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Affordability of care and quality of work. Policies to reduce irregular employment in elderly care

Provisional version

Abstract

The paper aims at investigating the conditions regulating the long term care market for elderly people and its division into regular and irregular work. Irregular work does not necessarily coincide with immigrant work. While in some countries the two figures coincide, this is not the case in others. We start from the premise that the extent of the grey care market is related to the employment regime, so that policies aimed at regularising care workers reflect the more general frame of employment policies. The first two sections analyse the care regimes and the characteristics of the care labour markets in a group of selected countries. We shall then focus on the policies that have been implemented in order to encourage the development of a regular care market and/or reduce irregular work in home care. The empirical analysis is based on the results of comparative studies on home care which brought together a number of European countries spanning different care regimes.

Key words: Care regimes, Employment models, female migration.

JEL Classifications: F22, I3, J3, O15.

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1. Introduction

Rapid population ageing has dramatically increased the demand for long-term care (LTC) for dependent elderly people, thereby exerting an enormous pressure upon the supply of care, both informal and formal, and on public and private finances. Meanwhile, the number of countries addressing LTC with systematic strategies has increased in Europe, as future spending projections on LTC brought increasing awareness of the need for public involvement. We thus observe a common shift towards home care and market provision, backed up by the introduction of cash for care programmes and different bundles of services in support of the family. In some countries, the greater care load shifted upon families, at a time of greater pressure because of the social transformation within the families, has resulted in an increasing share of care outsourced to the market. The increase in demand for care has thus outstripped supply. In most European countries the shortage of care workers has been met by a large inflow of immigrant, mostly female, workers. With cost constraints playing an increasingly important role, the substantial difference in cost between regular and irregular care diverted most of this demand towards the grey market. The extent of recourse to migration and the modalities of migrant involvement in the labour market differ widely across countries and across the various segments of the care labour market, with obvious consequences on the quality of care and care work. Thus, behind the common shift towards home care, monetary subsidies, contracting out and an almost general resort to migrant carers, we may observe the persistence of very different "care regimes" and care labour markets.

The paper aims at investigating the conditions regulating the care market and its division into regular and irregular work. Irregular work does not necessarily coincide with immigrant work. While in some countries the two figures coincide, this is not the case in others. We start from the premise that the extent of the grey care market is related to the employment regime, so that policies aimed at regularising care workers reflect the more general frame of employment policies. The first two sections analyse the care regimes and the characteristics of the care labour markets in a group of selected countries. We shall then focus on the policies that have been implemented in order to encourage the development of a regular care market and/or reduce irregular work in home care. The empirical analysis is based on the results of comparative studies on home care which brought together a number of European countries[1] spanning different care regimes.

2. Typologies of care regimes

Projections of the share of population over 80 years – this age is more suitable to estimate future care needs while accounting for postponement of the phase of severe dependency due to improvements in income and health - show a doubling of the share of the very old population by 2050 in all European countries (table 1). Concern over the "ageing bomb" has prompted reforms in all European countries to tackle the rising needs while safeguarding financial sustainability. In spite of common trends towards favouring home care and monetary transfers, countries still differ in terms of the extent of public support to care provision, financing, and coverage (Simonazzi 2009). The coverage ratio for home care (figure 1), testifies of the resilience of the "Nordic care regime", in spite of the severe problems of financial sustainability that did not spare these countries. Likewise, not unexpectedly, we find the Mediterranean and the newly accessing countries still ranking at the bottom of the scale. The situation is somewhat different for the share of old people in residential care (figure 2), where the heritage of past policies interacts with recent trends in determining a more blurred picture. All in all, although the growing complexity of LTC makes

[1] These countries are: Italy, Germany, Belgium; France, Austria and the UK (England).

comparison more complex, it is possible to say that recent reforms have not changed the old hierarchy, with Nordic countries on top of the scale for public involvement and the Southern and Eastern European countries still heavily relying on the family. However, there has been a common trend to ask for a greater involvement of families, both in time and in finance.

In Germany, for instance, the State participates in elderly care only with a subsidiary function, while the main responsible for care and assistance rests with the family[2]. In 2007 there were about 5,1 million persons in need of care, as against about 2.2 receiving LTC insurance benefits (Schultz 2010). The Social Long-term Care Insurance covers the risks associated with the need for care with a clear focus on nursing care, though a limited amount of domestic work and social company (for people affected by dementia) can also be reimbursed. Within the framework of the insurance, the beneficiaries can choose between cash benefits to support family care, home-based care services and institutionalised care services. Beneficiaries choose those elements of the care package they want to have covered by long-term care insurance, a freely contracted provider will then provide the selected bundle of care services. Most beneficiaries need support beyond what long-term care insurance funds provide. In fact the LTC Insurance provides only a partial coverage, with benefits depending on the recipient's dependency level (3 levels)[3]. The amount also varies with residential or home care, and depends on whether the home care is provided by family members or by professionals (Table 2)[4].

At present, 2.25 million people require care benefits from the long-term insurance in the form of material or monetary support and receive care at home or in institutions (Table 3). Some two thirds have opted for home care; of these, two thirds receive care exclusively from family members.

According to *The state of social care in England 2006/07* CSCI (2008), in 2006 out of an estimated 2,450,000 older people with care needs, just under 1.1 million older people used social care services, 68% of which in home care[5]. While the number of older people kept increasing over time, the number of people receiving publicly-funded community-based care of all types has decreased, reflecting the increasingly tightened eligibility criteria. In fact, healthcare is free at the point of delivery and funded by taxes, but it has become much harder for older people with lower levels of dependency to secure publicly funded home care (Means et al. 2002). Services are now provided to a smaller but more disabled population. Moreover, while the share of users' contributions remained fairly constant, its absolute value increased over time with total expenses[6].

In 1990, with the *NHS and Community Care Act*, responsibility for care was transferred from the Department of Social Security to Local Authorities (LAs): they assess people's needs, fix care fees on a means-tested basis[7], decide the allocation of their budget between community services and

[2] German law obliges children (including children-in-law, but not grandchildren), to support parents in case these are unable to bear the cost-of-living which may include expenses for care; in general, there is an assessment threshold under which they are exempted from this obligation for alimony. The basic legal foundation is included in the 'Bürgerliches Gesetzbuch' (§ 1601-1615o). http://dejure.org/gesetze/BGB/1601.html

[3] Complementary services on the local levels should still be designed to promote independent living and social integration of the elderly (e.g. transport services, accompany services, senior clubs). Based on national law the development of suitable offers is defined as optional for the municipalities and the mode of implementation should be adapted to the circumstances and needs of the individual municipality.

[4] The Long-term Care Insurance also covers necessary changes in the house or flat (up to 2,557 € per measure) and auxiliary devices or assistive technologies (up to 90% per device) if they are listed in a special catalogue (Hilfsmittelverzeichnis der gesetzlichen Krankenversicherung). At the same time, there are some special measures to support the families in their caring role such as the instruction of voluntary caregivers and improved counselling.

[5] Services for people at home include the following: Domiciliary services e.g. home help, home care etc.; daytime services outside of the home e.g. day centres, lunch clubs or day hospitals; meals on wheels; respite care which allows carers and people with dementia to have a short break; night sitting services; nursing home care.

[6] Personal Social Services Expenditure and Unit Costs, England for years 1998/99 to 2008/09 http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/personal-social-services-expenditure-and-unit-costs-england-final-2008-09

7 Charges for home care services are regulated by the Fairer Charging Guidance, while entitlements to publicly-funded care can vary substantially across local authorities, creating an arbitrary 'postcode lottery'.

residential care. While the aim of the act was to enable people to stay in their homes for as long as possible, it also promoted the role of the independent sector in the provision of formal care, to develop a 'mixed economy' in the field of community-based services. As a consequence, the share of publicly funded home care provided by private and voluntary organisations has drastically increased - from 5% in 1993 to 78% in 2007 (UKHCA, 2008) – and the number of contact hours provided by independent sector has tripled since 1998. The Local Authority's function has become one of 'commissioner' on behalf of service users: an estimated 80% of all homecare services supplied by private providers are purchased directly by LAs (UKHCA, 2008), with some providers working solely for LAs. The latter operate their own accreditation procedures and negotiate contracts with accredited providers. The bargaining power of LAs has been further strengthened through greater use of block contracts[8], that offer guaranteed service levels to providers in return for greater savings on unit costs. LAs can use their market power to negotiate fees at relatively low and potentially unsustainable levels. According to data provided by LAs, the fee rates paid to LA home care providers are consistently higher than those paid to independent providers (including voluntary providers). In 2008 the reported unit cost of LA home care was £23.20 as against £12.60 for independent providers (NHS Information Centre for Health and Social Care, 2010b). Part of the difference could reflect differences in the client base: anecdotal evidence suggests that LA-run home care establishments often tend to specialise in particularly complex client groups where the costs of care are likely to be higher. However, differences in the client base are unlikely to explain the entire difference in costs.

To sum up, in all countries there has been a tendency to focus on those more in need of care. Meanwhile, they implemented policies aimed at alleviating the economic and non-economic costs borne by families. With more care outsourced to the market, the cost of care varies with the cost of labour, and this is affected by each country's employment and migration policies. It has been argued that two alternative strategies to reduce the financial cost of public support and market provided care can be observed: a rationing of total hours of care, where care is expensive, that is carers' pay and working conditions are relatively good; extensive hours where wages are low and working conditions are relatively poor (Bettio and Verashchagina 2010). However, we are interested here to analyse those policies aimed at affecting directly the cost of care labour, to make it affordable to families.

2. The supply of care labour: national and migrant carers

The personal care sector has been one of the fastest growing sectors in terms of employment creation, mostly female. In 2007 it accounted for almost 10% of total employment in the EU27, with a few countries well over it (figure 3), and its growth is projected to continue in the future (EC 2010).

The increase in demand has far outpaced the increase in domestic supply of regular care labour. In fact, the existence of a sizeable irregular market is a common feature of the care sector in many countries. Differences relate to the extent and the composition of these irregular workers, that is the relative weight of national and foreign care workers (table 4). It is well-known that mostly irregular immigrant carers have been at the core of the Mediterranean care regimes (Bettio et al, 2006), but their importance has been growing also in other countries. Concern over the spreading of this phenomenon rose in the last decade, resulting in a series of policies aimed at reducing the growth of the irregular care market and favouring regularisation.

[8] There are different types of contracts: 1) block: payment for a pre-determined number of hours or clients whether taken up or not; 2)call-off: price per hour specified in advance, paid when service is provided; 3) spot: price agreed and paid when service is provided; 4) cost & volume: guaranteed block purchase of hours plus negotiable option to purchase further hours of service; 5) grant: general payment not linked to particular client or amount of service (Matosevic et al. 2001).

It is fairly well established that migration flows respond to demand and supply (pull and push) factors. There are differences across countries, that reflect their past and current migrant policies, but there is one common feature: the immigrant workers' poorer job quality. The jobs that are filled by immigrants are usually unskilled, low paid, characterised by hard, unpleasant or insecure working conditions, they are usually performed in an unstructured work environment and involve informal, personal relations between supervisor and subordinate (Piore 1979; Sciortino, 2009).

The market regulated care services fits this description well, so that it is not surprising to find (female) immigrants employed as care workers in those countries where an increased participation of women in the labour market has not been met by an adequate public provision of care services. The status of these immigrants, whether regular or irregular, will depend on care, employment and migration policies. We can expect a demand for irregular migrant labour to prevail in those countries in which public provisions are limited, or favour a private and unregulated market for care services through untied cash benefits.

The countries in our sample provide a good case in point, the analysis of their policies allows us to clarify the relationship between migration and employment policies and public provision of care on the one hand and the extent of the irregular care market on the other.

Italy. The immigration policy pursued by the Italian governments has always been characterized by a lack of planning and ex-post regularizations (Bettio, Simonazzi and Villa 2006). While a large informal market has significantly promoted unauthorised immigration, sporadic but frequent regularizations have had the unintended effect of fuelling new unauthorised migration flows in the medium run, despite the temporary decline in illegality that they produced. Thus the effect of this policy was the production of a sizeable segment of irregular workers that, at nearly regular intervals, was absorbed into the official labour market through an amnesty[9].

The last regularisation, concluded in 2009, was specifically directed to family assistants and housekeeping personnel. While the Italian Home Office had expected between 500,000 and 750,000 applications, in fact only about 295,000 applied, mainly Ukrainian (42,000), Moroccan (38,000), Moldovan (29,000) and Chinese (22,000) workers. This suggests that the majority of employees decided or were "asked" to keep working in the black economy. While the complexity of the procedures certainly influenced its failure, it was mostly the strictness of the financial conditions for the regularisation - the payment of 500 Euros as a flat rate to cover past social contributions, a suitable worker's accommodation, a minimum income (20 thousand Euros a year) for the employer, a contract for a minimum of 20 hours per week and, finally, the obligation to pay social contributions in full for the future, that initiates a system of rules, rights and duties – that discouraged the families to take advantage of the law (Di Santo & Ceruzzi, 2010). The National Association of Domestic workers (ACLI-Colf) estimated that between 30 and 40% of families that had declared their interest in the regularisation eventually gave up. It follows that a large share of the 'market' of family assistance remained underground.

Austria. Following the eastward expansion of the European Union Austria and Germany took advantage of an interim arrangement to limit free mobility of workers from countries that had joined the EU in 2005 and 2007. In force of this agreement (that will expire in May 2011), citizens from these countries need a work permit to work in Austria and Germany (and sustained the restriction to its labor market for workers from these new EU Member States (Schneider, Trukeschitz, 2008)[10].

Against this background, Austria has experienced a significant influx of foreign "irregular" labour from Central and Eastern Europe to work in the home care sector. This led in turn to amendments of the laws regulating the employment of foreign workers and the social care sector. In 2007 two

[9] In Italy, the last two amnesties were directed specifically at migrant domestic helpers and caregivers (Law n. 189/2002 and Law n. 3/2009.

10 http://www.eurofound.europa.eu/eiro/2004/03/inbrief/at0403201n.htm

legislative measures, the "Act on Home Care" (Hausbetreuungsgesetz, HBeG) and the amendment to the Industrial Code (GewO), were passed ruling that care workers from Austria or other EU Member States have to be formally employed with the person in need of long-term care, a relative, or with a non-profit social care agency (Schneider, Trukeschitz, 2008).

Foreign care workers can provide care on a self-employed basis, assisting care clients in housework and other instrumental and social activities of daily living (Federal Ministry of Social Affairs and Consumer Protection, 2007: 68). Since 10 April 2008, they have been authorized also to help their clients with personal hygiene and meals, while a few medical treatments – like medicine administration– have recently been added to the list of legally recognized tasks.

The recent legislation also specifies working conditions and pay[11], while introducing a financial support for 24-hour care (see section 4) (Federal Ministry of Social Affairs and Consumer Protection, 2007).

Germany. In Germany, the complexity of the legal frame concerning the employment of migrant care workers and their cost influences the size of the irregular care market (Döhner, 2008). We have in fact different work arrangements.

Legal migrant household helps. Households with a dependent person entitled to LTCI, (or blind or severely handicapped) can recruit a migrant household help. The latter must come from a country that has signed an agreement with Germany. The Federal Employment Office first checks whether there is a national worker available, but the potential employer can name a specific person, so as to legalise a migrant carer already irregularly working in the house. The employment has to be full-time, cannot last longer than three years and the tasks are restricted to housekeeping duties, although basic care, like help in washing, dressing, eating or mobility is explicitly tolerated (Karakayali, 2007). The wage must comply with local tariffs (1,029-1,306 Euro/month gross). Contributions to social security and health and accident insurance are shared between employee and employer. The employer is also responsible for providing appropriate accommodation. In accordance with the German contract for household helps, there is a 38.5 hours working week, an annual paid vacation (26 days for persons up to 29 years, 30 days for persons 30 years and older), and one month notice in case of dismissal (Bundesagentur für Arbeit 2008).

To sum up, legally employed migrant workers are not allowed to work around the clock, cannot provide personal care, have a contractual wage and social contributions. This makes them scarcely competitive with irregular carers. No wonder that, in spite of the high estimated number of migrant carers in Germany, the use of this form of employment is relatively low.

Self-employed home help. Up to May 2011, nationals of the new Eastern European member states are not allowed to work as employees without a work permit, but they can offer their services for household chores as entrepreneurs (professional care work and nursing tasks are excluded) (Karakayali, 2007). Many migrant workers seem to have used this option. Agencies registered in Germany, as in other Eastern European countries, offer mediation services to self-employed household helps. They also offer to arrange the legal administrative requirements on behalf of the migrant worker (obtaining a tax number and a trade license, insurance, registering at the local office etc.). The cost for a German household includes a monthly charge estimated at 800-1,200 Euro and a fee for the mediation agency[12].

Posted workers. Any company can offer its services within the EU in accordance with the principle

[11] 24-hour home care workers must provide a minimum of 48 hours and a maximum of 128 hours per week for two consecutive weeks. After 14 days, care work has to be interrupted for the same period of time. So, if 24-hour care is needed, two care workers have to be employed. Care workers who are not self-employed must be paid according to the national minimum wage in this occupational area (at least EUR 1,093.538 per month, gross income for 238 hours). If two nurses are required, the cost of 24-hour stand-by care may amount up to EUR 3,000 to 4,000 (incl. payroll taxes) (Schneider, Trukeschitz, 2008).

[12] Whether this form of labour is in accordance with German law is disputed, since the independence from directives and the number of principals are among the legal criteria for self-employment.

of freedom of enterprise. This means, for example, that a Polish firm can send a Polish worker to work in Germany at the prices and wages prevailing in the sending country. Any kind of care, including professional care, can be met (Rüßler, 2007) and prices vary with the worker's skill and qualification. A nurse with a driving license and a good knowledge of the German language can be hired for 1,900 Euros; a less qualified worker can command 1,200 Euros, while social security and taxes are paid in Poland..

Irregular migrant care work. Finally, a migrant worker can work without any official contract. This option can be attractive for both the employer and the employee, since taxes, social security and mediation fees can be avoided. Reports on wages vary: from 700 - 1,400 Euro (Meyer-Timpe, 2007) or 600 - 1,000 Euro (Karakayali 2007b). There is a pay hierarchy based on ethnicity, with Polish and Hungarian women on top, and Romanian women at the bottom. Although irregular workers cannot be funded by the LTCI, the combination of a German nursing service and a migrant household help seems to be a solution that professional services tolerate because in many cases the alternative would be to lose the cared-for to a nursing home (Karakayali 2007).

24 hours care. A 24-hour assistance by migrant care workers recruited through official agencies can cost 1,200 to 2,500 Euro per month, depending on the extent of the tasks, plus board and lodging, and, in some cases, a reimbursement of travel costs (Friebe, 2008). Costs for illegally employed migrant care workers (without social security contributions) are substantially lower - 500 to 1,000 Euro plus board and lodging (Friebe, 2008, Richter, 2004, 2006; Weinkopf, 2005). The cost of regular German outpatient care services for assistance around the clock ranges from 2,700 to 3,200 Euros, but most outpatient care services no longer provide 24-hour-care arrangements (Stiftung Warentest, May 2009) (table 5).

England. Social care for older people mainly relies on two broad types of worker: a 'direct care' workforce providing regular support (including care assistants, home carers and support workers); and professional staff (nurses, social workers, occupational therapists and other staff with care-related professional qualifications). In addition, workers are employed in managerial, administrative and ancillary roles. The introduction of 'cash for care' schemes (mostly untied) has led to the development of new functions, such as personal assistants working with people receiving direct payments (Ungerson 1999; 2003).

The labour market in the social care sector is characterised by low wages, high vacancy rates, and an overall negative perception of care work. Low pay is common (Low Pay Commission 2005): direct care workers were one of the groups to benefit most from the introduction of the National Minimum Wage in 1999[13] (figure 4). As noted above, given the dependence of care providers from LAs, pay levels are limited by public sector funding constraints. Thus, pay for care workers and support workers is particularly low in the private sector: the rates for home care workers are higher than those for residential care workers, but the median rate of pay is only marginally higher than the minimum wage (Eborall et al., 2010) (table 6). Since labour costs make up a significant proportion of the running costs of care providers[14], the way in which social care is purchased and provided is extremely price-sensitive (Knapp et al. 2001; Forder et al. 2004). Because of limited public financial resources, care providers are badly squeezed by Local Authorities to provide care at low cost. As a consequence, wages are pushed down, while long hours and shift work are the norm. The sector faces great difficulties in finding native workers prepared to work under these conditions. That's where migrant workers enter the scene.

According to recent LFS estimates, 135,000 foreign-born care workers were working in the UK in the last quarter of 2008 (table 7); they accounted for 18 per cent of *all* care workers, compared with 13% for the migrants' share in the overall labour force. This share has more than doubled over the

13 All providers are required to pay their staff at least the minimum wage, which in 2009 was £5.80 for adults over 22, £4.83 for adults aged 18 to 21, and £3.57 for people aged 16 to 17 (2009 prices) (Eborall et al., 2010).

[14] Care workers' wages account for half the costs of providing home care and between half and two-thirds of the cost in care homes (Wanless, 2006).

past decade (it was 8 per cent in 1998) (Cagiano et al. 2009). Migrant workers make up a higher share of the nursing workforce – 23 per cent, up from 13 per cent in 1998. However, while most nurses are employed in healthcare, migrant nurses are disproportionately concentrated in social care. Foreign nationals are less unionised[15], work longer hours, but do not work more overtime. A strikingly higher number report having worked night-shifts: 21.5 percent of British workers as against 60.9 percent for foreign workers (table 8).

France and Belgium. For these two countries the correlation between the migration policy and the extent of an irregular care market is not so evident and direct. France and Belgium are traditional receiving countries, with past inflows more directly connected with their colonial history. For France, the so-called "assimilationist" model, means that the collection of data on the basis of ethical criteria is forbidden by law. This makes difficult to calculate the amount of foreign care workers, or care workers of foreign origin. Estimates put the number of foreign carers at 28.6% of total carers, and the share rises (42.9%) when workers with foreign background are included (Ekert 2010). A factor that differentiate traditional receiving countries from new receiving countries (e.g., South European countries), is the participation rate of foreign workers (or workers with foreign background). While in countries of old immigration the participation rate of workers of foreign origin is usually lower than nationals, in South-European countries migrants have high participation and employment rates, significantly higher than nationals, but they are highly segregated in few sectors: for women care, domestic services and other services such as hotels. It is possible to suppose that in countries of old immigration, such as France and Belgium, where the employment policy has been addressed to the creation and regularization of jobs for unskilled workers, we find a high share of women of foreign background in the personal services sector (table 9).

To sum up, immigrant workers tend to be segregated into occupations of poorer job quality. Care is a traditionally low-pay, low-status sector, highly feminised, with a chronic excess demand, where migrants, mostly women, tend to concentrate. Concern about their legal status has given rise to different policies aimed at favouring their regular employment.

4. Regular and irregular care markets: a taxonomy.

Countries' strategies to promote the creation of a regular market for care and restrain the irregular care market rely on fiscal and financial measures aimed at reducing the cost of paid care to families.

The most important factor affecting the difference in the cost between regular and irregular workers is represented y the fiscal wedge, that is the difference between the take-home pay and the total labour cost. Average hourly labour costs and the structure of labour costs varied widely across the Member States in 2009. The relative importance of social contributions in total labour costs was more than 30 % in Belgium and France, while it was 15 % or less in the United Kingdom (Eurostat, 2010). The size of the wedge goes someway towards explaining the differences in the regularisation policies implemented by the various countries (figure 5). We can divide the 6 countries in our study in three different groups (Table 10):

- countries that implemented policies aimed at encouraging the creation of regular employment through subsidisation of social contributions and tax credits (France and Belgium).

- countries that supported the demand for regular employment by keeping the market value of care work low (Germany and England).

- countries that tolerated the grey market, with occasional reduction of irregular workers through amnesties and subsidies (Italy and Austria).

In this section, we provide an overview of the countries' policies in the 3 sub-groups.

[15] 13.2 percent of foreign workers versus 20.8 percent for British workers.

a) reducing care cost by subsidising regular care: France and Belgium.

France. A whole array of policies - tax deduction (direct and indirect) and subsidised social contributions, plus bureaucratic simplification – have been implemented in support of the users of the *services à la personne* (SAP).

Te Borloo-plan (2004) had the objective of favouring the development of a regular market for domestic services to create employment while supporting families' care needs. Cost and bureaucratic complexity, besides problems of information, trust and quality, were restraining demand, while poor job quality and unattractive employment conditions (pay and career opportunities) where restraining the supply. The goal of the law was to create regular jobs in the SAP by promoting the outsourcing of domestic services by: addressing the problems of cost and complexity, of pay and working conditions, and increasing service providers' efficiency and quality to reduce the bottlenecks deriving from the atomistic structures of "the market". The target was to create 500,000 new positions in the sector in the course of three years. The CESU (cheque emploie service universel) was the instrument to pay for domestic and personal care services aimed at the simplification of labour and fiscal practices.

Any person employing a home assistant through CESU can claim a tax credit corresponding to 50% of total expenditure (wage + social contributions) up to a maximum of 12000 euros, that is a maximum reduction of 6000 euros[16], and can take advantage of a reduction of social contributions of 15% (table 11). Through the combined effect of cuts in tax and social contributions the policy has made regular work cheaper than irregular work.

Creation, regularisation and diversion of jobs. Given its high cost, it is important to assess the efficacy of this policy. According to the President of the Agency for personal services (Cour des Comptes, 2010) between 2005 and 2009 102,000 full time equivalent jobs have been created in the sector (390000 new jobs). In 2009 the sector employed 2 million workers, for a VA of 16b euros (0.93% of GDP) and recorded 4% of total hours worked in the economy. However, there are several problems in trying to assess the success of this policy in *net* job creation. First of all, the estimate of the number of jobs effectively created is made difficult because of their atypical character (part-time, high turnover, multiple jobs). Second, there is the problem of estimating the elasticity of demand, distinguishing between job creation and regularisation. Estimates reported by official sources seem to suggest a very high elasticity of demand for regular employment. According to a 2008 study by the Assemblée Nationale, a 10% reduction in the degree of subsidisation of social contribution would lead to a 13.5% drop in service demand, and to a reduction of 4.9% of services declared (Cour de Comptes 2010). There is, finally, the problem of job diversion: employers that would have used the services anyway, and are now taking advantage of the fiscal benefit. This raises the serious issue of the possible regressive feature of this policy.

Belgium. The service voucher scheme is a consumer subsidy introduced in order to encourage the demand for domestic and proximity services, to create jobs, specifically targeted to long-term unemployed and other excluded groups, to provide incentives to convert undeclared work into regular employment, and to support reconciliation thus enabling female workers to (re-)enter the labour market. Each voucher, for one hour of domestic work, costs the user € 7.50. Since 30% of this is tax deductible, the final hourly cost for the consumer is of 5,25 €.

The users of the service vouchers must register with Accor - a private company which is contracted to issue the vouchers on behalf of the federal government. They can then purchase the voucher, contact a registered company for the provision of domestic services and pay the worker with the voucher, which is passed on to the company, that in turn returns it to Accor. Accor pays the

[16] The fiscal ceiling is set by the financial law. At present there are 3 ceilings:12 000 € (6.000 €) for a family; 13 500 € (7.500 €) for a family with one child or an elderly person; 20 000 € for an elderly person with 80% dependency assessment. There is no tax refund if the income tax which is due is lower than the reduction.

company the value of the voucher, € 7.50, plus a government contribution of €13.30 to cover the wage, social contributions and the profit, for a total of €20 per hour. There are no specific eligibility requirements for workers, but they must not belong to the user's family or be resident in the same house as the user, and they must have a 'service vouchers employment contract' from the relevant recognised company. SV workers are divided into two categories: category A workers, who are in receipt of unemployment benefits, minimum income, or social financial aid while working as a SV employee; and category B workers (covering all other workers) [17].

b) Reducing care costs by reducing regular workers' pay

England: consumer-directed care. Direct payments have been an option since 1996 (*Community Care Act*, 1996), to offer a choice to those who were not satisfied with council-commissioned care. At first the policy was optional; that is, LAs were not required to offer Direct Payments in lieu of direct provision of services. However, in April 2003, regulations came into force requiring councils to offer Direct Payments in lieu of services to all people assessed as eligible for community-based care and support. Direct Payments can only be paid to people with their consent, and the person can nominate someone to receive the payment on their behalf. Despite government efforts to expand their coverage just £2.50 in every £100 of social care spending was through direct payments (CSCI, 2009) and most was used to recruit care workers directly as personal assistants, rather than through a formal provider organisation[18].

The Personal budget (PBs), first proposed in 2005 in the Cabinet Office's Improving the Life Chances of Disabled People report, derives from a pilot project built on the experience of direct payments, and marks a possible new era in commissioning care, one that may fundamentally reshape the social care market (Cabinet Office, 2005). Like direct payments, PBs would aim to bring choice and control to the service user by allocating to them a budget from which they could purchase their own care. From one purchaser (the local authority) buying relatively standardised units of a limited range of services (hours of homecare, sessions of day-care etc); to many individual consumers buying bespoke units of an unlimited range of personalised services. In essence, a more mixed economy of commissioning may surface, to complement the mixed economy of provision introduced in the 1990s. Personal Budgets are not supposed to carry any restrictions on the use of money, although care plans (and therefore the budget allocation) do have to be agreed between the client and the LA.

The English social care system is under severe strain: with public support restricted to those with the highest needs, it leaves many individuals exposed to the risk of 'catastrophic' care costs. Moreover, it shifts an heavy burden on informal carers – who provide the majority of adult social care in the UK (Cagiano et al., 2009). With the average amount of Direct Payments decreasing (table 12), the personal budget can give way to the hiring of carers at rates below the minimum wage.

The German labour market and the Mini-Jobs. The Mini-Job reform was introduced in Germany in 2003 as part of the government's "making work pay" strategy. The main objective is to provide positive work incentives for people with low earning potential by subsidising social security contributions (SSC).

Before the reform, Mini-Jobs were defined as employment activity up to a maximum of 15 hours per week and 325 Euro of monthly gross earnings. A Mini-Job was characterized by full exemption of employees' social security contributions (SSC). Below the income threshold, earnings were also

[17] Pricewaterhouse, 2007, Audit financier du système des titres-services pour les emplois et services de proximité, http://www.emploi.belgique.be/WorkArea/showcontent.aspx?id=10286

18 Close relatives cohabiting with the cared-for person cannot be employed except where the authority is satisfied that this is necessary to meet the person's needs.

exempt from taxation if the employee had no other income. In April 2003, the wage level below which employees are exempted from social security contributions was raised from EUR 325 to EUR 400 and the maximum hours restriction was abolished. For each job falling below this threshold, the employer is obliged to pay a flat rate amounting to 30% of the wage, to cover pension schemes (12%), health insurance (11%) and taxes (2%). To avoid high marginal tax rates immediately above this threshold[19], a sliding pay scale (*Gleitzone*) was introduced: between 401 and 800 Euro (midi-jobs), the employee pays social security contributions that increase progressively from 4 to 21 per cent of the wage, the rate for regular employment. Employers pay the full contribution of 20.85 per cent, while the income tax is calculated according to the regular schedule (ILO, 2008).. Employees are covered by health insurance, but do not acquire any pension rights unless they voluntary add up to the normal SSC rate (Steiner and Wrohlich, 2005). Income tax below the exemption earnings level is limited to a flat rate of 2%, while at 401 Euro the standard taxation sets in. In contrast to the pre-reform regulations, income up to 400 Euro from a Mini-Job held as a secondary activity does not cumulate with the primary income for tax purposes (Bargain et al. 2006).

The current regulation strongly supports employment in private households in the framework of minijobs, allowing a 14.27% flat rate contributions for households as employers, as against 30% for business. Moreover, the simplified registration of minijobs and midijobs is tied in with tax refunds for expenditures on household helpers and handymen. This is considerably less than in France, but the overall amount of tax refunds is differentiated according to the status of the employer.

- Minijobs: the household can deduct 20% of the expenditure from tax, up to a maximum of 510 euros (equivalent to 2550 euros of expenses).
- The elderly person can claim back 924 euros for care services. It is not necessary to present proof of need for care. The tax refund can also be utilised by the relatives who are caring for the elderly person. Since most old age pensioners do not pay any taxes, they do not profit from the tax refunds.

Of the two options, the minijob is the more popular. It strongly favours employment in households over employment in firms because of the considerable difference in social security contributions.

There is a German counterpart to CESU bancaire: the “Haushaltsscheckverfahren” (household cheque system). It is much more limited in scope, since it does not entail as many subsidies as in its French counterpart (the cheque part of the French system is missing). It is merely a procedure for registering household’s help with a central organisation called Minijob-Zentrale. Central to the procedure are tax breaks for social security contributions.

Assessment of the effects of these reforms on job creation and regularisation are controversial. According to one view (Bosch and Weinkopf 2008) the most visible result has been a sort of Gresham’s law, with non-subsidised jobs been squeezed out by subsidised jobs, rather than easing the regularisation of irregular jobs. It is reported that, in their endeavour to reduce costs, private providers employ under-qualified or untrained staff to an extent largely in excess of the 50% rate of fully-trained personnel (Fachkraftquote) per establishment fixed by law. As a consequence, the share of unskilled workers and people under-qualified for their jobs has rapidly increased since the introduction of the long-term care insurance (Kummerling 2009). The net effect on job creation is therefore dubious, while the long run effects on the level of pensions of the increase in low-paid employments are still under-rated.

Finally, whether the development of a low-pay sector will crowd out the irregular migrant carer option is an open question. Persons with a migration background are over-represented among the marginally employed (mini jobs): in 2009 their share on total workers with a migration background was 11.5% compared to 7% for total employment. Women are especially dependent on marginal

[19] Given joint taxation, this created a strong discontinuity in the budgetcurves of married Mini-Job holders and strong incentives to remain at a low level of activity. See Bargain et al. 2006.

employment: in 2005, 14.6% of all female employees with foreign background were employed marginally (one in 6) – compared to 8% for women without a migration background.

c) reducing care costs by tolerating irregularity

Italy. Tax refund. The Italian financial law offers tax deductions for expenditures on domestic services bought from family assistants on the regular market. There are two types of tax benefits depending on the family employer's income.

- For employer's annual income up to € 40,000 there is a deduction from taxable income of 19% of costs incurred, up to € 2100, equivalent to a maximum tax credit of €399 (2100 x 19%, the flat tax rate for that level of income).

- for employers with income above that threshold: deduction from taxable income of the social security contributions (deductible charges) up to a maximum annual expenditure of € 1,549.37. The tax benefit varies with the income tax rate and it may range from a minimum of € 356 (for an income tax rate of 23%) to a maximum of € 666 (for the top Income Tax Rate of 43%).

The benefit can only be in the form of a tax credit. Hence, elderly people on low pensions, who usually do not pay the income tax, cannot benefit from the tax break. In this case, it is usually family members who recruit family assistants, in order to take advantage of the tax benefit.

The extremely low amount of tax benefits, also in comparative terms, does not cover the pay difference between regular and irregular carers, which remains high, particularly in the case of co-residence (table 13). A carer on a regular contract would cost about 40 percent more than an irregular worker, a percentage that varies depending on the tasks, nationality, working time, and the conditions prevailing in the black market. The condition of irregularity can be preferred also by the migrant carer, who may want to exchange a regular position for a higher wage. A regular contract is searched for when the residence permit has to be renewed, since the latter is linked to a regular work contract[20]. Even in the case of regular employment, it is usual to under-declare the hours of work to evade social contributions. In fact, a work permit requires a foreign worker to pay social contributions for a minimum of 25 hours per week. To declare the legal minimum, even when the carer works more hours, is at the mutual advantage, since both can gain by evading social contributions.

Tied care allowances provided at regional level. Following the law 328/2000, art.17, a number of regions introduced various schemes of cash allowances to older people in need of care. In spite of the huge differences between regions in relation to amount and access criteria, some of them[21] have tied the provision of these regional cash benefits to the legal/regular employment of a family assistant, providing a subsidy just enough to pay for social contributions (Gori et al., 2009).

In conclusion, the amount of subsidy granted is still far below what is required to fill the gap between the cost of a regular versus irregular worker. Economic conditions therefore work against the regularisation of the care market. Given these premises, the failure of the last amnesty (see section 2 above) was largely predictable, and perhaps also politically acceptable. As a result, a large share of the 'market' of family assistance has remained underground.

Austria. The Austrian care allowance – which is provided by the insurance for dependency (Pflegegeld) and reaches about 380,000 people - covers only basic needs (though it may be supplemented by social assistance). The necessity for many families to cover 24-hour care has given rise to a flourishing grey market, fuelled by illegal immigrants organised on a rotating basis

[20] Families can not employ foreign workers lacking a valid residence permit or in possession of a permit which does not authorize to work (eg, a tourist visa): violation of this provision now constitutes a criminal offense, punishable by imprisonment (from 3 months to 1 year) and a fine of 5,000 €.

[21] Abruzzo, Emilia-Romagna, Veneto, Valle d'Aosta, Friuli-Venezia Giulia and Sardegna.

of two-week shifts. In fact, at 50 euros per day (1500 euro/m) the total cost amounts to 273.8 million euros per year – that is, barely 15% of the care allowance. It has been estimated that, at the time the amnesty law was passed, there were about 30,000 (irregular) carers employed on a 24-hour basis, caring for 15,000 families[22].

In July 2007 a law was passed that aimed at regularising the 24-hour migrant workers. Comprehensive coverage of care needs would have been too costly: thus the law applies only to the medium and most severe levels of disability (levels 3 to 7) and the subsidy does not cover the whole cost of care, but only the extra-cost connected with legalisation (that is, social security contributions, which differ according to the type of contract) (table 14).

Even after adding the LTC insurance allowance (last column in table 14), the remaining cost may still be too high for a lower-middle income family. That is why, although the law proved a great success - with 75% of attendants regularised in the 2 years since its approval - the overwhelming majority of regularisations were to be found among the free-lance workers. By January 2010 the scheme covered 22,000 free-lance workers but only 500 employed carers. Although the law provides for some education and training, it does nothing to improve migrant carers' pay and working conditions, raising concern that, with transitional regulation of migrant flows ending 1-5-2011, carers will move to other more rewarding or less exacting sectors, or to higher wage countries, leaving families without attendants.

5. Conclusion

"Countries that satisfy their need for cheap labour through standard employment do not develop large non-standard sectors of their economies. Countries that do not promote cheap labour in the standard sector, on the other hand, end up relying on an army of non-standard workers (including immigration) to meet their cheap labour needs" (King and Rueda 2009)

Is there a trade-off between the two policy goals of ensuring regular "good" jobs and decent working conditions in the care sector and affordability of care for the greatest possible number of those who need it? The analysis carried out in this paper seems to suggest that cheap domestic labour in the standard sector allows economies to rely less on the non-standard, irregular sector (migrant carers). Deregulation of the labour market can open up the regularisation of former irregular migrant care workers, who can be hired on relatively economical conditions, at the cost of further debasing care work. Or that regular (good quality) jobs in the care sector are possible only if they are highly subsidised.

Supply and demand factors may enter into determination of the cost of care by affecting the level of pay. On the supply side, a reservoir of cheap labour contributes to keeping wages down. On the demand side, wages are constrained by the high price elasticity of demand induced by income constraints. However, a trade-off seems to be the most likely outcome of a more general context of fiscal restraint and labour market deregulation. The families' limited capacity to pay makes subsidisation an essential measure to sustain demand for regular work in all those regimes lacking a developed system of in-kind services provision. However, the budgetary implications of policies subsidising demand for regular workers may be considerable, and hardly sustainable without overhaul of the whole policy on dependency. Private and public budget constraints may thus lure towards a "low road" solution, based on either irregular or badly paid care work models. Ample availability of cheap (irregular) care labour, combined with unconditional cash allowances may represent a tempting way to open the market up, also to a large share of lower-middle income families even at relatively low levels of subsidies (Simonazzi 2011).

[22] Estimates of the total number of irregular migrant carers vary between 10,000 and 60,000.

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Tables and Figures

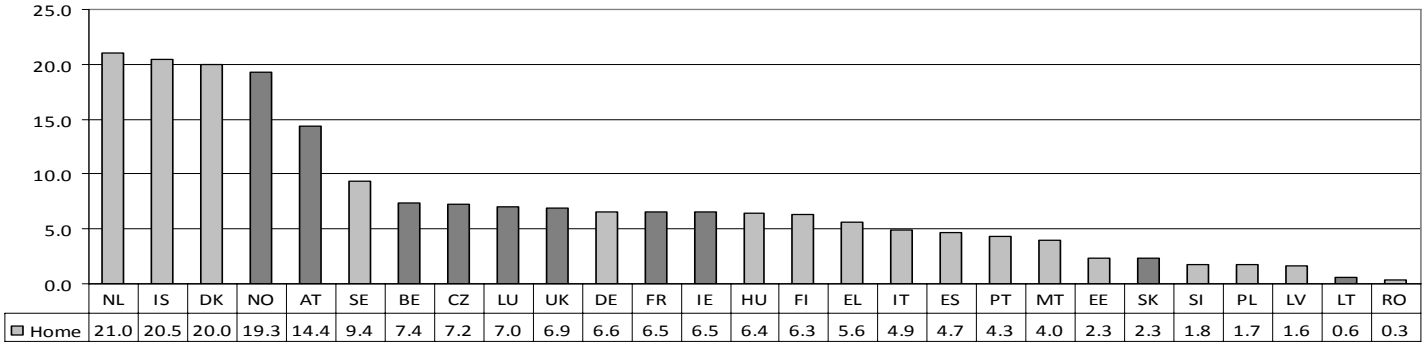
Table 1.

Very elderly population (80 and over) (as % of total population)

	07 – 60	2007	2010	2020	2030	2040	2050	2060
EU 27	7,8	4,3	4,7	5,7	6,9	8,9	11	12,1
BE	5,7	4,6	4,9	5,6	6,5	8,4	10	10,2
IT	9,6	5,3	5,8	7,3	8,5	10	13,1	14,9
FR	5,9	4,9	5,3	6	7,3	9,3	10,5	10,8
AT	6,9	4,5	4,7	5,2	6,7	8,4	11,5	11,4
DE	8,6	4,6	5,1	7,1	8	10,3	14	13,2
UK	4,5	4,5	4,6	5	6,3	7,3	8,9	9

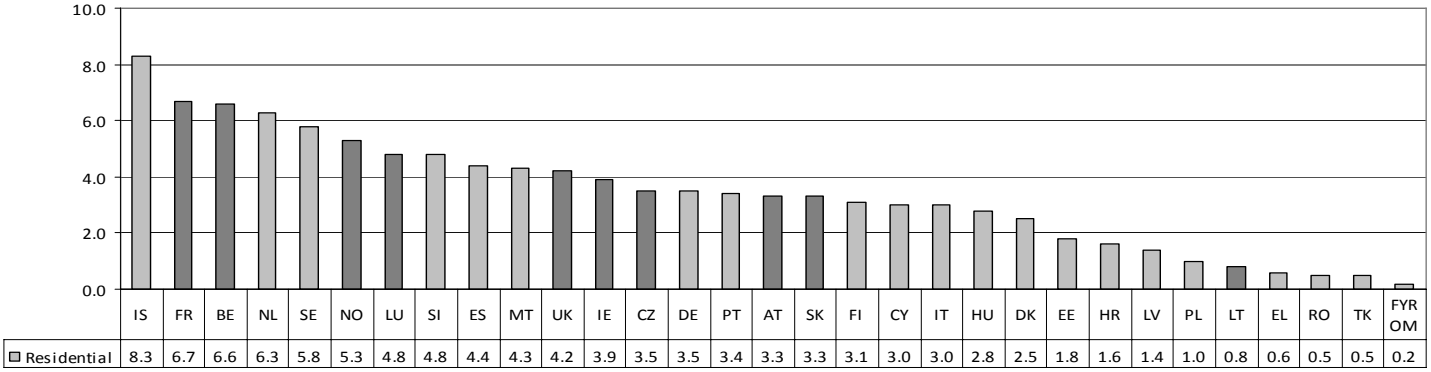
Source: Eurostat, Ageing Report, 2009

Figure 1. Home care: coverage rates (old people over 65), 2008



Source: Bettio et al., 2010

Figure 2. Residential care: coverage rates (old people over 65), 2008



Source: Bettio et al., 2010

Table 2. Germany: Long Term Care Insurance: payments in Euro for services according to each category

	Monthly payment for domestic care (cash payment)	Monthly payment for domestic care (professional services)	Monthly payment for nursing home care
Grade I	205	384	1,023
Grade II	410	921	1,279
Grade III	665	1,432	1,432
Special hardship		1,918	1,688

Source: http://www.alzheimer-europe.org

Table 3: Germany: Recipients of LTC insurance (all age-groups, both sexes), 2007

Type of benefit	**Number of recipients**
Total	2,246,829
Outpatient care	504,232
Inpatient care	709,311
Care allowance	1,033,286

Source: Mollenkopf et al. 2010

Figure 3. Share of personal care services in total employment. 2007.

Fonte. Nostra elaborazione sui dati Labour Force Survey, (settori ISCO 223, 323,346,513,913)

Source: Bettio and Simonazzi (2011).

Table 4 RELEVANCE OF ILLEGAL/IRREGULAR (MIGRANT) CARE-WORKERS IN THE SELECTED COUNTRIES					
	Relevance	**Care workforce (home care)**		**migrant regular care workers (000 and % of total workers)**	**irregular/illegal migrant care workers (estimates) (000 and % of total workers**
		Total care workers	**share of care workers in total employment**		
IT	xxx	971.367	4,17	464.033 (INPS) +295.000 (amnesty in 2009)	700.000-800.000 (72%) (Pasquinelli 2010)
DE	xxx	3.309.957	8,81	3.051 in 2008 placed by the ZAV (*Bundesagentur für Arbei, 2006*)	60.000-100.000 (3%) (Lutz 2008)
BE	x	412.124	9,52	9,4%	?
FR	xx	3.575.838	14,17	28.6% foreigners; 42.9%, parents born outside France (Ekert 2011)	?
AT	xx(x)	380.950	9,65	15.000 regularized in 2008 (3,9%) (Schmid 2010)	10.000/60.000 (7,9%) before 2006
UK	x	3.615.404	12,80	19% (up from about 7 % in 2001)	?

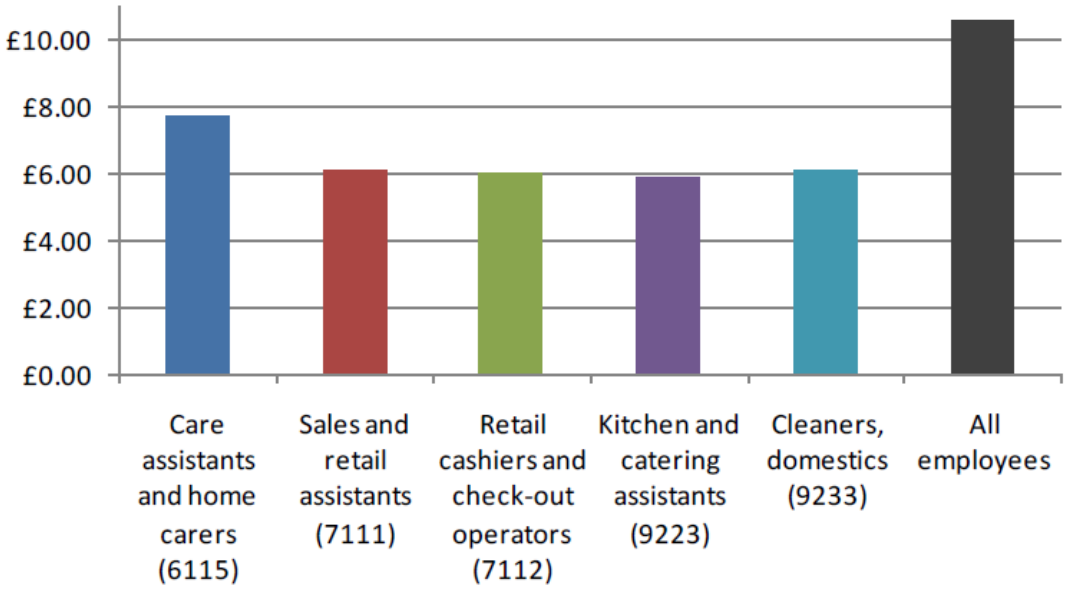
Source: Authors' elaboration on national reports.

Table 5 Cost of a migrant carer. Germany 2007.

Legal migrant domestic help	1029-1300 (1500-2000)	gross
Self-employed	800-1200	Plus mediation fee
Posted care worker (less qualified)	1200	Social contributions and tax in the sending country
Irregular worker	600-1400	
24 hours carer		
Regular German national	2700-3200	gross
Regular migrant	1200-2500	plus board and lodging
Irregular migrant	500-1000	Plus board and lodging

Source : Authors' calculation on various sources.

Figure 4: UK: Gross median hourly pay of care workers, comparison with other low-paid occupations, 2008



Source: Annual Survey of Hours and Earnings, UK

Table 6 Care workers and support workers median and average hourly rates of pay by sector, England (includes residential as well as non-residential workers)

	Private sector		Voluntary sector		Council	
Job role	Median	Average	Median	Average	Median	Average
Care Worker	£6.00	£6.16	£7.03	£7.22	£7.73	£8.20
Senior care worker	£6.70	£6.80	£8.08	£8.19	£10.69	£10.46
Support worker	£6.50	£6.68	£7.90	£8.10	£9.80	£9.71

Source: NMDS-SC based on records received between Oct 2008 and September 2009 (Eborall et al., 2010)

Table 7: Estimates of the workforce in selected care-related occupations in UK, by UK/foreign born. 2008

	Absolute values			% of foreing born
	Foreign born	Uk born	Total	
Care workers	135	595	730	18%
Nurses	122	417	538	23%
Nurses auxiliaries	40	191	232	17%
Housing and welfare officiers	16	160	176	9%
Childminders and related occupations	23	95	118	19%
Youth and community workers	8	111	118	6%
Social workers	14	87	100	14%
All workers	3,807	25.530	20346	13%

Source: Cangiano et al., 2009

Table 8: Job characteristics for British and foreign care assistants and home carers, 2008

	British (%)	Foreign national (%)
Employed in public sector	27.6	16.8
Full-time	55.6	72.7
Hours worked without overtime	29.8	33.2
Hours worked with overtime	40.5	43.2
Trade union member	20.8	13.2

Source: LFS 2008-4; Franca van Hooren, 2010

Table 9. Belgium: Foreign workers in the personal services sector

	2005 (N=16.255)	2006 (N=31.907)	2007 (N=50.184)	2008 (N=68.516)
Belgique	86,9%	85,5%	83,2%	n.a.
EU-15	4,5%	5,3%	6,2%	n.a.
EU-27	1,4%	1,9%	3,0%	n.a.
NON EU-27	5,4%	6,0%	6,4%	n.a.
Autres/indéfini	1,7%	1,2%	1,3%	n.a.
Total	**100%**	**100%**	**100%**	

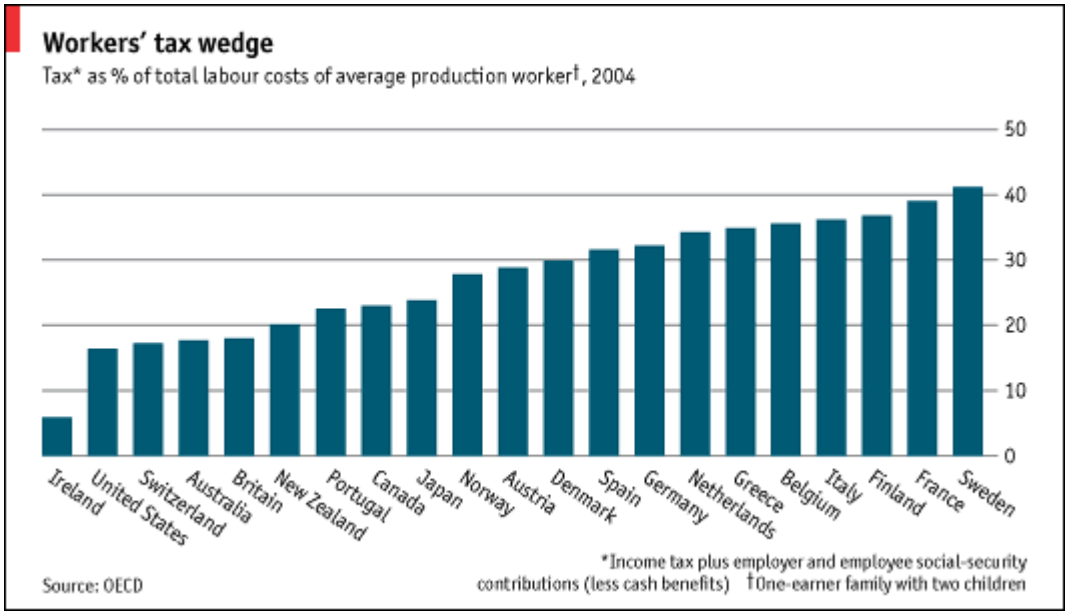
Source: IDEA Consult sur base des données de la banque carrefour

Table 10. Policy measures in support of families employing regular care workers. Selected countries, 2010

	Instruments	Subsidised social contributions	Tax breaks	Tax refund	Incentives for regularisation/ amnesty
ITALY	National level			x	x
	Regional: tied care allowances	x			
GERMANY	Mini – job	x		x	
BELGIUM	Titres-services	x		x	
FRANCE	CESU	x	x	x	
AUSTRIA	Allowance for 24 hours home – care	x			x
ENGLAND	Personal Budget				

Source: Authors' elaboration on national reports.

Figure 5.



Source: The economist, 17-3-2005

Table 11. France: policy to create regular workers in the personal services

	Social contributions	Tax credits	VAT
user			
Direct employment	15% Total if >70 or >65 not self-sufficient	50% of expenses ceilings: 6000 Child and >65 co-habiting 7500 >65 severely disabled Co-habiting 20000	
prestataire		50% of expenses ceilings: 6000 Child and >65 co-habiting 7500 >65 severely disabled Co-habiting 20000	Reduction of VAT from 19.6 to 5.5
CESU prefinancé (firms)	The CESU is not considered as wage, so no social contributions are due up to 1830 e.	25% up to 500.000 e.	
Accredited organisations	No contributions up to the minimum wage Total exemption for workers caring for >70 or dependent people (no wage limit)		VAT reduction if working only in the SAP sector

Table 12. Estimated average payment per week to Direct Payments users and number of users, England, 1998/99 to 2008/09, 2008/09 prices

	£s per person per week	Number of users
2000/01	174	500
2001/02	173	900
2002/03	169	2700
2003/04	153	6000
2004/05	145	7400
2005/06	144	13000
2006/07	155	17000
2007/08	129	27000
2008/09	137	37000

Source. Payment per week: Personal Social Services Expenditure and Unit Costs, England 1998/99- 2008/09 http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalexpenditure/DH_4000111 and http://nascis.ic.nhs.uk/Portal/Library.aspx
Number of users: Community Care Statistics: Referrals, Assessments and Packages of care (RAP) for years 2000/01 to 2008/09, table P2f.1
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalsocialcare/DH_4086767 and http://nascis.ic.nhs.uk/Portal/Library.aspx

Table 13. Italy: Minimum pay for family assistant at home (Level CS, 2009)

Co-residing worker (per month)	Non co-residing worker (per hour)	Night assistance for older people with LTC needs (per month)
880.17 €	6.10 €	1012.20 €

Source: Ministry of Labour, 2009

Average cost per month for a family assistants at home (Level CS, 2009)

	Co-residing (54 h/week)	Co-residing (25 h/week)
With contract “COLF”	1350 €	850 €
Without contract (average)	850 – 1000 €	700 €

Source: Gori, 2009

Table 14. Austria: Cost of care attendants and amount of subsidy granted

	Cost (48h/w; 168h/month)	Subsidy	Cost to the family	Care allowance (3-7)*
Carer employed by:				
family	3200	1200	2000	442.8 - 1665.8
NGO	4600	1200	3400	
Free lance	1500	500	1000	

* Disability level 3 to 7 only; plus pocket money: 43,29 euros per month.

Source: T**.** Schmidt, Migrant carers in private households, mimeo April 2010.