weeks. Practical and theoretical	Yes	
	No	Specialisation for Care Worker	Home and Community Care CHC40208	730-740 hours/up to 18 weeks. Includes additional work placement training, voluntary	Yes	
Austria	Yes	Home Assistants (*Heimhilfe*)	Basic training	200 hours theoretical course, 120 hours of practical training in ambulatory working stations and 80 hours in stationary departments	Yes	
	Yes	Care Assistants (*Plegehilfe*)		Minimum 17 years of age, mental and physical fitness. One year/1 600 hours of theoretical and practical instruction	Yes	
Canada	No	Ontario: Personal Support Worker (PSW)	PSW training programme	Two academic years (eight months), 384 hours of in class theory. 386 hours of practical experience. In-service training with employers	Regional	Overseen by the National Association of Career Colleges
	No	Personal Attendants		Similar to PSW programme but shorter in duration	Regional	
	Yes	Worker of Basic Social Care		Basic education + 150 hours expert course. Duty of 24 hours of additional education annually	Yes	
Czech Republic	Yes	Health Assistant		Four years high school		
		Nurse (assistant)		Three years high school		
Denmark	Yes	Social and Health Care Helper		One year seven months: 20 week basic course, 24 weeks school study, 31 weeks practical training	Yes	Six months relevant work experience, command of Danish
	Yes	Social and Health Care Assistant		One year, eight months, 32 weeks school study, 48 weeks practical training periods	Yes	Nordic/EU citizen
Estonia		Social Care Worker		Training of two years, of which 25% practice		

Table 5.2. **Initial training levels for the lower-level LTC workforce across the OECD** *(cont.)*

	Nationwide training programmes available for LTC workers	Job title or category	Training scheme	Training content and duration	National minimum requirements in curriculum?	Remarks
France	No	Home aid (*aide à domicile*) Household Assistant (*aide ménagère*) Family and Life Assistant (*auxiliaire familiale et de vie*)	Qualification for Social Carer (*Diplôme d'État d'auxiliaire de vie sociale*)	504 hours of technical and methodological training, 560 hours of practical training. Voluntary, Employer based	Yes	Pre-requisites: 3 000 hours of work over the last ten years
Finland		Long-term Care Worker		Vocational education, three years, 120 credits in total, with at least 29 credits of on-the-job training	Yes	
Germany	No	Elderly Carer		In accordance to Geriatric Nursing Act (2004), three years training programme. 200 hours theoretical training and 2 500 hours professional practice teaching	Local (*Länder*)	
		Additional institutional care workers (*Betreuungskräfte*)		Five day orientation internship, three modules of at least 160 hours, plus two weeks internships	Yes	
Ireland	Yes	Care Assistant for Elderly	FETAC Level 5 Certificate in Healthcare Support	36 weeks. 16 weeks training with Training and Employment Authority (FAS), 15 weeks integrated training (FAS and host employer), and five weeks on-the-job training with a host employer	Yes	At least 16 years of age
Japan	No	Home Helper		Special academic institutions	No	
	Yes	Certified Care Worker		To be eligible for State Examination for Certified Care Workers: One-year programme at training facility, or two- to four-year programme or three years of experience in personal care-related occupation	Yes	
	Yes	Certified Social Worker		To be eligible for State Examination for Certified Social Workers: Completion of a combination of theoretical and practical training for two to four years or college/university education in care-related subject	Yes	

Table 5.2. **Initial training levels for the lower-level LTC workforce across the OECD** *(cont.)*

	Nationwide training programmes available for LTC workers	Job title or category	Training scheme	Training content and duration	National minimum requirements in curriculum?	Remarks
Korea	Yes		2nd degree	120 hours dedicated training		Licensing required before one can work as LTC worker
			1st degree	240 hours dedicated training		
Norway		Skilled Care Worker	Health and Social Care Programme	Completion of lower secondary education. 2-3 years, 50% theory	Yes	
Netherlands	Yes	Care Work Assistant		Level 1: One year of training, no prior requirement. Mainly practice based		Dual trajectories: either a practice based education (BBL) or more theory-based (BOL) (full time)
	Yes	Care Work/Social Care Work Helper	Vocational training Level 2	Level 2: At least age 16, two years full-time assistant vocational education. Theory based	Yes	
	Yes	Individual Carer	Vocational training Level 3	Level 3: Requires preparatory intermediate vocational education (VMBO) or equivalent prior education (incl. diploma level 2); three years	Yes	
Slovak Republic				High school for nurses. 220 hours, emphasis on practical experiences		
Sweden	Yes	Auxiliary Nurse	Upper secondary level education	Three years	Yes	
	No		Private Association Training	Depending on programme: A few days to a month		
United Kingdom	Yes	Care and Support Workers	National Vocational Qualification Level 2 or 3 in Health and Social Care	Level 2: one year – six units, four mandatory and two optional units. Units of study vary according to educational institution	Yes	Government Target: 50% of all personal care must be provided by NVQ qualified by 2008
				Level 3: two years – eight units, four compulsory and four optional. Units of study vary according to educational institution		
United States	Yes	Home Health Aid		Two weeks training	Yes	High school diploma
		Personal Care Assistant		No Federal training requirements	Yes	
		Certified Nursing Aid		75 hours of classroom and practical training (some states require 120 hours). Competency evaluation within four months of work	Yes	Working in a federally certified nursing home

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing, and additional country documents.

third of the workers feeling underemployed. In Australia, 13% of the community care workers have higher but untargeted qualifications (Martin and King, 2008). Such outcomes are in line with more general outcomes according to which women often work below their qualification level (OECD, 2007a).

While LTC workers, on average, have lower qualifications than health workers (Fujisawa and Colombo, 2009), in many countries those working in institutional care have higher qualifications than those working in home care. In Australia, community care workers are more likely to have post secondary qualifications than institutional care workers, even though unrelated to their aged care work (Martin and King, 2008). Smith and Baughman (2007), and van der Windt *et al.* (2009) provide a similar picture for the United States and the Netherlands.

5.3. What are the working conditions in long-term care?

Benefits and wages are lower in home care

Wages in LTC are generally low (Table 5.3). Fujisawa and Colombo (2009) state that low-skilled LTC workers in most countries earn somewhat more than the average for low-skilled workers. For instance, the median hourly pay for care workers in adult care services in the United Kingdom is GBP 6.56, which is 14% higher than the national minimum wages (Cangiano *et al.*, 2009a; 2009b) and lower than in the health care sector, particularly in home care. Data are scarce, however, and inconclusive.

Furthermore, experience may not translate into remuneration. Direct care workers in the United States often lack annual wage increases, while home-care workers are exempt from minimum wages and overtime protection as they do not fall under the Fair Labour Standards Act. German, US and New Zealand data indicate nurses in long-term care earning lower wages (and working fewer hours) than those in other parts of health care (Rothgang and Igl, 2007; Ministry of Health/Auckland University, 2004). Wages may also differ according to region. Canada, for instance, reports lower wages for LTC workers in rural areas.

As in many other sectors, there are gender differences in pay levels in LTC.[6] In Japan, male nursing care workers earn 11% more than their female colleagues (Health and Welfare Bureau for the Elderly, 2010), irrespective of the number of years of continued employment in the sector, while institutional earnings are higher than in home care (Hotta, 2010).

Besides wages, in some countries, LTC workers lack job benefits, such as health insurance in the United States (PHI, 2007; 2010), or have more limited benefits than most other workers have. Partly, this is because there is an overrepresentation of part-time work in the LTC sector, and, in general, part-time workers have more limited access to such benefits. Low wages combined with part-time work may therefore lead LTC direct care workers to remain dependent on public safety nets. In the United States, many LTC workers are dependent on public support programmes such as food stamps, Medicaid, public housing, child care, energy and transportation assistance.

Care work is demanding and burdensome (Korczyk, 2004; Cangiano *et al.*, 2009a), leading often to early retirement due to stress and burnout (European Foundation for the Improvement of Living and Working Conditions, 2006). The likelihood of poor work-related health, too, is an important reason for discontinuing employment (Ministry of Health/ University of Auckland, 2004). While Dutch care and welfare workers are satisfied with their jobs compared to those in other sectors, they are also less likely to state their willingness to continue working until their 65th birthday (CBS, 2010, p. 145). Similarly,

Table 5.3. **Wages in LTC**

	Wages (monthly gross, unless mentioned otherwise)	Remarks/sources
Australia	Registered nurses (RN) Level 1 top per annum wages: AUD 55 123 (around EUR 40 122) to 61 869 (around EUR 45 038). Personal care worker: AUD 28 079-37 267 (around EUR 20 440-27 128) to AUD 36 131-38 986 (around EUR 26 299-28 377) (levels around 2009)	Wages vary according to function and jurisdiction. Wages for personal care workers at max classification may include managerial positions Wages are 50% more than minimum weekly in 2002 (Fujisawa and Colombo, 2009)
Belgium	Basic annual (gross) wages 2009: EUR 21 997-34 562: Nurse assistant EUR 22 798-37 596: Registered nurse	*www.werk.belgie.be/CAO/330/330-2009-000655.pdf* Exclude additional payments (inconveniency, annual leave, etc.)
Canada	Home-care workers: CAD 16.1 (around EUR 11.8) per hour. LTC workers: CAD 12.7 (around EUR 9.3) (home-service workers) to CAD 24.4 (around EUR 17.9) hourly (RNs)	Fujisawa and Colombo (2009)
Czech Republic	Nurses: CZK 22 900 (around EUR 944) Nurses auxiliary and ambulatory attendants: CZK 14 400 (around EUR 593) Salaries in social services sectors: Nurses: CZK 24 009 (around EUR 989) Nurses auxiliary: CZK 18 395 (around EUR 758) Ambulance attendants: CZK 16 179 (around EUR 667) per month	2008 data. Average salary: CZK 24 282 in 2008 (according to Czech Statistical Office)
Estonia	Nursing care hospital workers salary (March 2009) EEK 22 809 (around EUR 1 458) (March 2008: EEK 18 550; around EUR 1 185)	
Finland	(end 2009) Average salary licensed practical nurse: EUR 2 370 RN: EUR 2 860	There are no significant differences in salary levels between local government and private sector
France	Monthly wages (2009) at 31 years of age in private not-for profit sector: – *infirmier diplômé d'État* EUR 2 442 – *aide-soignant* (personal carer) EUR 1 852 – *aide médico-psychologique* EUR 1 856 – *auxiliaire de vie sociale* EUR 1 856	LTC workers in private contract earn minimum wage, while those working through agencies earn 50% more (Fujisawa and Colombo, 2009)
Germany	72% of all elder care full-time employees interviewed earn under EUR 2 000; 48% earn less than EUR 1 500	Nölle and Goesmann (2009); Fuchs (without year); reported in: Oschmiansky (2010)
Ireland	Annual Home Help: EUR 29 352-EUR 30 659 (levels: 2008) Nurses aides (Dublin, non-paypath): EUR 29 269-EUR 30 630	
Japan	**Home helper,** age 43.9 years, 4.4 years service, nine overtime hours: JPY 211 700 (around EUR 1 888) monthly; special annual wage: JPY 278 600 (around EUR 2 485) **Nursing care worker of welfare facility,** age 35.8 years, 5.2 years service, four overtime hours: JPY 215 800 (around EUR 1 924) with special annual wage JPY 505 000 (around EUR 4 502) **Home-visit care workers,** average monthly: JPY 207 641 (around EUR 1 844) **Institutional care workers:** JPY 217 415 (around EUR 1 937)	(data reported June 2008) *Heisei Nijyu Jyuhachi Nendo Kaigo Rodo Jittai Chosa* (2008 Fact Finding Survey on Long-term Care Work) Wages appr. 64-47% of average (Fujisawa and Colombo, 2009)
Luxembourg	*Infirmier:* EUR 2 978-EUR 6 071 *Aide-soignant:* EUR 2 373-EUR 4 402	Excl. inconveniences, annual leave, etc.
Netherlands	Example: "*Ziekenverzorgende in de wijk*": Wages: EUR 1 729 to EUR 2 558 (2008), depending on experience	Wages based on collective labour agreements (CAO-VVT-2008-10). Employers receive compensation for "wage sensitive" costs. Wages exclude overtime, inconvenience rostering, annual extras
New Zealand	Median hourly wage for personal and home-care aids (2000): NZD 7.50 (around EUR 4.2)	Health Outcomes International (2007)
Norway	(as of end 2008): NOK 29 000 (around EUR 3 657) per month	
Slovak Republic	2009: EUR 276-EUR 385 gross monthly (both institution and home care)	Overall average salary: EUR 766.41; minimum (2009): EUR 295.5

Table 5.3. **Wages in LTC** *(cont.)*

	Wages (monthly gross, unless mentioned otherwise)	Remarks/sources
Slovenia	Basic monthly wages: Nursing assistant II, 15 wage grade (WG): EUR 817.43 Nurse holding secondary education degree, 21 WG: EUR 1 034.30 The basic wage for a social carer, 13 WG: EUR 755.75	Wages between 50-70% of national average (Fujisawa and Colombo, 2009)
United Kingdom	Median hourly wages for LTC in adult social care: GBP 6.56 (around EUR 7.62)	14% above minimum; lower than in health care, esp. in home care Private sector pays lower than not for profit, lower than public sector (Cangiano *et al.*, 2009a, 2009b)
United States	2007: Direct care workers: Median hourly wages USD 10.48 (around EUR 7.67) (2007). In 2008: 0.5% decrease	Wages are 31% below US median. 2008: US Median increases by 3% (PHI, 2007, 2010) Wages appr. 51% of average wage in 2007 (Fujisawa and Colombo, 2009)

Notes: Country currencies are converted into euros using the 2011 exchange rates. LPN: Licenced professional nurse. RN: Registered nurse.
Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing, unless other sources are mentioned.

Australian data suggest that there may be limits to how long-term care workers remain in the sector (Martin and King, 2008). Even though, in Australia, the United States and New Zealand, some LTC workers continue to work until their 70th birthday, few LTC workers generally remain active in the sector until retirement.

Work-related accidents and injuries are common in LTC. In the United States, nursing aides, orderlies and attendants have the third highest number of injuries and illnesses, second only to truck drivers and labourers (US BLS, reported in Squillace *et al.*, 2009). A third of the certified nursing aides incurred at least one work-related injury, leading almost one in four unable to work for at least one day during the last year. Depression and – due to lifting and carrying of care recipients – lower back problems and being hurt on the job are common (Gleckman, 2010). High psychological pressures, caused by high work pressures and lack of labour satisfaction are also said to contribute to sickness (BGW, 2006). Especially the care for people with dementia can lead to high psychological stress (Schmidt and Hasselhorn, 2007).

High work pressures may also contribute to violence. Half of residential care workers in New Zealand feared violence by clients, as opposed to 25% in home care (Ministry of Health/University of Auckland, 2004), while verbal abuse by especially dementia patients is not uncommon. The *European Nurses Early Exit Study* (NEXT) found that 22% of nurses experience violence by patients or family at least once per month (Estryn-Behar *et al.*, 2008), with nursing aides more often experiencing violence. Frequent work interruption, high workload, longer working-week duration, working in night shifts, all increased the likelihood of experiencing violence. Those working in geriatrics and long-stay departments reported at least monthly violence by patients or family (those in day care and home care experienced least violence). Those experiencing the highest levels of violence have the highest incidence of burn out and are more likely to leave the employer or even the sector. Nearly half of the Canadian institutional care workers experience violence (verbal, sexual, racial) on a daily basis (Banerjee *et al.*, 2008). Such experiences, are likely to be associated with understaffing, lack of communication and collegial support (Banerjee *et al.*, 2008). Similar problems have been signalled by Koshitani (2008) for Japan.

Relationships with management affect how LTC workers deal with experiences of high work pressures and violence. For instance, bureaucratic procedures, a blame culture, the lack of trust between direct care workers and their management, as well as management's focus on residents, all prevent workers in Canada from reporting incidents (Banerjee *et al.*,

2008). Similarly, most Japanese care workers have major concerns about how they are treated and evaluated by management (Hotta, 2010). Work pressures and unskilled or inadequate management, coupled with high turnover including in management, can lead workers to feel inadequate, and take blame where pressures are systemic such as in the case of staffing shortages.

Despite often poor working conditions, LTC workers in many countries consider their work meaningful and rewarding and an option for growth (Kushner *et al.*, 2008; BGW, 2007, for Germany; Hotta, 2010, for Japan). They like their caring responsibility and teamwork in institutions, giving recipients dignity and respect as well as a sense that they are not alone. There is also the family's satisfaction with the job done, and learning from residents' life experiences (Teal, 2002; Cangiano *et al.*, 2009a). Compared to most other sectors, Dutch workers in health and welfare score third among the most satisfied with their work (CBS, 2010, p. 142). They also, however, consider their work more varied. This is despite workers' considering their work heavier in terms of the required use of force and uncomfortable working positions, or psychosocial stress and emotional demands.

Job appreciation seems to have an age-related component. For instance, German care workers aged 50 or over are happier with their job than younger care workers, even though both categories appreciate their work to a similarly positive extent (BGW, 2006; 2007, Box 5.1). Caregivers in Japan also appreciate the flexibility of the work, but younger workers experience a lack of prospects (Hotta, 2010).

Box 5.1. **Working conditions in home care differ from those in institutional care**

The differing location and character of service delivery in home care and institutional care have consequences for working circumstances (van Ewijk *et al.*, 2002; Korczyk, 2004; Rothgang and Igl, 2007; Bourgeault *et al.*, 2009). In both, issues relate to night- and broken shifts and fixed term contracts. In home care more than institutional care, there is a lack of compensation for travel costs, and lack of compensation for team meetings and travel between clients. Working circumstances may be especially difficult in socially less advantaged neighbourhoods and in difficult home situations and often there are no options to work in a safe and healthy way. In institutional care settings, colleagues may act as direct soundboard, while there is super- or inter-vision. In home care, such mechanisms are often lacking and workers act in isolation (Ministry of Health/University of Auckland, 2004). Moreover, in home care, conflicts of interest can arise between the care recipient, the available family members and the worker's knowledge, attitude and allowed responsibilities, while in institutional care colleagues are available, including a hierarchy. In institutional care, however, the share of care recipients with severe cognitive problems tends to be higher than in home care, as well as the share of care recipients without family network.

German workers reflect on work in residential and home care as follows (BGW, 2007):

"*Institutional care involves much lifting and carrying, high emotional and quantitative demands, too much engagement during work, much psychic exhaustion (burnout). Younger workers feel the meaning of their work is hardly recognised by others, while older workers experience uncertainty about employment, relative bad health and a very high degree of daily life impairment as a result of spinal disorders. On the positive side workers are happy about the management quality, interhuman relationships and with wages. Both young and (especially older) workers feel high commitment with the facility.*

Box 5.1. **Working conditions in home care differ from those in institutional care** *(cont.)*

Home care: Fewer negatives, more positives: Workers experience little influence on work, working conditions and circumstances burdening the family, while family's worries influence the work. Especially younger workers experience high uncertainty about the treatment, involvement in work is 'excessive' (younger but especially older workers). Mental exhaustion (and the risk of burnout) is relative strong, especially for older workers. Positive for workers are: Little lifting, few quantitative labour demands, good developmental possibilities at work (especially older workers), good management and social support by management as well as social support by colleagues (younger workers only), good interhuman relationships (especially older workers), relative high labour satisfaction, high commitment with the facility."

Regulations concerning home-care delivery are often far less detailed or strict than those in institutional care, and also relate to worker guidance and protection. Given the longer tradition of institutional care *versus* home care in many countries, it is also likely that institutional care workers have a higher unionisation rate, thus having a better voice for their needs.

The subsectors seem also to reflect worker characteristics such as age and education levels. Wages in home care tend to be lower than in institutional care (for the same qualification level), but educational requirements are also lower.

Poor working conditions lead to recruitment problems and high turnover[7]

Poor working conditions can lead to recruitment problems, high turnover, workers leaving the sector and workers limiting the number of years spent working in the sector. For instance, vacancy rates in social care in the United Kingdom are twice as high as in other sectors (Cangiano *et al.*, 2009a). In the United States, between two and three out of five home-health aides leave the job within a year, and over two-thirds leave in the first two years. For Certified Nursing Assistants, the turnover was 71% annually, leading to staffing shortages (IOM, 2008). Similarly, turnover in the Japanese LTC sector (27.5%) is higher than in other industries especially for non-permanent employees in institutional care (Hotta, 2010; Japan Long-term Working-condition Survey, 2008; Japan employment situation survey, 2008). Many of those leaving an LTC job leave the sector altogether.

While turnover may be higher for lower-level workers, vacancy rates for higher-level LTC workers – especially nurses – may have more adverse consequences because they often hold higher responsibilities, and often fulfil middle management tasks. Low staffing levels of registered nurses in nursing homes have led to adverse resident outcomes, such as urinary tract infections, pressure ulcers, catheter use and weight loss (Decker, 2008). Recent US vacancy rates in LTC are higher for registered nurses (16.3%) than for licensed practical nurses/licensed vocational nurses (11.1%) and for certified nurse assistants (9.5%) (American Health Care Association/National Center for Assisted Living, 2009).

The costs of high turnover and recruitment efforts affect the public budget, as in many countries a major share of LTC is publicly funded. For instance, estimated turnover costs for the US public programmes Medicaid and Medicare are USD 2.5 billion, based on a cost per replacement of USD 2 500 (Seavey, 2004).

5.4. Foreign-born workers play a substantial and growing role in some countries

Why care workers migrate?

In a number of OECD countries, foreign-born care workers play a substantial role in the care sector (Table 5.4). They may enter LTC by active recruitment in their home country, but can also, especially when already in the host country, be a target group to fill vacancies. In 17 of 23 European countries that took part in the Eurofamcare study, migrant care workers played a more or less significant a role (Mestheneos and Triantafillou, 2005).

Table 5.4. **Foreign-born care workers in LTC**

	How many foreign-born LTC workers?	Source
Australia	25% of care workers (2007)	Fujisawa and Colombo (2009)
	33% in residential aged care (2007)	Martin and King (2008)
	27% in home-based care (2007)	
	12.5% of nurses are foreign-trained (2005)	OECD (2007b)
Austria	50% of all (formal and family) care providers	Fujisawa and Colombo (2009); Di Santo and Ceruzzi (2010)
	40 000 illegally operating care workers (mid-2006)	European Foundation for the improvement of living conditions (2009)
Belgium	3.3% foreign nurses (2005)	OECD (2007b)
Canada	23% of institutional care workers	Bourgeault *et al.* (2009)
	7.7% of registered nurses foreign-trained (2005)	OECD (2007b)
Denmark	6.2% of registered nurses foreign-trained (2005)	OECD (2007b)
	11% of all LTC workers have a migration background*	Rostgaard *et al.* (2010)
France	50/70% of those providing IADL support	Di Santo and Ceruzzi (2010)
	1.6% foreign nurses (2005)	OECD (2007b)
Finland	0.3% of nurses foreign-trained (2005)	OECD (2007b)
Germany	Circa 200 000 migrant care workers (2007)	Di Santo and Ceruzzi (2009)
	3.8% of nurse s foreign trained (2005)	OECD (2007)
Greece	Circa 250 000	Di Santo and Ceruzzi (2009)
	70% of care workers in private households	Fujisawa and Colombo (2009)
Italy	Appr. 1 million, 72% of all care workers	Lamura *et al.* (2010)
	Circa 700 000 migrant workers in home care	Di Santo and Ceruzzi (2009)
Ireland	14.3% of registered nurses	OECD (2007)
Israel	55 000 migrant LTC workers, about 50% of all LTC workers	OECD (2010b)
Netherlands	8% of LTC workers	Fujisawa and Colombo (2009)
	1.5% of registered nurses foreign-trained (2007)	OECD (2007b)
New Zealand	24.3% of nurses are foreign traineed (2004)	OECD (2007b)
Sweden	20% of 19 000 new employees in health and welfare	Swedish Association of Local Authorities and Regions (2006)
	13% of all employees in care of the elderly and disabled (2005)	
	2.7% of registered nurses foreign-trained	OECD (2007)
United Kingdom	Nurse auxiliaries: 17%	Cangiano *et al.* (2009a)
	Nurses in home care: 23%	
United States	Of direct care workers: 21% (2007) to 23% (2009)	PHI (2007, 2010)
	33% of home personal and home-care aides	Martin *et al.* (2009)
	3.5% of registered nurses foreign-trained (2004)	OECD (2007b)

Source: OECD Secretariat compilation.

Pull factors attracting foreign-born care workers to a foreign country include geographical proximity, language, culture, and wealth – and thus options to earn a living – of the host country. Some countries have a history as immigrant countries and are perceived as attractive, while others may be attractive for certain people for certain reasons, amongst which climate, options for education, options for *temporary* migration, or an already existing migrant community. Across countries, all these factors or just a few can

be observed. For instance, the attractiveness of LTC work in Greece for Philippine workers seems linked to the opportunity to work while language, culture and geographical proximity and other factors do not play a substantial role. A significant share of the foreign-born LTC workers in the United Kingdom has a student status (Cangiano *et al.*, 2009a). Proximity, as well as language and cultural likeness can be seen in the 15% nurses migrating to Australia from New Zealand, as well as in the 10% Belgium-trained nurses in the Netherlands (OECD, 2007b).

Patterns of migration show similarities for LTC workers and for nurses. Geographical proximity, combined with high cross-border earning differences, seem important, for instance in Southern Europe, Germany and Austria. The enlargement of the European Union in 2004 facilitated such migration patterns. Half of the Italian recognition procedures (2005) referred to Romanian nurses, for example (OECD, 2007b, p. 189).

Profile of migrant care workers

The overall profile of foreign-born LTC workers generally follows that of other LTC workers. Most are middle-aged women (Fujisawa and Colombo, 2009), although recently migrated foreign-born care workers in the United Kingdom are, more often than other care workers, aged between 20 and 35 years (Cangiano *et al.*, 2009a).

Qualifications levels differ, but in many countries a phenomenon of de-skilling can be observed (OECD, 2007b; 2009; Fujisawa and Colombo, 2009; for the United Kingdom: Jennings, 2009). In Canada, 44% of the foreign-born care workers is a registered nurse in the country of origin, but works at a lower level (Bourgeault *et al.*, 2009). Similarly, many foreign-born nursing aides in the United States are university trained in their home country (Redfoot and Houser, 2005). Of the Moldovan family assistants in Italy, 70% have a university degree (Di Santo and Ceruzzi, 2010). For most countries, however, the share of foreign-born LTC workers with a nursing qualification is unknown. Data on foreign-born nurses in Table 5.4 are therefore likely to underestimate the migration of those *qualified* as a nurse in their home-origin country and not – yet – recognised in the host country. Indeed, for some foreign-born nurses, working at lower level in a host country can be a phase while working towards the recognition of qualifications (Bourgeault *et al.*, 2009, p. 62).

Data from around 2000 about foreign-born and/or foreign-trained and recognised nurses, of which an unknown share may work in long-term care, suggest a fourfold categorisation. Countries with both high inflow and high outflow of nurses include Luxembourg, Canada, the United Kingdom, New Zealand and Ireland. Countries with high immigration and low emigration of nurses are the United States, Australia, Austria and the Czech Republic. Finland was the only OECD country with little inflow but high outflow of nurses. Other countries have both little immigration or emigration (OECD, 2008, p. 31). Of the foreign-born nurses in Australia, 48% is from the United Kingdom or Ireland (OECD, 2007b).

Working conditions of migrant care workers

Foreign-born care workers often work with shorter contracts, more irregular hours, broken shifts, for lower pay and in lower classified functions than non-migrant care workers and may have to work with the least favourable care recipients (Bourgault *et al.*, 2009; Fujisawa and Colombo, 2009; Cangiano *et al.*, 2009a). Uncertainty about immigration rules and their rights may lead them to adhere more closely to employers' wishes and stay in the job longer than domestic workforce (Cangiano *et al.*, 2009a). They may be subject to verbal abuse or outright refusal to be cared for by the client, especially at the starting phase of a caring contact

(Walshe and O'Shea, 2009), but they may also experience such behaviour from colleagues and employers (Cangiano *et al.*, 2009a). Those in round-the-clock live-in arrangements are especially vulnerable to personal and financial exploitation (Cangiano *et al.*, 2009a; 2009b; Lamura *et al.*, 2010) due to lack of communication problems, and lack of freedom to move. Opportunities for upward mobility and training may also be more restricted for foreign-born workers, while they can lack trade union support (Cangiano *et al.*, 2009a).

Poorer working conditions than for native-born workers can be observed across the OECD. For example, fewer foreign-born health professionals have a permanent contract, compared to natives (OECD, 2007b, p. 75). In both the EU27 and EU15,[8] higher shares than native nurses and health professionals work longer than 41 hours per week, work at night regularly, and work "usually" on Sundays. However, foreign-born nurses are just as likely as native-born to have a permanent contract (OECD, 2007b, p. 199).

Nearly a third of the foreign-born care workers in the United Kingdom earn wages below the national minimum, as opposed to 22% of UK-born care workers (Jennings, 2009). Higher shares of foreign-born care workers can be found in the private sector in Ireland and the United Kingdom, as opposed to the better paying and more unionised public sector (Walshe and O'Shea, 2009; Cangiano *et al.*, 2009a; Yeates, 2005; Lamura *et al.*, 2010). For the United States, employers are quoted saying that they hire foreign-born workers because they are more willing to accept lower wages and less flexible working conditions relative to native workers. Lower wages for foreign-born workers, are, however, not specific for long-term care. Such differences have been analysed for several countries in the labour market as a whole (OECD, 2010a, pp. 170-172).

In England, foreign-born LTC workers tend to work in institutional facilities, whereas in Southern Europe they are mostly working in home-based settings (Cangiano *et al.*, 2009a; Jennings, 2010). In the United States, substantial shares of foreign-born workers are in institutional LTC but even higher shares work in households.

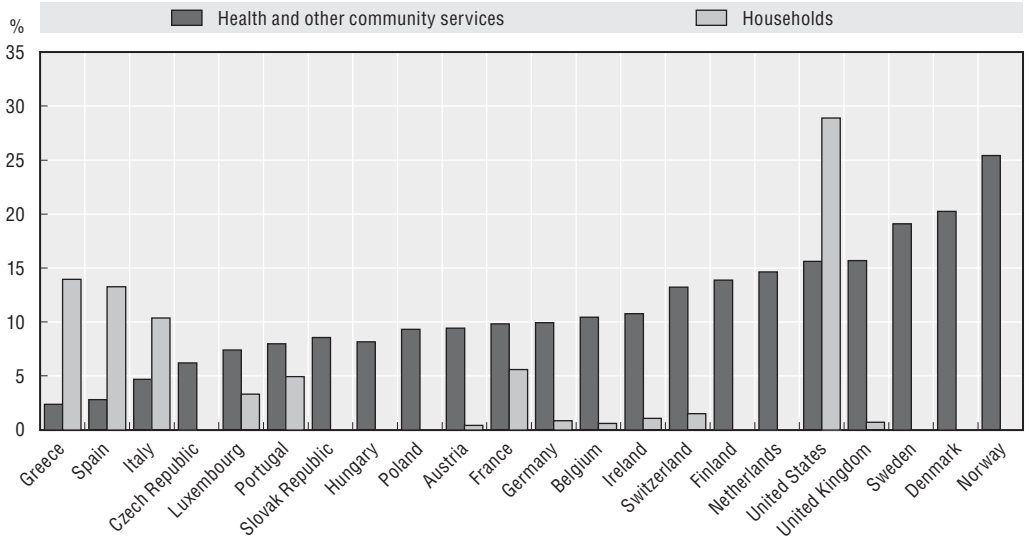
Are migrant care workers over represented?

Figure 5.6 shows the share of foreign-born in the household sector, and the health and community sector. In Greece, Portugal, Spain and France, migrants are overrepresented in household services, including home care, *i.e.,* the share of foreign-born employment in the sector is larger than the share of foreign-born employment in general. Similarly, in Greece, the Czech Republic, Poland, Austria, Ireland, Switzerland Finland, the United Kingdom, Sweden and Denmark, foreign-born workers are over represented in health and community services. Data may, however, under-represent un-contracted migrant care workers.

While a multi ethnic workforce may reflect the increasing diversity in a country's population and demand for care, overrepresentation of minorities in LTC jobs may point to the sector being unattractive to native-born workers. For instance, more than half of the direct care workers in the United States are from an ethnic minority with a further 23% foreign-born (PHI, 2010). Similar overrepresentation of minorities is reported for Australia, New Zealand, and the United Kingdom (Martin and King, 2008; Ministry of Health/University of Auckland, 2004, Cangiano *et al.*, 2009a). Partly, such patterns may reflect *past* immigration processes. On the other hand, the Dutch health and care professions have substantial underrepresentation of workers with a Turkish or Moroccan background (Ministerie van Volksgezondheid, Welzijn en Sport, 2007).

Figure 5.6. **Employment of foreign-born in health and other community services and households**

Share of all foreign-born employment, 2005-06 average



Note: For the United States, "Health and other community services" refer to the wider "Education", and the "Households" to "Other services". Data for Germany refer to 2005 only, for Japan to 2006 only.

Source: European countries: *European Community Labour Force Survey* (data provided by Eurostat); Japan: *Labour Force Survey*; United States: *Current Foreigners Population Survey*, March Supplement, reported in: *OECD International Migration Outlook* (2008).

StatLink http://dx.doi.org/10.1787/888932401558

Migrant care workers follow different channels

Migration processes may differ. Many foreign-born LTC workers in the United States are actively recruited in their home country by specific job agencies (Martin *et al.*, 2009). In several low-income European Union countries, job agencies specialised in sending workers to other EU Member States operate (Di Santo and Ceruzzi, 2009). But most foreign-born care workers in the United Kingdom are recruited domestically (Cangiano *et al.*, 2009a) or have entered the country via non-labour related channels, such as being refugee, in the context of family reunification schemes, working holiday, or as students (Cangiano *et al.*, 2009b). Similarly, a major share of the foreign-born care workers in the United States has been naturalised, an indication of a longer stay in the country.

In some OECD countries, especially southern European countries, several migrant carers work without legal immigration papers or work contracts. This is due to a combination of factors, such as economic incentives for both the migrant carers and the employer, as well as to the lack of formal legal migration possibilities for low-skilled workers (see for example the case of Italy in Box 5.2). Formal legal entry into a country's care workforce may also be difficult as it may require linguistical skills, *a priori* proof of a certain minimum income in the host country, adaptation periods and recognition of professional qualifications (Redfoot and Houser, 2005; Martin *et al.*, 2009). Moreover, while almost all OECD countries stimulate immigration of highly skilled workers, few have programmes that allow for easy access of migrants in relation to lower-level jobs (OECD, 2009, see also Chapter 6).

As options for legal entry for lower skilled jobs are limited in some countries despite high demand, irregular inflows can exceed the regular one, as for example in the United States, Spain and Italy (OECD, 2009, p. 125). In 2009, estimates of the share of illegal

Box 5.2. **Italian family assistants**

Home-based care provision in Italy relies mainly on foreign-born care workers. This is almost entirely due to a universal, unregulated cash-benefit system; a fast ageing population with increasing female labour participation; and geographical proximity to low-wage countries (both within and outside of the European Union), coupled with entry via legal channels, illegal border crossing and overstay. In 2010, 13% of the households involved in care had hired migrant carers, especially for heavy care tasks. While, in 1991, 16% of the 181 000 workers had foreign background, currently some 72% of the 1.5 million care workers is foreign-born (Lamura *et al.*, 2010). Several regularisation measures have been taken. In 2002, 22% of the 646 000 foreigners working in the black economy were regularised, while between 2002 and 2008, 300 000 family assistants (including nannies and care workers) were regularised, an estimated 42% of all family assistants. Not only were there more applicants than available visas, but families seeking care workers had immediate needs and could not wait for a visa, while employers did not apply for a visa without having seen the foreign worker. The 2009 regularisation processed 39% out of the 750 000 expected, possibly because migrants had to pay EUR 500 in social insurance contribution. Employers had also to prove the worker's accommodation, have a minimum – declared – income of EUR 20 000 per year, while the contract should be at least 20 hours per week. Moreover employers were to pay social contributions after regularisation. Studies suggest that other migrants than care assistants took advantage of the scheme as well.

For foreign-born workers, working as a family assistant often is the easiest or only job to find. One third lives permanently with the family. House cleaning is part of the job for 80% of them, and more than half goes shopping. Half cares for an older person, and a third provides ADL support, while 29% provides medical assistance. Newly arrived foreign-born care workers, more than those arrived since the mid-1990s, often work on an hourly basis instead of 24 hours/7 days, and focus on shorter periods of work before returning. More than half of the foreign-born family assistants work entirely or partially without a contract, while regular workers, too, increasingly work undeclared.

Recently, some regions implemented registers for family-care assistants, while local councils installed social care helpdesks. Moreover, home-tutoring initiatives and training courses to further educate and train the migrant care workers have been started at local level, but content varies and certification has no wider value. Regions such as Abruzzo and the Veneto Region introduced further incentives for legalisation: up to full compensation for the required social security contributions, in the shape of an additional allowance, under certain conditions, amongst which a contracted or registered status as family assistant.

Italian-born family assistants currently account for 10% of those working in private households.

Source: Bettio *et al.* (2006); Chaloff (2010); Lamura *et al.* (2010); Di Santo and Ceruzzi (2010).

migrants in OECD populations varied from 0.2% in Japan to 3.9% in the United States, with illegal migrants accounting between 3.7% of all foreign residents in Austria to 63.5% in United States (OECD, 2009). For Canada, it was estimated that some 60 000 migrants were in the country illegally, most of which refugees (Bourgeault *et al.*, 2009).

5.5. Changes in LTC policies affect LTC labour markets

Worsening working conditions for lower-level LTC workers

Most people requiring LTC prefer care at home, and both institutional and home-care settings are increasingly populated by higher-need care recipients (CBS, 2010; Ministry of Health/University of Auckland, 2004). But across the OECD, the number of workers per care recipient and the qualification mix have remained stable over time, possibly leading to heavier workloads and more intense care processes in both subsectors, *ceteris paribus* (such as the mix of technology and labour). Lower-level care workers appear to be especially affected by changes. According to Oschmiansky (2010), the introduction and expansion of market-based incentives for care providers in Germany led to deteriorated working conditions – less job security, smaller contracts and less social security – for lower-level care workers, while at the same time conditions for a new class of highly qualified LTC specialists improved. The LTC insurance law led to job differentiation and professionalisation, while also leading to increased shares of "atypical" workers in the LTC workforce (*e.g.*, workers with small contracts). Since 2003, previously existing traditions of employers providing qualification options in LTC were replaced by short-term training options. These changes took place in a context of labour market policies under the framework of the European internal market. Data for Japan and Germany show a substantial increase in, especially, lower-level care workers, resulting in a reduction of the share of nurses in the sector.

The 2007 Dutch introduction of tendering procedures for the delivery of household care led to risk transfer from central government to local authorities, and subsequently from these to care provider organisations. These then shifted the risk to low-level care workers by deteriorating working conditions and labour contracts (Box 5.3). Toronto

Box 5.3. **The Dutch transition of IADL support to the Social Support Act**

In the Netherlands, IADL care was transferred from the Exceptional Medical Expenses Act (AWBZ) to the new Social Support Act (WMO) in 2007. It included a transfer of EUR 1 billion for the provision of household care from the AWBZ to the municipalities, the executors of the WMO.

As of 2007, home-care providers were to bid for contracts, while previously, IADL care was contracted by regional "care offices" – the executive branches of the AWBZ – under a relative competition-free environment. While IADL previously was provided by so-called "helpers 1" and "helpers 2", in certain ratios (for instance, 35:65), many municipalities reversed this ratio, requiring providers to accept lower tariffs. However, while the composition of the workforce reflected the old ratios, with available tariffs often below cost (for the new ratio), some providers refused to enter a bid, others felt obliged to but either accepted losses or adjusted working conditions, especially for those providing IADL. Layoffs and rehiring for worse conditions occurred. Other workers had to change employer, or accept a worse collective labour agreement, for instance that for cleaning agencies (Roerink and Tjadens, 2009). Van der Windt *et al.* (2008, pp. 76-77) add that some workers were additionally trained, while new employees got only temporary contracts, and for a more limited number of hours. Many workers had to accept the option to work as "alfa worker", a self-employed worker against tariff, who can work for maximum 24 hours per week. The care recipient is to pay part of sickness benefit in case the alfa worker becomes incapacitated to work. Often, the previous employers acted as job agency with the clients sometimes unaware of this change in status, even though, now, they were employer.

Box 5.3. **The Dutch transition of IADL support to the Social Support Act** *(cont.)*

While between 1998 and 2005 the number of alfa workers declined steadily (CBS Statline), 2008 estimates suggest that the number of alfa workers was higher than in 1998 (Torre and Pommer, 2010). For 2009, further increases were expected. This development led to repair laws stimulating employers to rehire workers "transferred" into alfa workers, and forbidding care provider agencies from acting as "employment agency" for alfa workers. Per 2010, a care recipient decides whether to receive care in cash (and hire an alfa worker), or receive "care in kind" (de Klerk *et al.*, 2010). It is estimated that by the end of 2010 some 16 000 alfa workers will be re-employed (Torre and Pommer, 2010).

home-care workers cite heavy provider competition as undermining co-operation and leading to lower wages (Kushner *et al.*, 2008; see also Hunter, 2009). Several reports point at the wage pressure in the LTC sector, often a consequence of cost control measures leading to relative high shares of foreign-born workers in the United States, the United Kingdom and Australia (AAHS/IFAS, 2007; Charlesworth and Marshall, 2010; Cangiano *et al.*, 2009a; Spencer *et al.*, 2010).

The role of self-employed and agency workers

Using "external workers", such as those hired through a job agency, is one way for providers to deal with shortages and high turnover. The use of agencies is becoming increasingly common. For instance, in Japan, almost one in three workers is hired through an agency in facilities providing institutional care services, although high shares can also be seen in other types of facilities (Hotta, 2010). External workers, however, may lack relevant qualifications. Moreover, due to agency fees, external workers may come at a higher cost.

Another type of external worker is the self-employed worker. Estimates for the United States suggest that between 400 000 (PHI, 2010) and 560 000 (PHI, 2007) direct care workers work as independent contractors. A substantial share of those that were forced into self-employment in the Dutch decentralisation of IADL provision does not wish to return to employee status. Self-employment has the attraction of allowing workers to provide the services as they see fit. Some self-employed may focus on the more "endearing" care recipients and circumstances that fit their own requirements, an option often not available for employees. For others, the self-employed status may provide them with an option to get work, without relevant qualifications. However, self employment comes at a cost, as workers will have to arrange for their own social security, and there may be more uncertainty about future work. Issues may finally arise as to quality, responsibilities and the supervision of the self-employed. Without supervision of the way resource *(e.g.,* cash benefits) are spent, grey and black labour markets serviced by self-employed workers may develop (Di Santo and Ceruzzi, 2010).

The impact of cash benefits on LTC labour markets

Cash-benefit schemes may have differential consequences for the labour market, depending on their regulation. Some schemes provide relatively low allowances and expect the care recipient to contribute to the costs of services. In some cases the cash benefit is only provided if no in-kind services are available.

Cash-benefit systems can reinforce a direct connection between worker and care recipient, which is often shown to increase care recipient satisfaction as s/he is empowered to take decisions. The direct connection is also one of the elements that is often favoured by care workers, and which may lead them into self-employment. Such systems introduce an employer-employee relationship into the care situation, with both desirable and undesirable effects for both the care recipient and the care worker, especially if a family member becomes the employed care worker. Furthermore, cash benefits may increase the entry of non-qualified workers in home-care settings, as it is up to the beneficiary to choose and employ workers.

The impact of cash benefits on LTC labour markets is mixed. Unregulated cash benefits led to high use of irregular workers in a number of countries (Fujisawa and Colombo, 2009), in some cases introducing competition between those acting on the black labour market and the formal LTC workforce, such as in Germany.[9] The unregulated Austrian and Italian cash-benefit schemes led to high demands for cheap labour, and to competition with contracted care workers.

Some cash benefits are explicitly aimed at supporting family carers. The Spanish system provides cash benefits when no public services are nearby; and the Korean LTC insurance provides a cash benefit when it is impossible to use formal LTC services, for instance due to natural disasters or related reasons, and when individuals are unsuitable for admission in an institution. In the Netherlands, the budget is lower than the comparable in-kind benefits as the expected co-payments are taken into account in advance. Eligible people are free to hire the services they want and feel is best-equipped to deal with their particular need. Budget holders are, however, required to declare their expenditures. Unspent budget has to be returned, and in case of fraud, people may be restricted from further use of the budget option. In general, people do not spend their full budget while being satisfied with service delivery.

While Germany seems to manage to save money in its LTC scheme due to lower cash benefits and, in the Netherlands, supervision of expenditure takes place, Doty *et al.* (2010) report higher costs for pilot cash and counselling (C&C) programmes in the United States, as compared to "traditional" programmes. The C&C programmes are consumer directed LTC programmes, giving the care recipient not only "employer authority" but also "budget authority". The higher per-user costs can be explained by the fact that the care recipients using C&C benefits were successful in hiring alternative care workers, where "traditional" providers suffered from recruitment and retention problems. In Arkansas, those in the comparison group received only two thirds of their eligible services, especially in rural areas. The popularity of C&C led, in three years, to major savings on nursing home care, because, even though individual costs were higher than expected, overheads fell to a third of their previous level.

As LTC recipients become employers, other recruitment patterns appear with consequences for required qualifications and quality. Nies and Leichsenring (2010), for continental Europe, Glendinning *et al.* (2008) and Glendinning (2009) for the United Kingdom, and Galantowitz *et al.* (2010) for the United States, point to quality-control issues in cash-benefit systems. When family members are hired, the relationship may change into a business agreement, with many hired family workers feeling compelled to work more hours than contracted. This may lead to more stress than previously. Some programmes require users to hire from registered agencies only – or provide other guarantees. The

Dutch Health Care Inspectorate, for instance, recently raised questions about the way personal budgets are currently organised in the Netherlands, and the consequences for vulnerable older people (Mot, 2010). Doty *et al.* (2010) report that overcoming resistance against the empowerment of care recipients from within the system especially by focusing on quality, is important for the success of such programmes**.** However, others argue that quality in such schemes is guaranteed because care recipients are in the position to hire and fire assistants, which empowers them to such an extent that regulation is then to be considered as paternalistic (Arksey and Kemp, 2008).

5.6. Conclusions

This chapter analysed the size, composition of and some of the complex features of LTC workforces across the OECD. The size of the LTC workforce is increasing along with the share of the population aged over 80 years. The majority of the LTC workers are employed in institutional care, usually with part-time contracts – even though most care recipients receive care at home. A large proportion of the LTC workers are female and middle aged.

Although minimum qualification requirements exist in most OECD countries, variations can be observed in qualification mixes and ratios. Particularly for lower-level care workers, required entry-level qualifications vary widely across the OECD. Wages are generally low, in some cases lacking annual increases or job-related benefits. Even though workers find their job meaningful, they regard it as demanding. This can lead to early retirement and work-related accidents.

Vacancies and turnover rates can be high. Many OECD countries employ external workers, for instance through a job agency. Migrant workers – usually middle-aged women – play a significant role in LTC in some countries. Many are employed as lower-level care workers, but may have more qualifications than native-born care workers. Their working conditions can, however, be harder than those of non-migrant care workers, while their earnings is in many instances lower than for non foreign-born workers. In some OECD countries, illegal migrants participate in the LTC workforce.

Future research in this field is needed, in order to address potential data limitations and to encourage countries to collect reliable information.

Notes

1. Additional Dutch data – using broader workforce indicators – show a further differentiation between subsectors: 5.3 users per FTE in home care; 1.7 users per FTE in residential care homes; and 0.6 users per FTE in nursing homes (*Source*: Eggink *et al.*, 2010; 2005 data).
2. *http://stats.oecd.org/Index.aspx?DatasetCode=FTPTC_I.*
3. *http://stats.oecd.org/Index.aspx?DatasetCode=ANHRS.*
4. Responsibilities, qualifications and competences of LTC workers vary widely, due to differentiation between categories of lower-level workers, while differentiations between "registered" and "licenced" nurses exist, with the latter being lower-grade nurses than the former.
5. Licensed practical nurse: A graduate of a school of practical nursing whose qualifications have been examined by a state board of nursing and who has been legally authorised to practise as a licensed practical or vocational nurse (LPN or LVN), under supervision of a physician or registered nurse. Registered nurse: A graduate nurse who has been legally authorised (registered) to practise after examination by a state board of nurse examiners or similar regulatory authority, and who is legally entitled to use the designation RN. *Source*: *http://medical-dictionary.thefreedictionary.com*.
6. According to feminist critiques, perceptions about gender roles also play a role in wages for care workers (Browne and Braun, 2008; Charlesworth and Marshall, 2010).

7. Annual replacement rate of workers. A turnover of 75% implies that three out of four workers need to be replaced on an annual basis.
8. EU15: The European Union of 15 Member States, before 1 April 2004. EU27: The European Union after 2007, when in total 12 new states had joined.
9. In Germany, with an estimated gross cost of EUR 1 200 per month for 24 hours/7 days care, hiring *three* family care workers becomes cheaper than one arrangement respecting labour law (EUR 4 000). Expenditure by the care recipient is not supervised, although regular checks exist to assess the care recipients' situation.

References

AIHW – Australian Institute for Health and Welfare (2008a), *Nursing and Midwifery Labour Force 2005,* AIHW, Canberra.

AIHW – Australian Institute for Health and Welfare (2008b), *Nursing and Midwifery Labour Force 2008,* AIHW, Canberra.

American Association of Homes & Services for the Aging and the Institute for the Future of Aging Services (2007), *The Long-term Care Workforce: Can the Crisis be Fixed? Problems, Causes and Options,* Prepared for National Commission for Quality Long-term Care, AAHS/IFAS, Washington DC.

Arksey, H. and P.A. Kemp (2008), "Dimensions of Choice: A Narrative Review of Cash-for-Care Schemes", *Working Paper*, No. DHP 2250, University of York, Department of Social Policy and Social Work, York.

Banerjee, A., T. Daly, H. Armstrong, P. Armstrong, S. Lafrance and M. Szebehely (2008), "*Out of Control*": *Violence against Personal Support Workers Long-term Care,* York University/Carleton University.

Bettio, F., A. Simonazzi and P. Villa (2006), "Change in Care Regimes and Female Migration: The 'Care Drain' in the Mediterranean", *Journal of European Social Policy,* Vol. 16, No. 271.

BGW (2006), *Aufbruch Pflege. Moderne Prävention für Altenpflegekraft. BGW Pflegerapport,* Erstveröffentlichung 02/2006, Stand 12/2007, Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege, Hamburg.

BGW (2007), *Sieht die Pflege bald alt aus? BGW-Pflegereport 2007. Stand 08/2007,* Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege, Hamburg.

Bourgeault, I. *et al.* (2009), "The Role of Immigrant Care Workers in an Aging Society. The Canadian Context and Experience", University of Ottawa.

Browne, C.V. and K.L. Braun (2008), "Globalization, Women's Migration and the Long-term Care Workforce", *The Gerontologist*, Vol. 48, No. 1, pp. 16-24.

Canadian Home Care Human Resources Study (2003), accessible at *www.cha.ca/documents/pa/Home_Care_HR_Study.pdf.*

Cangiano, A., I. Shutes, S. Spencer and G. Leeson (2009a), "Migrant Care Workers in Ageing Societies", Report on Research Findings in the United Kingdom, Centre on Migration, Policy and Society (COMPAS), University of Oxford.

Cangiano, A., I. Shutes and S. Spencer (2009b), "Memorandum to Social Care Inquiry", ESRC Centre on Migration, Policy and Society (COMPAS), University of Oxford, November.

CBS – Central Bureau of Statistics (2010a). *De Nederlandse samenleving,* CBS, Den Haag.

CBS – Central Bureau of Statistics (2010b), *Gezondheid en zorg in cijfers,* CBS, Den Haag/Heerlen.

CBS – Central Bureau of Statistics (2011), "Werken in de zorg zwaar, maar geeft veel voldoening", *Webmagazine*, Monday 24 January 2011, 9:30, accessible at *www.cbs.nl/nl-NL/menu/themas/gezondheid-welzijn/publicaties/artikelen/archief/2011/2011-3287-wm.htm.*

Centre de Formation et de Rencontres Internationales, Ile-de-France (2010), "DEAVS, diplôme d'État d'auxiliaire de vie sociale", accessible at *www.cpcvidf.asso.fr/page/deavs.html.*

Chaloff, J. (2008), "Mismatches in the Formal Sector, Expansion of the Informal Sector: Immigration of Health Professionals to Italy", *OECD Health Working Paper*, No. 34, OECD Publishing, Paris.

Charlesworth, S. and H. Marshall (2010), "Chosen Sacrifices? Some Paradoxical Effects of Strategies to Attract and Retain Care Workers", *Working Paper*, No. 8, RMIT University, Centre for Applied Social Research, School of Global Studies, Social Science and Planning, Melbourne.

Commonwealth of Australia (2008), "CHC20108 Certificate II in Community Services", *CHC08 Community Services Training Package*, Vol. 2 of 3, Qualifications Framework, accessible at *www.training.nsw.gov.au/cib_vto/cibs/documents/chc20108.pdf*.

Cort, P. (2002), "Vocational Education and Training in Denmark", Danish Institute for Educational Training of Vocational Teachers, accessible at *www.cedefop.europa.eu/EN/Files/5130_en.pdf*.

Department of Health (2000), "Domiciliary Care national Minimum Standards", London, accessible at *www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4083671.pdf*.

Department of Health and Human Services (2003), "The Future of Long-term Care Workers in Relation to the Ageing Baby Boom Generation", Washington, accessible at *http://aspe.hhs.gov/daltcp/reports/ltcwork-A.htm*.

Di Santo, P. and F. Ceruzzi (2010), "Migrant Care Workers in Italy. A Case Study", *Interlinks*, European Centre for Social Welfare Policy and Research, Rome/Vienna.

Doty, P., K.J. Mahoney and M. Sciegaj (2010), "New State Strategies to Meet Long-term Care Needs", *Health Affairs*, Vol. 29, No. 1, pp. 49-56.

Eborall, C., W. Fenton and S. Woodrow (2010), "The State of the Adult Social Care Workforce in England, 2010", Fourth report of Skills for Care's Research and Analysis Units, Skills for Care, Leeds, May.

Eggink, E., D. Oudijk and I. Woittiez (2010), "Zorgen voor zorg Ramingen van de vraag naar personeel in de verpleging en verzorging tot 2030", SCP, Den Haag.

Enomoto, Y. (2007), "Population Aging and Support to the Elderly People in Communities in Japan", Japan International Corporation of Welfare Services, accessible at *www.jicwels.or.jp/about_jicwels/ASEAN&JapanHighLevelOfficialsMeeting/5th%20Country%20Report%202007%20-Community%20Services%20for%20the%20Elderly-/Japan.pdf*.

Estryn-Behar, M., B. van der Heijden, D. Camerino, C. Fry, O. Le Nezet, P.M. Conway and H.M. Hasselhorn (2008), "Violence Risks in Nursing. Results from the European 'NEXT' Study", *Occupational Medicine*, Vol. 58, pp. 107-114, published online 21 January 2008, *DOI:10.1093/occmed/kqm142*.

European Foundation for the Improvement of Living and Working Conditions (2006), *Employment in Social Care in Europe,* Office for Official Publications of the European Communities, Luxembourg.

Ewijk, H. van *et al.* (2002), "Care Work in Europe: Current Understandings and Future Directions", in P. Moss (ed.), *Mapping of Care Services and the Care Workforce: Consolidated Report*, *Working Paper*, No. 3, Thomas Coram Research Unit, Institute of Education, University of London.

Fag og Arbejde Denmark, "Welcome to the Social and Health Sector", accessible at *www.foa-international.dk/art_uk/social_uk*.

Federal Institute for Vocational Education and Training Germany (2004), "Vocational Training for Human Services".

Finnish National Board of Education (2004), "Vocational Education and Training in Finland", accessible at *www.ammatillinenkoulutus.com/upload/images/muut_kuvat/pdf/alakoht/English/Vocational_education_%20and_training in_Finland.pdf*.

Fujisawa, R. and F. Colombo (2009), "The Long-term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand", *OECD Health Working Papers*, No. 44, OECD Publishing, Paris.

Galantowitz, S., S. Crisp, N. Karp and H. Accius (2010), *Developing Effective Criminal Background Checks and Other Screening Policies for Home Care Workers*, AARP, Washington.

Gleckman, H. (2010), "The Faces of Home Care. Report from the Field", *Health Affairs*, Vol. 29, No. 1, pp. 125-129.

Glendinning, C. (2009), "Cash for Care: Implications for Carers", *Health and Ageing*, Newsletter, No. 21, The Geneva Association.

Glendinning, C., D. Challis, J. Fernandez, S. Jacobs, K. Jones, M. Knapp, J. Manthorpe, N. Moran, A. Netten, M. Stevens and M. Wilberforce (2008), *Evaluation of the Individual Budgets Pilot Programme: Final Report,* Social Policy Research Unit, University of York, York.

Harmuth, S. (2002), "The Direct Care Workforce Crisis in Long-term Care", *North Carolina Medical Journal,* Vol. 63, No. 2, pp. 87-94, March/April.

Health and Welfare Bureau for the Elderly (2010), *OECD Japan Mission 2010 Basic Information,* Ministry of Health, Labour and Welfare, Japan.

Health Outcomes International (2007), *Health Evaluation of the Home-based Support Service (HBSS) Training Initiative,* Health Outcomes International, St. Peters, South Australia.

Health Professionals Regulatory Advisory Council (Ontario) (2006), "The Regulation of Personal Support Workers", accessible at *www.health.gov.on.ca/english/public/pub/ministry_reports/personal_support_workers/personal_support_workers.pdf*.

Hotta, S. (2010), "Kaigo Jyūjisha Mondai" (Professional Caregiver Issue in Japan), in H. Miyajima, S. Nishimura and T. Kyogoku (eds.), *Shakai Hoshō to Keizai (Social Security and Economy),* Vol. 3*, Shakai Sabisu to Chiiki (Social Services and Community)*, University of Tokyo Press, pp. 149-172, Tokyo.

Hunter, J. (2009), "Response: The Case Against Choice and Competition", *Health Economics, Policy and Law*, Vol. 4, pp. 489-501.

IFAS (2007), "The Long-term Care Workforce: Can the Crisis be Fixed? Problems, Causes and Options", Prepared for National Commission for Quality Long-term Care, Washington DC, IFAS, January.

IOM – Institute of Medicine (2008), "Retooling for an Aging America: Building the Health Care Workforce", accessible at *www.iom.edu/agingamerica*.

Jennings, C. (2009), "Migrant Workers in Adult Social Care in England", Report for Skills for Care, accessible at *www.skillsforcare.org.uk/nmsruntime/saveasdialog.aspx?lID=4483&sID=444*.

Kirino *et al.* (2006), "Kaigoshokuin ni kiin suru storess ga shisetsukoureisha no seishintekikenkou ni ataeru eikyou", *Kouseinoshyou,* Vol. 53, No. 6.

Klerk, M. (de), R. Gilsing and J. Timmermans (eds.) (2010), *Op weg met de WMO. Evaluatie van de Wet maatschappelijke ondersteuning 2007-2009*, SCP, Den Haag.

Korczyk, S. (2004), "Long-term Workers in Five Countries: Issues and Options", AARP Public Policy Institute, Washington DC.

Koshitani, M. (2008), "Influence on Caregiver's Psychological Health of Patients' Violence against Caregivers in Nursing Homes and Group Homes", *Long-term Care Welfare Journal*, Vol. 15, No. 1, pp. 62-73.

Kubalčíková, K. and J. Havlíková (2010), "Current Strategy of Social Services for the Elderly in the Czech Republic: The Domiciliary Care. Opportunities and Risks", European Population Conference 2010, accessible at *http://epc2010.princeton.edu/download.aspx?submissionId=100178*.

Kushner, C., P. Baranek and M. Dewar (2008), "Home Care: Change We Need", Report on the Ontario Health Coalition's Home Care Hearings, 17 November.

Lamura, G., C. Chiatti, M. Di Rosa, M.H. Mechiorre, F. Barbabella, C. Greco, A. Principi and S. Santini (2010), "Migrant Workers in the Long-term Care Sector: Lessons from Italy", *Health and Ageing Newsletter,* No. 22, The Geneva Association, April.

Mandl, I. and A. Dorr (2009), "Gearing Adult Education towards Occupational Mobility: National Assessment Report Austria", accessible at *www.mobility-training.eu/final/report/austria.pdf*.

Martin, S., B. Lindsay Lowell, E.M. Gzodziak, M. Bump and M.E. Breeding (2009), *The Role of Migrant Care Workers in Aging Societies: Report on Research Findings in the United States,* Institute for the Study of International Migration, Walsh School of Foreign Service, Georgetown University.

Martin, W. and D. King (2008), *Who Cares for Older Australians? A Picture of the Residential and Community Based Aged Care Workforce 2007*, National Institute of Labour Studies for the Department of Health and Ageing, Flinders University, Adelaide.

Maucher, M. (2008), "Modernisation Processes in the Field SSGI: Challenges Related to Employment and Qualification", 2nd Forum on SSIG, Paris, accessible at *http://cms.horus.be/files/99931/MediaArchive/2008-FPEU+DG-EMPL-2nd-Forum-SSGI-28.+29.10.08-Paris-text-MM.pdf*.

Mestheneos, E. and J. Triantafillou (eds.) (2005), "Supporting Family Carers of Older People in Europe – The Pan-European Background Report: Empirical Evidence", *Policy Trends and Future Perspectives*, Lit Verlag, Hamburg.

Ministry of Education and Culture Finland, "Vocational Education and Training in Finland", accessible at *www.minedu.fi/OPM/%20Koulutus/ammatillinen_koulutus/?lang=en*.

Ministry of Health, Labour and Welfare Japan (2006), "Overview of Certified Social Workers and Certified Care Workers", accessible at *www.mhlw.go.jp/english/wp/wp-hw3/dl/8-11.pdf*.

Ministry of Health/University of Auckland. Disability Support Services in New Zealand (2004), *The Workforce Survey*, *Final Report*, 20 August.

Ministry of Labour and Social Affairs, "Odpovědi na časté dotazy k dalšímu vzdělávání sociálních pracovníků a pracovníků v sociálních službách", accessible at *www.mpsv.cz/files/clanky/8109/Povinne_dalsi_vzdelavani.pdf*.

Ministry of Social Affairs and Health Finland (2005), "Act on Qualification Requirements for Social Welfare Professionals", accessible at *www.finlex.fi/fi/laki/kaannokset/2005/en20050272.pdf*.

Ministerie van Volksgezondheid, Welzijn en Sport (2007), *Arbeidsmarktbrief 2007 Werken aan de zorg*.

Mot, E. (2010), "The Dutch System of Long-term Care", *CPB Document*, No. 204, CPB, Den Haag.

Nies, H. and K. Leichsenring (2010), "Quality Management and Quality Assurance in Long-term Care", *European Overview Paper*, Interlinks, Utrecht/Vienna.

Norwegian Directorate for Education and Training, "Vocational Education and Training in Norway", accessible at *www.udir.no/upload/Fagopplaring/Vocational_Education_and_Training_in_Norway.pdf*.

O'Brien-Pallas, L., C. Alksnis and S. Wang (2003), *Bringing the Future into Focus. Projecting RN Retirement in Canada,* Canadian Institute for Health Information, Ottawa.

OECD (2007a), *Babies and Bosses. Reconciling Work and Family Life, A Synthesis of Findings for OECD Countries*, OECD Publishing, Paris.

OECD (2007b), *International Migration Outlook,* OECD Publishing, Paris.

OECD (2008), *The Looming Crisis in the Health Workforce: How Can Countries Respond?*, OECD Publishing, Paris.

OECD (2009), *International Migration Outlook,* OECD Publishing, Paris.

OECD (2010a), *International Migration Outlook,* OECD Publishing, Paris.

OECD (2010b), *OECD Reviews of Labour Market and Social Policies: Israel*, OECD Publishing, Paris.

Oschmiansky, H. (2010), "The Marketization of Formal Elder Care in Germany and its Consequences for the Labour Market", Paper for the International Conference "Transforming Care: Provision, Quality and Inequalities in Later Life", Copenhagen, 21-23 June.

PHI (2007), *Facts* No. 3. *Who Are the Direct Care Workers?*, PHI, New York.

PHI (2010), *Facts* No. 3. *Who Are the Direct Care Workers?,* PHI, New York, February 2010 Update.

Redfoot, D. and A. Houser (2005), *We Shall Travel on Quality of Care "Economic Development, and the International Migration of Long-term Care Workers"*, AARP Public Policy Institute, Washington DC.

Roerink, H. and F. Tjadens (2009), *From Household Care to Household Help in the Dutch Transition from AWBZ to WMO. Consequences for Workers and Clients,* Bureau Secondant/Health and Social Care Associates, Alphen aan den Rijn, October.

Rostgaard, T., C. Chiatt and G. Lamura (in press), "Care Migration – The South North Divide of Long-term Care", in B. Pfau-Effinger and T. Rostgaard (eds.), *Care Between Work and Welfare in Europe,* Palgrace, Houdsmills.

Rothgang, H. and G. Igl (2007), "Long-term Care in Germany", *Japanese Journal of Social Security Policy,* Vol. 6, No. 1, pp. 54-84.

Rothgang, H., D. Kulik, R. Müller and R. Unger (2009), *GEK Pflegereport 2009,* GEK, Schwäbishc Gmünd.

Schmidt, S. and H. Hasselhorn (2007), "Gesundheitsrisiko Altenpflege. Ein Projekt zur Verbesserung der Qualität in Altenpflegeeinrichtungen", *Pflegen: Demenz*, Vol. 5.

Seavey, D. (2004), "The Cost of Frontline Turnover in Long-term Care. Better Jobs, Better Care", IFAS/AAHSA, Washington.

Smith, K. and R. Baughman (2007), "Caring for America's Aging Population: A Profile of the Direct Care Workforce", *Monthly Labor Review*, September, pp. 20-26.

Spencer, S. *et al.* (2010), "The Role of Migrant Care Workers in Ageing Societies: Report on Research Findings in the United Kingdom, Ireland, Canada and the United States", International Organisation for Migration, Geneva.

Squillace, M.R. *et al.* (2009), "The National Nursing Assistant Survey: Improving the Evidence Base for Policy Initiatives to Strengthen the Certified Nursing Assistant Workforce", *The Gerontologist*, Vol. 49, No. 2, pp. 185-197.

Stone, R. and J. Wiener (2001), *Who Will Care for Us? Addressing the Long-term Care Workforce Crisis,* Urban Institute and the American Association of Homes and Services for the Aging, October.

Swedish Association of Local Authorities and Regions (2007), *Care of the Elderly in Sweden Today 2006,* Stockholm, January.

Teal, C. (2002), "Direct Care Workers. Number One Quality Indicator in Long-term Care. A Consumer's Perspective", *North Carolina Medical Journal*, Vol. 63, No. 2, pp. 102-105, March/April.

Theobald, H. (2004), "Care Services for the Elderly in Germany: Infrastructure, Access and Utilisation from the Perspective of Different User Groups", Veröffentlichungsreihe der Arbeitsgruppe Public Health Forschungsschwerpunkt Arbeit, Sozialstruktur und Sozialstaat Wissenschaftszentrum Berlin für Sozialforschung (WZB), accessible at *http://bibliothek.wz-berlin.de/pdf/2004/i04-302.pdf*.

Torre, A. and E. Pommer (2010), *Voorlopig advies over het WMO budget huishoudelijke hulp voor 2011 van het Sociaal en Cultureel Planbureau Uitgebracht aan het bestuurlijk overleg*, SCP, Den Haag, 1 April.

Training and Employment Authority Ireland, "Healthcare Assistant Traineeship", accessible at *www.fas.ie/en/Training/Traineeships/Traineeship+Courses/Personal+Service+Occupations/Care+Assistant+Care+for+the+Elderly+Traineeship.htm*.

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

Walshe, K. and E. O'Shea (2009), *The Role of Migrant Care Workers in Ageing Societies: Context and Experiences in Ireland,* Irish Centre for social gerontology, National University Galway.

Windt, W. (van der), R.C.K.H. Smeets and E.J. Arnold (2008), *Regiomarge 2008. De arbeidsmarkt van verpleegkundigen, verzorgenden en sociaal-agogen 2008-2012*, Prismant, Utrecht, June.

Windt, W. (van der), R.C.K.H. Smeets and E.J. Arnold (2009), *Regiomarge 2009. De arbeidsmarkt van verpleegkundigen, verzorgenden en sociaalagogen 2009-2013*, Prismant, Utrech, June.

Winsløw J.H. and V. Borg (2008), "Resources and Quality of Care in Services for the Elderly", *Scandinavian Journal of Public Health*, Vol. 36, pp. 272-278, accessible at *http://sjp.sagepub.com/content/36/3/272.full.pdf+html*.

Yeates, N. (2005), "Migration and Social Policy in International Context: The Analytical and Policy Uses of a Global Care Chains Perspective", Arusha Conference, "New Frontiers of Social Policy", 12-15 December.

Web pages

www.azwinfo.nl.

www.cbs.nl.

www.werk.belgie.be/CAO/330/330-2009-000655.pdf.

http://medical-dictionary.thefreedictionary.com.

http://stats.oecd.org/Index.aspx?DatasetCode=FTPTC_I.

http://stats.oecd.org/Index.aspx?DatasetCode=ANHRS.

https://drei.verdi.de/2010/ausgabe-36/ausblick/seite-8/zwangsteilzeit-im-altenheim (accessed 10 December 2010).

http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf.