VET CARE

Building Capacity and VET for Migrants Care Workers in Europe

WP2/A5 Report on migrant care workers landscape and training

Date: 08/July/2024

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P1	PT	CECOA - Centro de Formação Profissional para o Comércio e Afins	
P2	IT	FORMA.Azione S.r.l.	
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P4	ES	Fundación Ronsel – Inserción Sociolaboral e Fomento do Emprego	

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1. About the VET CARE project

The VET CARE project aims to provide practical and useful answers regarding qualifications for the labour market, in the segment of long-term care (LTC) services, contributing for integration and social inclusion of migrants. Migrants are one of the major workforces in this area. VET CARE aims as well to transfer knowledge from different levels of stakeholders, contributing for implementing a logic of national/transnational cooperation and partnership in the sector.

The expected results are to contribute for a better knowledge and understanding of the migrant care workers landscape and training/qualification needs; capacity building and upskilling of migrant care workers, within a logic of integration and social inclusion of vulnerable populations; to foster cooperation among stakeholders from the care services sector that will allow to create suitable care work pools answering the needs of the labour market at European level.

The transnational project partnership supported by the Erasmus+ programme will be led by CECOA (Portugal) in cooperation with the following partners: FORMA.AZIONE (Italy), IDEC (Greece) and Fundación Ronsel (Spain).

The VET CARE project started in December 2023 and will end in November 2025.

For more information, visit each partner’s website:

CECOA - www.cecoa.pt

FORMA.AZIONE - www.azione.com

IDEC - www.idec.gr

Fundación Ronsel - www.fundacionronsel.org

2. Executive Summary

Work package (WP) n°2 is labelled as following:

→ Migrant Care Workers needs analysis and mapping of best practices on existing VET formal and non-formal programs.

→ WP2 started in December 2023 and will end in July 2024, being developed over six (6) activities.

→ WP2/A3 is about collecting the **12 good practices** developed at European level regarding formal and informal training on long-term care services identified in WP2/A1 into **4 national reports**, including a migrant national characterization/landscape.

→ At least **12 countries** will be targeted: Portugal, Spain, Greece and Italy, plus 2 other EU countries by each partner.

→ All partners will follow the template provided by FORMA.Azione in this document.

WP2/A3 is scheduled to take place in April to July 2024.

3. Migrant care workers national characterisation and landscape

3.1 Introduction

Europe is aging, resulting in 3 (three) challenges for the long-term care (LTC) sector in the EU (European Union): (i) aging demographic trends; (ii) need for skilled care workers; and (iii) increasing number of migrants in Europe, representing the major labour force in this sector.

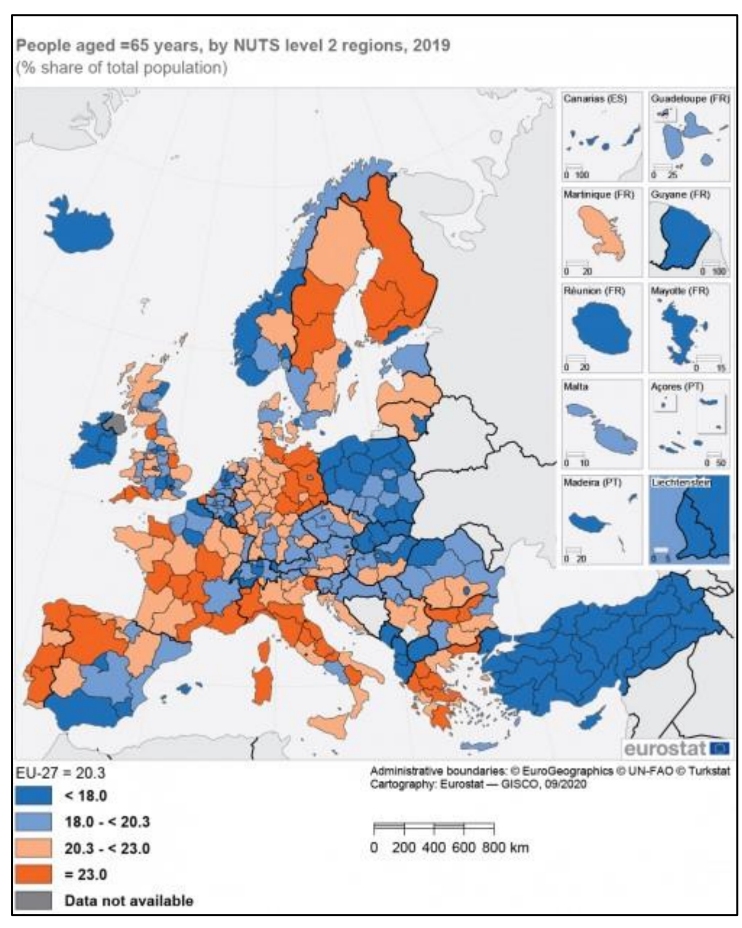


Figure 1: [Eurostat 2023]

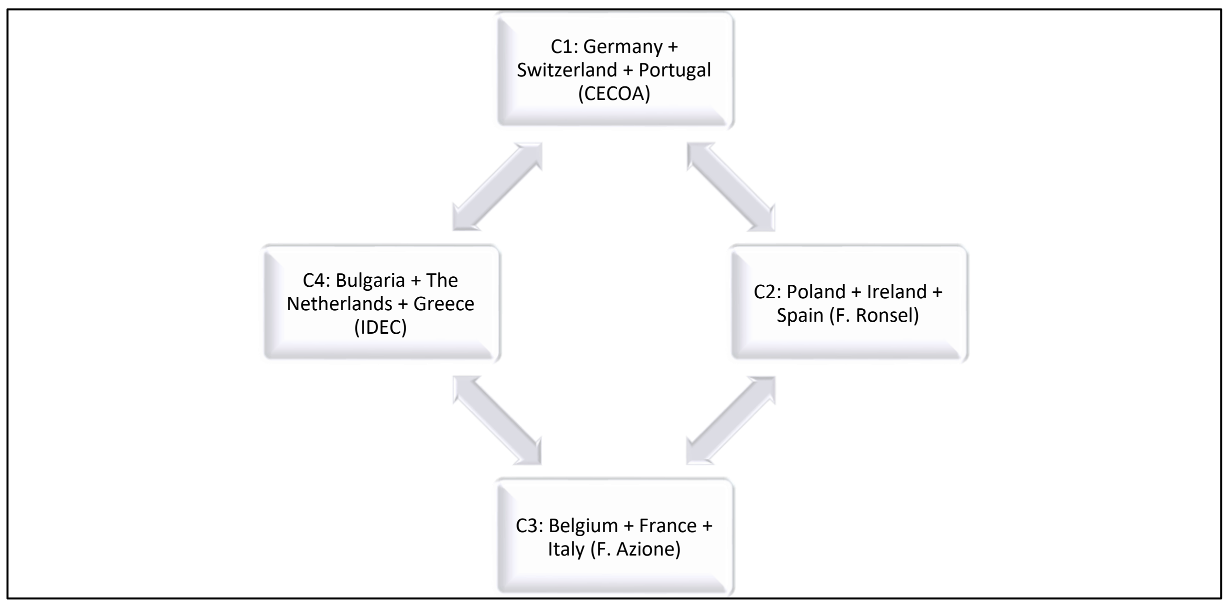
According to CEDEFOP, by 2035,

> *the number of individuals aged 65 or older will surge by 23%, amplifying the demand for long-term care services. In stark contrast, the projected employment growth in the care sector is a mere 7%. The*

gap between demand and supply is undeniable, and it's not just about numbers; it's about the skills required to provide high-quality care in a rapidly changing landscape (Directorate-General for Employment, Social Affairs and Inclusion 2024[1])

VET CARE project aims to contribute for the reinforcement of the 18th principle of the European Pillar of Social Rights on LTC, which establishes that all people have the right to affordable long-term care services of good quality, in particular homecare and community-based services. To follow the EU guidelines on LTC, there is the need of capacity building to improve knowledge and develop a suitable training answering the needs of both the agents (i.e. care workers) and the labour market (i.e. private and public, community and family level, home cares and entities supporting on demand). Moreover, in "Europe, the commercialisation of home care has been accompanied by the emergence of private, for-profit care agencies, who recruit circularly migrating care workers from Eastern European countries and place them in households in the wealthier EU countries"[2].

Bearing that in mind, the VET CARE consortium collected 12 (twelve) good practices of formal and informal/non-formal training on LTC services in 12 (twelve) different European countries, including the countries of the partnership (i.e. Portugal Spain, Italy and Greece), divided into four (4) clusters by leading partner, as following:



Clusters by partners – VET CARE consortium

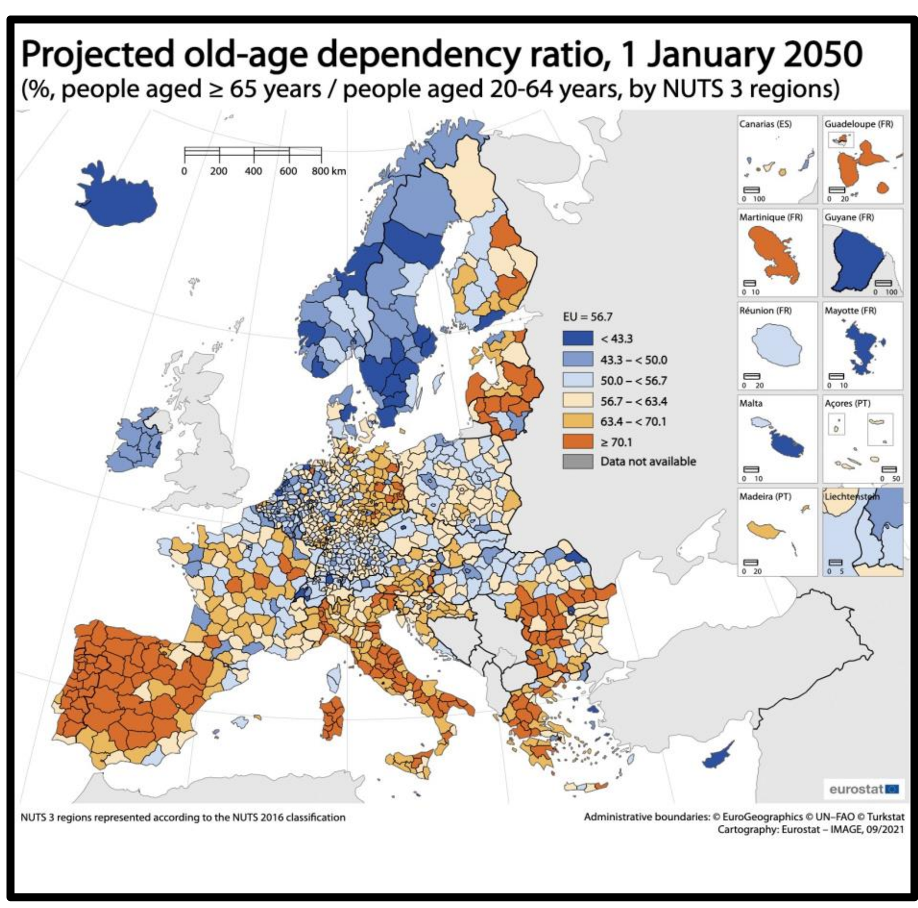
Firstly, an overview of each country regarding the LTC and aging scenarios will pre presented, followed by the good practices identified by the VET CARE consortium, with details on methodology and description of the training developed.

[1] In https://year-of-skills.europa.eu/news/unlocking-potential-skills-long-term-care-sector-2024-01-08_en
[2] In https://ijal.se/article/view/1460 , p. 24.

3.2 Cluster One: Portugal, Germany and Switzerland

3.2.1. Portugal

In Portugal there is no official data regarding migrant care workers, because mainly they are developing their tasks under the label of ‘domestic service’, in what is called “underground care” (Soeiro 2022[3]). Nonetheless, from qualitative data collected by CECOA strategic partners and during the Focus Group (FG) and Theory of Change (ToC) VET CARE activities carried out in Lisbon F2F and online, including other regions of the country, it is possible to underline that, in Portugal, such as in other European countries, most of the labour force are women. Apparently, in the Portuguese landscape the Brazilian women are replacing the former care workers women coming from Portuguese-speaking African countries, especially from Guinee Bissau and Cape Verde, as well as from Eastern Europe, from countries such as Ukraine.



Source: https://ec.europa.eu/eurostat/web/products-eurostat-news/-/edn-20210930-1

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[3] Soeiro, José (2022), “O regime de cuidados em Portugal: desigualdades e desafios democráticos”, in TAVARES, Inês; CARMO, Renato; CÂNDIDO, Ana Filipa (eds.), *Que futuro para a igualdade? Pensar a sociedade e o pós pandemia*, Observatório das Desigualdades, pp. 81-113.

The care system in Portugal follows essentially a family model, which considers care services as a family obligation and not a social right[4]. Indeed, Portugal is one of EU member states with the highest rate of informal care workers (European Commission, 2021[5]). It is expected that the situation of informal care workers, a status recognized by law since September 2010 (Law nº 100/2019, of 6 September), could change in the near future. However, in 2021, only 997 persons had the status of informal care worker out of a number that can be estimated in hundreds of thousands, underlining that the support allowance was only given to 352 persons in Portugal, being below the poverty line (around 282 euros)[6]. Indeed, and according to OECD (2019[7]), 70% of the informal care workers in Portugal are women, with 95,8% of women in the LTC professional segment (European Commission, 2021). Data from 2021, underlines that more than 800,000 persons in Portugal used care services in a universe of near half a million of the total population in need (European Commission, 2021), adding that in "Portugal, there are only 0.8 LTC workers per 100 people aged 65 and over, which compares with 3.8 on average across 25 Member States" (ibid: 343). Furthermore, care workers have low levels of qualifications. Finally, salaries are lower than other when compared in the health sector, not being attractive. In general, the "main reasons for being a LTC healthcare assistant were financial need, the absence of other job offers and job stability (as demand for such jobs exceeds supply)". In a nutshell, the EU (2021: 337) considers the following regarding the LTC care sector in Portugal:

Highlights

- Adverse demographic trends clearly point to a potential increase of the population in need of long-term care (LTC) in Portugal and to an increase in public spending on LTC. This, in turn, raises issues regarding the system's financial sustainability.
- In the formal LTC system in place, beyond LTC Social, the National Network for Integrated Continuous Care (RNCCI) integrates health and social, and includes different types of services, most of which show very high usage rates. Issues regarding access and affordability persist.
- Portugal is one of the EU-27 Member States with the highest rates of care provided by informal caregivers. Overlooked until recently, the situation of informal carers will change following the recent approval of a formal status for them.
- Ensuring that the implementation of the status effectively supports informal carers is a major challenge to be addressed, along with promoting increased access to and affordability of formal LTC.

Portugal LTC highlights, European Union (2021)[8]

[4] Soeiro 2022.

[5] European Commission (2021). *Long-term Care Report Trends, challenges and opportunities in an ageing society-Country Profiles*. Volume II. Luxembourg: Publications Office of the European Union.

[6] Soeiro 2022, ibid.

[7] OECD (2019), *Health at a Glance 2019: OECD Indicators.* OECD Publishing: Paris.

[8] In https://op.europa.eu/en/publication-detail/-/publication/b39728e3-cd83-11eb-ac72-01aa75ed71a1

3.2.2. Germany

In Germany, the population that requires care is 4,127,605 out of 84,607,016 (total population). According to the 2024 Statistisches Bundesamt (Destatis), the number will go up by 37% until 2055 due to aging population[9]. "The cost of long-term care for the elderly (65+), including both cost of nursing home and home health agency, reached 61 billion euro in 2019. Half of these spending are for nursing homes while only about 22.5% of beneficiaries use these institutions"[10]. Indeed, since "2022 18.6 million people living in Germany are 65 years of age and older, including 6.1 million who are 80 years and older"[11].

Provision of care	People in need of care	
	total	including: females
	number	%
Total	4,127,605	62.3
⌞ People in need of care receiving domiciliary care	3,309,288	60.2
⌞ Of whom		
⌞ Cared for by relatives alone [1]	2,116,451	57.2
⌞ Cared for together with/by home care service(s)	982,604	66.6
⌞ People in need with care level one and exclusively benefits under state law or without benefits [2]	208,330	64.9
⌞ People in need with care level one and semiresidental care [2]	1,903	77.1
⌞ People in need of care receiving full-time residential care	818,317	69.7

Statistisches Bundesamt (Destatis) 2024[12]

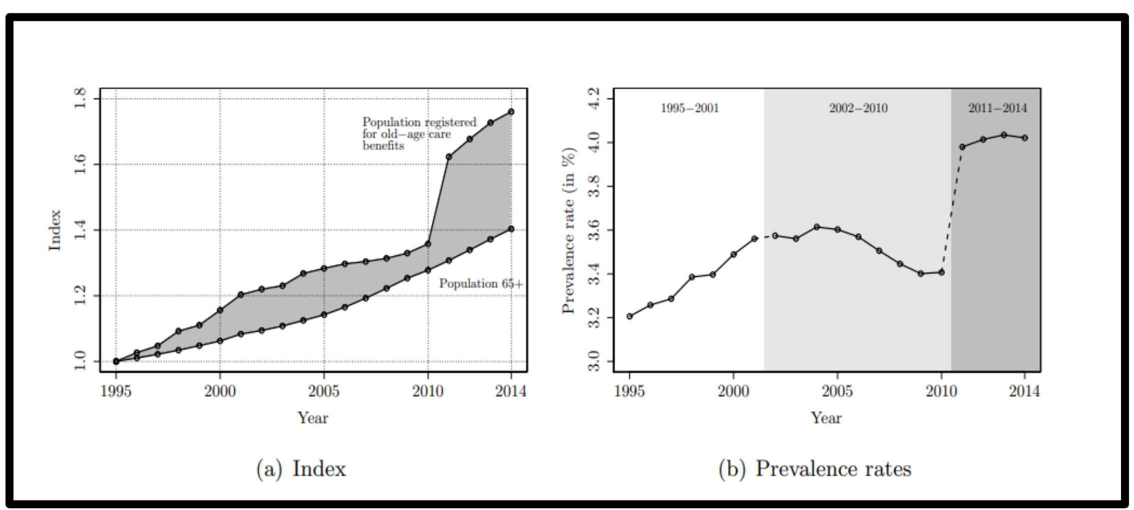
Germany is one of the aging countries in the world, in which "nearly 50% of all individuals older than 65 receive some type of care. Their share increases to 80% for the group of individuals older than 85"[13]. Furthermore, as mentioned by the German National Bureau of Economic Research (2023), "Unpaid informal care inside or outside the household is, at 54%, most common for individuals older than 65. Only

[9] In https://www.destatis.de/EN/Press/2023/03/PE23_124_12.html
[10] In https://www.nber.org/papers/w31870
[11] In https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10565879/pdf/johm-8-3-61.pdf
[12] In https://www.destatis.de/EN/Themes/Society-Environment/Health/Long-Term-Care/_node.html
[13] In https://www.nber.org/system/files/working_papers/w31870/w31870.pdf , p. 44.

7% live in a nursing home. At the age of 85 or older, about 17% of those individuals who need care reside in a nursing home while the share of informal care as the only source of care is reduced to 21%."[14]

3.2.3. Switzerland

According to OECD (2017), in Switzerland, "Almost one-fifth of the population is already 65 years old or more, a share set to reach 30% by 2060. While reaching 65 years previously denoted 'old age', a Swiss 65-year-old can expect to live another 21 years, amongst the highest in the OECD"[15]. As in Portugal and Germany, the care service market, especially looking at care workers qualifications, is characterized by a lack of qualified staff in the near future.



Source: "Population registered for old-age care benefits for the years from 1995 to 2014"[16]

In Switzerland, the "majority of adults in need of care live in private households and are mainly cared for privately by their partners", underlining that "Care in the global north is increasingly being delegated to women migrating from poorer to wealthier countries"[17]. Furthermore, in the "2024 fiscal sustainability report for Switzerland" it is stated that public finances will face growing tension until 2060, because of the aging demographic[18]. In addition, it is underlined that according to OECD and the European Commission, "a distinction is made between long-term care (from the age of 65) and the other areas of healthcare expenditure (excluding long-term care), because the development of expenditure in these areas is influenced differently by the cost drivers in the healthcare system"[19].

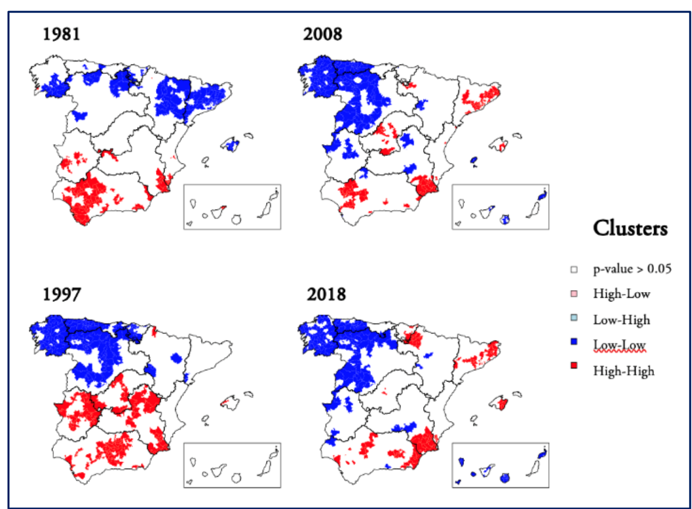
[14] Ibid.
[15] In https://www.oecd-ilibrary.org/sites/9adc88d2-en/index.html?itemId=/content/component/9adc88d2-en
[16] In https://serval.unil.ch/resource/serval:BIB_353642822986.P001/REF.pdf , p. 6
[17] In https://ijal.se/article/view/1460 , p. 24.
[18] In https://www.admin.ch/gov/en/start/documentation/media-releases.msg-id-100782.html
[19] In https://www.newsd.admin.ch/newsd/message/attachments/87128.pdf , p.26.

3.2 Cluster Two: Spain, Poland and Ireland

3.2.1. Spain

In Spain, the trends are similar, with a large number of aging population, needing LTC services, apart from all the dependent population who do not fit this profile. According to the National Institute of Statistics (INE 2023), 20.43% are people over 65 years of age in the country. Previsions show that "in 2050 Spain will be one of the Member States with the highest percentages of people aged over 65 and over 75, and the highest old-age-dependency ratios" (EU 2021: 135[20]). Furthermore, in Spain, "informal care still playing a significant role. Informal care work continues to dominate the social structure of care (ibid: 136).

Therefore, it can be said that Spain is a rather aged country, with a low birth rate (10.7% according to INE), in which LTC both in this sector and in the disability sector are basic needs.



Total fertility rate of years 1981, 1997, 2008 and 2018 (Carioli, Recaño and Devolder 2021[21])

Even so, public services do not respond to the number of people who need services both at home and in residences, and private services are unaffordable, considering that an average pension is about 1,200 euros and a residence can cost between 2,000 and 3,000 euros, or more. As a result, the high demand for LTC services and the limited supply promote exist in an unregulated market. Consequently, Spain is facing a labour unbalanced scenario in the LTC sector, especially focused on care workers in the process of administrative regularisation, namely women and migrants. Both segments of the population are exposed to long working hours, low salary, with internships for less than 1000 euros per month, affecting the rights of these people and the quality of care. Quality care should be a qualified job, meeting specific needs of the people being cared for, according to national and EU standards.

> *The health sector is finding it ever more difficult to compete with other sectors that offer better work-life balance, career opportunities and fair remuneration, factors that are increasingly*

[20] Ibid.

[21] https://www.redalyc.org/journal/289/28967988010/html/

> *important for the new generation of workers in the EU (…) Strengthening the health workforce to build health system, societal and economic resilience is one clear and important lesson coming from COVID-19 pandemic responses* (European Observatory on Health Systems and Policies 2023: 1-2[22]).

In general, the landscape on migrants and LTC is described as following:

- According to data from the International Labour Organisation (ILO), of the almost 76 million people doing domestic work in the world, 76.2% are women.
- In 2023, in Spain there were more than 355,000 domestic workers, according to data from the Special Scheme for Domestic Workers. Of these, 159,114 were foreigners in a regular situation.
- 36% of domestic work is carried out informally, and one in four migrants who do it is in an irregular situation, according to a survey by the University of A Coruña and the Platform for Household and Care Employment with Full Rights.

In 2022, the Royal Decree-Law 16/2022, of September 6, aiming at improvement of working conditions and social security issues for domestic service workers. Moreover, to guarantee a quality care service, recognition and professionalisation of the work in the LTC services are central to answer EU and national needs, guarantying also the well-being, labour rights and integrity of people who work in professional care, especially migrants, who are more vulnerable and more exposed to certain types of discriminatory violence. In a nutshell, the EU (2021: 132) considers the following regarding the LTC care sector in Spain:

Highlights

- The population aged 65 and over represents 19.4 % of the Spanish population (2019), a percentage that is expected to reach 23.8 % in 2030.
- In 2019, the 'system for autonomy and care for dependency' (SAAD) covered 1,115,183 people aged 65 and over – 80.5 % of the recognised beneficiary population – with benefits and services. Public spending on long-term care (LTC) was 0.7 % of GDP in 2019.
- There is still limited development of homecare and community-based services, and there are territorial imbalances in the supply of services and the different co-payment criteria.
- Formal employment is characterised by excessively high rates of temporary and part-time employment, while informal care work continues to dominate the social structure of care. In 2016, 11.5 % of the population aged 16 or above were carers in Spain, the vast majority of whom were women. Only some of these receive economic benefits to support informal care.
- The Spanish LTC system faces the challenge of improving its effectiveness in the light of the growth of the dependent population, as well as changes in the structure of informal care. This will require: reducing high waiting lists for access to services; expanding the supply of home and community services (the maximum number of hours per month of homecare received by highly dependent people is less than two hours per day); making community care benefits more flexible and compatible; further developing the SAAD in rural areas; standardising the criteria for co-payments in the autonomous communities; strengthening the reconciliation between informal care and working life; and improving co-ordination between the central and regional administrations.

Spain LTC highlights, European Union (2021)[23]

[22] In https://eurohealthobservatory.who.int/publications/m/enhancing-the-labour-market-for-health-and-care-workers

[23] In https://op.europa.eu/en/publication-detail/-/publication/b39728e3-cd83-11eb-ac72-01aa75ed71a1

3.2.2. Ireland

Ireland, as Spain, have also an ageing population. Indeed, it is projected that by 2031, Ireland's population comprising those aged 65 years and over will be over 1,000,000[24]. In fact, there is no statutory regulation in this field, producing a home care sector mainly represented by informal and irregular workers.

The absence of industry wide home care standards and the lack of transparency regarding the cost of services have generated huge competition within the industry. This has resulted in a flooring of the cost of services which has negatively affected both care standards and working conditions[25]. In fact, migrant workers, who are a big presence in this area, have more risk of suffering different forms of discrimination based on immigration status and ethnicity. They are often subjected to less favourable treatment than their colleagues and can experience racism at work.

In conclusion, this situation facilitates a lack of recognition and value for care work, Insufficient training provided to perform all aspects of the work, no job progression opportunities, etc.

Below see the conclusions of the report made by MRCI (Migrants Rights Centre Ireland) in 2020, called *Migrant Workers in the Home Care Sector: Preparing for the Elder Boom in Ireland*:

MRCI'S CONSULTATIONS WITH HOME CARE WORKERS IN 2015 HIGHLIGHTED THE FOLLOWING ISSUES:

- A lack of recognition and value for care work.
- No enforceable standards for the home care sector worker, different pay rates and terms and conditions depending on the employer.
- Tight schedules with multiple work locations often results in workers having to cut short allocated time with clients in order to reach their next client in time.
- Standard and quality of care provided impacted by insufficient time with clients.
- Growing complexity of client needs is not compatible with a rigid services delivery model which lacks the flexibility required to respond efficiently to patient care needs.
- Insufficient training provided to perform all aspects of the work.
- No budget allocation for travel, transport expenses or time in transit – a particular problem for rural workers who travel long distances between clients.
- Discrimination and racism in the workplace is not addressed.
- Prohibitive complaints mechanisms result in workers losing paid hours and clients losing hours of care if they file a complaint.
- No clear job description or delineation of roles.
- Occupational health and safety issues: one worker doing the job of two people; no hoists; inappropriate / broken equipment; no vaccinations for influenza or hepatitis A / B.

MRCI'S CONSULTATIONS WITH MIGRANT HOME CARE WORKERS DIRECTLY EMPLOYED BY FAMILIES / INDIVIDUALS ALSO HIGHLIGHTED THE FOLLOWING ISSUES:

- No employment contracts.
- Working on call/night shifts without extra pay.
- Not receiving minimum wage, annual leave, public holidays, overtime.
- No sick pay, no sick cover.
- Excessively long hours with no rest periods.
- Heavy workloads including care and all domestic chores.
- Occupational health and safety hazards including manual handling of patients without training, homes lack required equipment i.e. hoists, working with sick people.
- No job progression opportunities.
- No FETAC training provided.
- No training in manual handling, nutrition, first aid, elder abuse, challenging behaviour training such as dementia.
- No relief worker to give respite.
- No job security.
- No health insurance, despite working with sick people.
- No complaints mechanisms.
- No trade union representation or support system.
- Isolation in employers' homes.
- Difficulties managing family relationships
- Blurred boundaries between work and private time.
- Racism, verbal abuse and exploitation.
- Reluctance to complain for fear of becoming jobless, homeless, and losing one's immigration status.

3.2.3. Poland

In the case of Poland, it has the most ageing population in the European Union (EU). It is expected that in 2060, the proportion of the population aged 65–79 will double and the population aged 80+ will triple.

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[24] https://www.mhc.ie/latest/insights/the-nursing-homes-sector-in-ireland

[25] https://www.mrci.ie/app/uploads/2020/01/Migrant-Workers-in-the-Home-Care-Sector-Preparing-for-the-Elder-Boom-in-Ireland.pdf

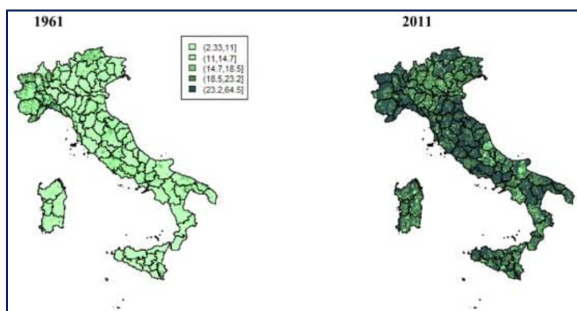
LTC services are not formally regulated and standard, and they are provided by private and public suppliers. Indeed, the reality, like in the other countries mentioned before, is that this includes unpaid carers and a grey zone (including immigrant carers), as well as non-for profit and for-profit residential care providers[26].

There are several programs, like those which finance care services in rural areas and smaller towns, which are particularly prone to depopulation and ageing due to migration processes[27].

3.3. Cluster Three: Italy, France and Belgium

3.2.3. Italy

Even if demographic challenges involve the whole European area, Italy is one of the most affected countries in terms of ageing, with the highest rate of 65+ years old citizens and a life expectancy in good health condition at 65 of 9,5 years, slightly below the EU average (9,9).



Comparative proportion of the population over 65 years in Italian municipalities from 1961 to 2011 (Reynaud and Miccoli 2018[28])

According to the last available data provided by the National Institute for Social Security (INPS) in 2022, regular domestic workers[29] in Italy are slightly less than 900.000 and, even if the public investment for LTC is consistent, this sector is still characterised by a strong presence of informal care workers, mostly migrant and largely without a regular work contract (51,8%), exposing workers to struggles such as lack of security, low salaries and long working hours, making the profession unattractive.

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[26] https://ltccovid.org/covid-19-and-the-long-term-care-system-in-poland/

[27] https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8396&furtherPubs=yes

[28] In https://www.mdpi.com/2071-1050/10/4/1004#

[29] With the expression "domestic workers", not only care workers are intended, but also workers that attend to cleaning and maintenance tasks in peoples' homes. However, the disaggregated percentage is specified a few lines below, stating that regular care workers in Italy are 48% of the total number of domestic workers. This does not mean that care workers don't manage the house of the assisted person as well, a scenario that can be considered both plausible and regular in occurrence.

The regular domestic workers come mainly from Eastern Europe (35,4%, Romania and Ukraine being the first countries in the list), followed by Asia (17,2%), South America (9,9%) and Africa (6,7%), while only 30,5% of them are Italian: 48% of the total are care workers. The sector employs mainly women (86,4%), but in the last years a slight increase in male care workers has been recorded as well.

A national collective contract for domestic workers is in force and administers various aspects, from sick leaves, holidays, salary and a general regulation and protection of the working conditions, but the bureaucratic procedures to regularise the position of migrant care workers is perceived as a deterrent in this picture. Interesting to note that the total number of regular domestic workers is in slight decrease, after the growth registered in 2020 and 2021 due to the restrictions adopted to contain the COVID-19 pandemic and the necessity to allow movements to reach the workplace despite a general prohibition to leave the house if not for strictly necessary reasons.

New developments in the legislative aspect of the care sector come from a very recent law, n.33/2023 activated by a legislative decree on March 15th 2024, whose main aim is to promote the health and active ageing of the elderly and to intervene on support measures for the non-self-sufficient person, outlining a unified system for care services that connects the national, regional and local level, together with in-structure and domestic care, and simplified access procedures for all people over 65. The effects of this new measure are of course yet to be experienced and analysed. One of the first provisions is an economic support until 2026 for non-self-sufficient 80+ year olds with low income, that covers but a limited part of the assisted people in LTC, showing that the intervention in this sector needs to be organic, inclusive and multi-level.

In a nutshell, the EU (2021: 182) considers the following regarding the LTC care sector in Italy:

Highlights

- Italy is the EU-27 country with the highest share of people aged 65 and over and 75 and over among the population. But living longer in Italy does not mean necessarily living in better health: healthy life expectancy at age 65 is 9.5 years in Italy, below the EU-27 average level (9.9 years) and lower than most EU-15 Member States. These latter data show that the problem of frail older people is more pronounced than in many other countries.
- Although public expenditure on long-term care (LTC) is not low compared with the EU-27 average, the Italian public LTC system is still strongly based on informal care and migrant care workers, often with irregular contracts, and with a limited diffusion instead of residential and homecare services.
- In homecare and residential care there are no national standards, and many decisions and evaluation criteria are delegated to the regional and municipal level. This situation produces an extreme heterogeneity in evaluation conditions and access criteria.
- The most important LTC scheme in Italy is the companion allowance[464] (CA), which does not require of beneficiaries any type of accountability on how the money granted is spent. More than half of Italian public expenditure on LTC therefore goes to a programme that intrinsically does not include any quality-assurance safeguards.
- The current COVID-19 pandemic has dramatically shown the weaknesses of such a system. For the first time in decades, the attention to LTC in Italy has strongly increased due to the dramatic events related to the pandemic – and more specifically, to the situation (and deaths) in residential care. The number of deaths and the need to shelter the population in the upcoming months from a new upsurge of the pandemic might be a trigger for rethinking the whole public LTC system, which does not need too many added resources but a better way of using them, strengthening services instead of focusing (mainly) on cash transfers.

Italy LTC highlights, European Union (2021)[30]

[30] In https://op.europa.eu/en/publication-detail/-/publication/b39728e3-cd83-11eb-ac72-01aa75ed71a1

3.3.2. France

Following the European trend[31], the French population is also facing a progressive ageing, with an estimate of 23,9% of the population being aged 65+ in 2030; projections foresee that the citizens that will need LTC services will have an overall increase of 76% from 2015 (1.265.000) to 2050 (2.235.000).

The social and healthcare sector provides a wide range of services that cover both home and residential care, with the addition of integrative options. These services are governed by different regulations (related to healthcare or social care systems), creating complexity from a financial and administrative point of view. Fragmentation is therefore one of the main challenges in this sector and improving the coordination of the institutions involved in LTC has been a priority in the last years.

This lack of unity makes it complicated to estimate the actual number of professionals working with older people, between healthcare and social care workers. To this picture it can be added that the vast majority of the French elderly receives informal care (21% of the 60+ population), which involves a wider array of tasks compared to the ones performed by professional care workers (e.g. preparing meals, personal care, etc.).

Even if qualification and specific training programmes are in force, the LTC sector is still considered not attractive due to the difficult working conditions, such as work-related health problems and accidents, low salaries and working times.

3.3.3. Belgium

The ageing of Belgian population[32] presents some differences across the regions, with the Flanders being the area most affected by this demographic challenge and the Brussels area having an overall younger population. Projections state that by 2050 the number of people expected to need LTC services will be 1.226.600, meaning 10,3% of the population which, however, will represent a lower increase compared to the European average.

LTC in Belgium is fragmented as well, resulting in a shared governance of institutions, organisations and providers both for home and residential care between the federal government and federal entities such as regions and communities.

Similar to many nations, Belgium struggles with a lack of available nurses. This scarcity makes it difficult to secure adequate nursing staff across all healthcare sectors, including both hospitals and LTC facilities. This widespread challenge creates competition between various institutions for nurses in the job market. A significant gender disparity exists in Belgian LTC, with women making up nearly 94% of the workforce. Additionally, short-stay and daycare centres play a crucial role in providing respite care. The homecare sector also faces personnel shortages, including nurses and general practitioners. Despite this, homecare

[31] Ibid, pp. 151-166.
[32] Ibid, pp. 6-19.

offers comparatively better working conditions compared to the broader social care sector. Notably, a high percentage (42%) of homecare workers in Flanders are foreign-born, with a demographic dominated by women (98%), older individuals (25% above 50), and those with lower educational attainment (60% lacking a high school diploma in 2016). Informal caregivers, comprising family members and neighbours, contribute significantly to caregiving, estimated at roughly 800,000 people in Belgium.

3.4. Cluster Four: Greece, Bulgaria and the Netherlands

3.4.1. Greece

Migrant care workers in Greece encounter many barriers that prevent them from achieving their full potential in their profession and society. Many of them work in the informal sector without fixed income, medical care, and other social services. Those trends follow the national high levels of unemployment and unstable working conditions, however, "*Greek studies found that immigrants experience higher unemployment and poverty rates, hiring and wage discrimination, segregation into low-paid occupations, and tend not to receive insurance*" (Drydakis 2021: 3[33]). When looking at the risk of crossing the line of poverty, "*in 2008 for immigrants stood at 32 percent compared to 19 percent for Greeks, while in 2016, the corresponding rates reached 41 percent and 19 percent*" (Ibid). Local government has a key role in the inclusion and integration of migrants, being the municipalities developing work with local Associations and NGOs to implement national policies on this matter (Anagnostou at el. 2016[34]).

Moreover, to get work permits and legal documents is a not a simple process in Greece, resulting in many migrants living in a state of legal ambiguity, unable to obtain stable employment, "particularly the case with immigrant female domestic workers who are largely confined to undeclared work" (Anagnoust at el. 2016: 20[35]). Indeed, "care provision continues to be performed in the family realm by women (mothers and/or grandmothers, but also sisters and in-laws)"[36], adding that "women do most of the work everywhere in Europe, but Greece scores very highly even by Southern European standards".

In this scenario, "migrants working in the provision of services to households is very high in Greece (20.5% of the total, against less than 2% in the UK and a mere 1.2% in the US). While one out of every five immigrants is involved in work described as 'other services', more than one in two female immigrants are involved in such activities (2001 Population Census)"[37]. Frequently, these women have direct contacts with networks of co-nationals or specialized recruiting agencies, specialized in providing care services.

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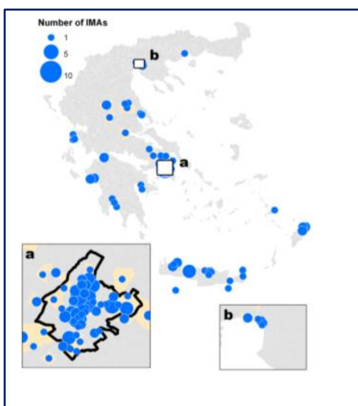
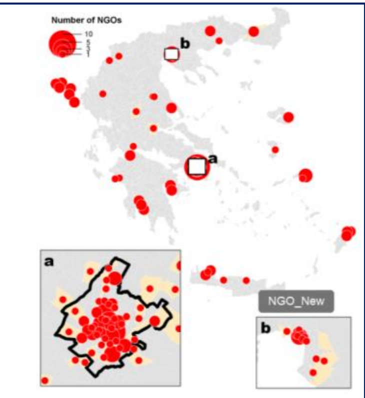
[33] In https://ocs.iza.org/dp14700.pdf
[34] https://www.eliamep.gr/wp-content/uploads/2015/12/Case.study_.report.FINAL_.pdf
[35] See note 17.
[36] In https://www.researchgate.net/publication/227614954_Migrant_Women_Care_Work_and_Women's_Employment_in_Greece, p. 20
[37] Ibid.





Geographical distribution of IMAs (Immigrant Associations) and NGOs (Non-Governmental Organizations) in Greece, Athens(a) and Thessaloniki (b)[38]

Another issue when looking at migrant care workers in Greece is the formal process of recognition of qualifications acquired in the origin country, which can lead to low-paid jobs and few chances for career growth. The Greek government has introduced several measures to support migrant workers, yet these measures are often considered inadequate. Integration programs, supported by the EU and implemented by the Greek government and NGOs, focus on teaching migrants local language and offering vocational training, with few state-sponsored programs that focus on the professional development of migrant care workers. The offer is done by NGOs or private organizations, having limited coverage.

In a nutshell, the EU (2021: 182) considers the following regarding the LTC care sector in Greece:

Highlights

- In Greece, long-term care (including prevention and rehabilitation services) continues to be an underdeveloped policy area, given that there are no comprehensive formal long-term care services guaranteeing universal coverage.
- Long-term care is based on a mixed 'quasi-system' of services, comprising formal care (provided by public and private entities) and informal care (provided by family carers and paid carers), where primary responsibility for the financial and practical support of dependants rests squarely on the family.
- Increasing the system's coverage, improving the quality of service provision and governance, along with ensuring the availability of formal carers and providing support for informal family carers are among the main long-term care challenges in Greece. Concerted action is needed to ensure that the challenges are adequately addressed.
- Greece still lacks a comprehensive long-term care policy; there is a need for concrete action to implement a major reform of the long-term care system. This becomes even more imperative, given the pressure imposed by the rapidly ageing population and the negative impacts of the financial crisis/economic recession (e.g. cuts in public spending, deterioration in the health of the population, increasing hardship among households, etc.).

Greece LTC highlights, European Union (2021[39])

[38] In https://www.researchgate.net/publication/256438851_Challenges_to_immigrant_associations_and_NGOs_in_contemporary_Greece

[39] In https://op.europa.eu/en/publication-detail/-/publication/b39728e3-cd83-11eb-ac72-01aa75ed71a1

3.4.2. Bulgaria

Like other Eastern European countries, Bulgaria suffers from several demographic problems such as an increase in the average age of the population and a decline in the working-age population. These factors have led to the expansion of the care sector and the employment of care workers, many of whom are migrants. The National Statistical Institute of Bulgaria reports that the migrants are a small but vital part of the care workforce and hail from countries like Ukraine, Moldova, and other non-EU countries.

Migrant care workers in Bulgaria face several barriers that hinder their integration and career progression. Formal constraints are especially evident; the procedures of employment and residence permits are rather complicated, which results in many workers being employed informally. This is further exacerbated by the problem of recognition of their qualifications, as most of the migrant care workers hold qualifications and certification from their home countries that are not recognized in Bulgaria. This leads to underemployment and poor career advancement prospects.

Language differences are also a key issue that affects the process. Poor Bulgarian language skills prevent effective interaction with employers, patients, and coworkers, thus compromising the quality of care and social adaptation. Also, cultural differences can result in conflicts and loneliness, which are factors that add to the challenges of integration for the migrant care workers.

The Bulgarian government has adopted policies to address the situation of migrant workers, but these measures are sometimes inadequate. Current legislation like the Law on Labor Migration and Labor Mobility is meant to safeguard the rights of the migrant workers and their integration. Nonetheless, the legal frameworks and their enforcement are often weak, and many migrant care workers remain at risk of abuse and poor employment conditions.

EU-funded integration programs implemented by the Bulgarian government and NGOs are designed to enhance the language proficiency and vocational training of migrants. Some programs include the Asylum, Migration, and Integration Fund (AMIF) which provides assistance in language classes, legal services, and social inclusion. Nevertheless, the number and quality of state-supported initiatives aimed at the professional development of migrant care workers are still rather scarce. Most training opportunities are provided by NGOs or private organizations which may not have the means to address everyone in need.

3.4.3. The Netherlands

The Netherlands has always been considered one of the most socially liberal countries and has a very developed healthcare system. However, such as in other European countries, faces an increased elderly population followed by the need for care givers. Most of the care workers are mainly from European Union countries, as well as other countries such as Philippines and Indonesia. According to the Central Bureau of Statistics of Netherlands, migrant workers form a significant part of the health care industry including nursing assistants, home care aides and domestic care givers.

Even though the country has a well-developed system of migrant integration, the care workers encounter several barriers. One issue is the recognition of foreign qualifications. Most of the migrant care workers possess skills and certification from their home countries that are not easily transferable or recognized in the Netherlands. This often results in underemployment where professionals are compelled to work in jobs that do not require their level of education and training.

Another issue is the language. Although many migrants speak English, sometimes at a native level, in addition to their local or national languages, Dutch is important for communication with patients, colleagues, and within the community. Language barriers can be a disadvantage in the workplace and in interacting with other people. Also, cultural differences can lead to conflicts and impact the quality of care and the integration process.

The Dutch government has put in place several policies to help migrant workers. The Netherlands has strong legal frameworks like the Foreign Nationals (Employment) Act that governs the employment of non-EU nationals and seeks to promote their welfare. There are also many programs funded by the government and the European Union aimed at helping migrants to integrate into Dutch society.

Measures like the Civic Integration Act, for instance, make it compulsory for migrants to undertake language and orientation classes to enable them to assimilate into the Dutch society. Also, there are numerous vocational training programs that assist migrant workers to acquire better skills and qualifications. However, there are still challenges in guaranteeing that all migrant care workers have access to the necessary tools for their complete professional inclusion.

4. Good practices for EU formal and informal training on long-term care services

4.1 Methodology

The desk research done by the VET CARE consortium used seven (7) criteria to select the best practices of formal and informal training on LTC in twelve (12) European countries, namely:

- ✓ Providing a variety of training options, providers and course structures, to reflect the different approaches and possibilities offered in the researched countries
- ✓ Type of training program (formal and non-formal)
- ✓ Number of trainees reaching the labour market
- ✓ Best description of the practice or project answering the needs that were identified by the bibliographic research done previously regarding needs for qualifications and lacks already identified on the care work service market
- ✓ The reality of the migrant population, considering the proposals that offered language training, legal advice or training in labour rights
- ✓ Analysing both social sector or the public sphere, and private entities with a social vision.
- ✓ Reliability of the provider, the accessibility and the structured definition of the subjects and learning outcomes in connection with the practical and concrete characteristics of care work.

The twelve (12) countries researched by the VET CARE consortium have different realities, which allowed for a deeper understanding regarding the social welfare systems and the LTC services and needs. The VET CARE consortium identified 10 (ten) main areas of knowledge regarding the care area, as described below, which integrated the criteria to select the best practice as well in each country.

Themes	1) Digitalisation and technology (e.g., learning how to use tablets, smartphones; how to work with software's and/or online platforms to manage clients, to organise client records; use technology to facilitate communication)
	2) Language skills and communication (e.g., learning how to communicate in the local language and be able to communicate both with clients and family)
	3) Well-being (e.g., nutrition; cultural activities; in and outdoors activities; assistance with activities of daily living)

	4) Physical health (e.g., what are the limits and possibilities of each client; knowledge of appropriate exercises; time and planning of a healthy physical roadmap for each client)
	5) Mental health (e.g., how to identity and deal with mental health issues; how to support client in need; to know staff and channels available for professional mental health support; provide psychological support)
	6) Identification and knowledge of the care workspace (e.g., having practical knowledge of emergency exits; number of rooms; number of people available)
	7) Emergency preparedness (e.g., first aid services)
	8) Health information for care worker purposes (i.e., being able to get information when needed; having knowledge regarding the national health system and how it works; support of the health national staff; know the national health network available)
	9) Awareness of professional profile for being a care worker
	10) Awareness of personal profile for being a care worker

4.2 Cluster One: Portugal, Germany and Switzerland

4.2.1. Portugal

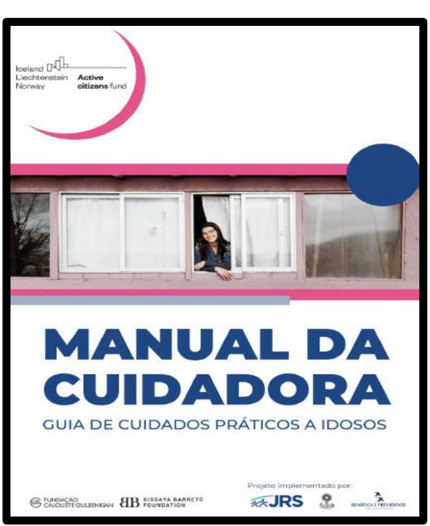
In Portugal, there are several formal and non-formal training programs that answer the need for qualifications for care workers, but no holistic training program that can give guidance when looking to the 10 (ten) themes/areas of knowledge in the care sector identified by the VET CARE consortium.

The best practice identified in Portugal was a project called "Corações que Cuidam" ("Caring hearts")[40] on non-formal (and not informal)[41] training program on long-term care services. Thos project was developed by an International Catholic non-governmental organization (NGO), Jesuit Refugee Service (JRS), that is present in around 50 countries, following 500 000 migrants per year.

[40] Presentation in PT and EN (YouTube) available at https://www.youtube.com/watch?v=4iWP4wWkovE

[41] Definition of non-formal at https://europa.eu/europass/en/validation-non-formal-and-informal-learning (EN) and https://bocatalogo.anqep.gov.pt/webapi/api/documentos/145 (page 81, PT)

In Portugal, JRS was established in 1992 and since then we have been supporting migrants and refugees by providing them social, psychological, medical and legal support, and also by implementing projects that focus on language learning, training, developing skills and access to the labour market. JRS Portugal also runs a shelter to host homeless migrants, Centro Pedro Arrupe, and is present daily at the only migrant detention centre in the country, Unidade Habitacional de Santo António, where we provide psychosocial support and monitor detention conditions and legality. JRS Portugal is also responsible for the coordination of the technical aspects and operations[42] *on the ground of the Refugee Support Platform (PAR) and for the management and technical support of the Temporary Centre for Refugees (CATR) of the Lisbon Municipality.*



Furthermore, in Lisbon, JRS "provide support to around 1300 people per year who need help with their social, legal and socio-professional issues. On average, the JRS receives 40 people per day looking for social support, psychological support, medical and medication support, legal support and job integration and training support"[43].

JRS have done 6 (six) training programs with 80% employability, fulfilling 9 (nine) themes/areas of the knowledge in the care sector identified by the VET CARE consortium. Moreover, in the activities proposed, JRS also guides migrants on job search techniques, storytelling sessions, coaching and practical training in nursing homes. The project is developed in two different regions of the country, namely Lisbon and Porto, contributing for the offers of qualification following a decentralized policy.

The project resulted also in a guide that presents the syllabus developed about care focused in three main areas:

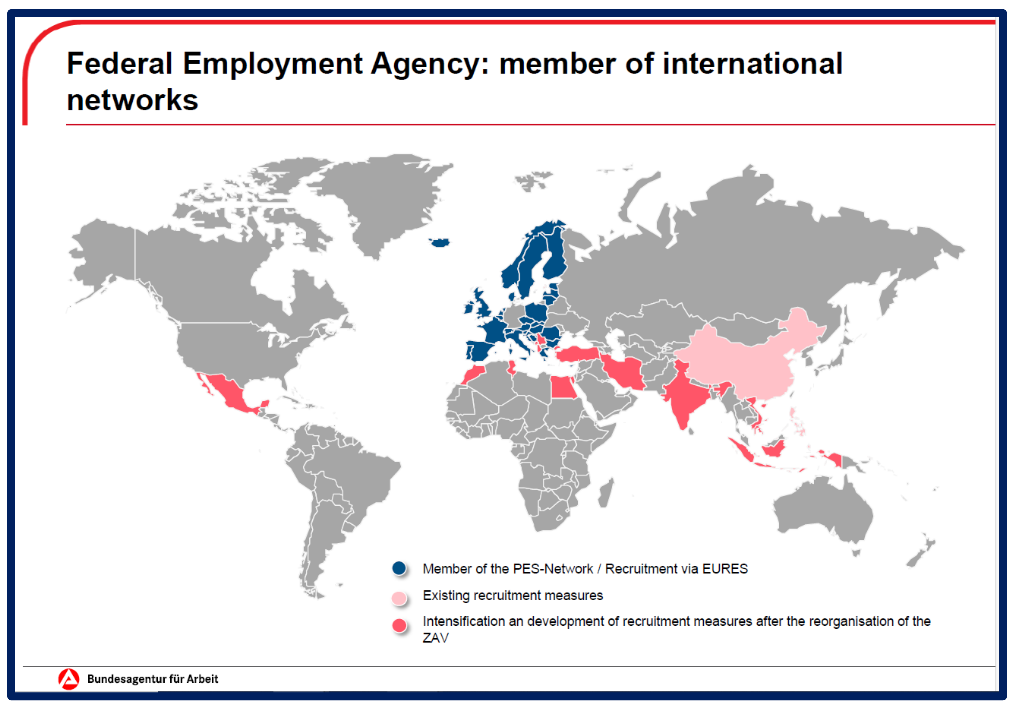
- Personal development – 30 hours
- Basic care for the elderly – 50 hours
- Embrace life by accepting death – 35 hours.

4.2.2. Germany

In Germany, the best practice identified is related with the social welfare system and public policies directed to answer care's needs, which requires hiring skilled migrants due to aging health staff. Bearing that in mind, the project "Triple Win nurses – Sustainable recruitment of nurses from third countries for

[42] In https://www.jrsportugal.pt/en/about-us/
[43] Ibid.

employment in Germany"[44] is described, involving countries such as Bosnia and Herzegovina, Philippines, Tunisia, Indonesia, Jordan, Kerala (India). We focused on Kerala (India) as an example for the public policy developed by Germany to answer the growing need of care workers, organized by ZAV (branch of the Federal Employment Agency), GIZ (main German development agency) and Norka Roots (a registered Government company under Government of Kerala). In the map below, it is possible to see the recruitment countries which the German government is aiming in the near future to fill the gap of aging care workers versus qualified migrants.



Source: https://www.arbeitsagentur.de/datei/zav_ba027205.pdf

This project started in 2013, and "4,900 nurses have been placed with German employers, in clinics, geriatric care homes and out-patient services. Of these above 3,500 have already started working in Germany"[45]. This is a formal training program on long-term care services, developed in German language, requiring knowledge at B1 level, having activities such as learning German language, get to know German nursing system, understand the visa process and labour market in Germany.

The project implements a selection and integration process among the two cooperating countries: India and Germany. In India, the care workers have an interview, a language course to assess their level of Germany (need at least B1), followed by professional nursing orientation and preparation of recognition documents. After the first stage, a matching process begins with employers and nurses, with all visa and

[44] For an overview of the project, see https://www.youtube.com/watch?v=Mg9HEEv0I7U

[45] In https://www.giz.de/en/worldwide/41533.html

work permits requirements taking care of. When in Germany, the care workers will have an advisor. To be part of this project, the following criteria are required:

- Graduated from accredited nursing education institution in India and holding one of the following Qualifications: (i) Diploma in General Nursing & Midwifery (GNM); (ii) Bachelor of Science in Nursing B.Sc (Basic); and (iii) Indian Nurse Registration Certificate.
- 18 or more years old
- B1 level of German language[46].

Germany public policy aims at qualified nurses to answer the need for care workers, having established cooperation with the countries mentioned above.

4.2.3. Switzerland

In Switzerland, the best practice selected was the one developed by the Swiss Red Cross (SRC) Canton of Zurich, being one of the 24 Red Cross cantonal associations, working with the national Swiss Red Cross and part of the international Red Cross and Red Crescent movement. The SRC develops training in areas of integration and migration to empowering people through low-threshold training courses in formal and non-formal sectors. The “Basic principles for getting started in the care sector - SRC Health Care Assistant training course” is a formal training program on long-term care services.

The criteria to engage in the training are the following:

- Attend an information event
- Flow Chart with the information regarding the certificate of SRC Health Care Assistant
- Knowledge of the German language at level B2 in order to enrol on the training course
- If no knowledge of German language, SRC Canton of Zurich offers preparatory course of “German as second language in the care sector”

The syllabus of the SRC Health Care Assistant training course is divided in 3 (there) stages:

- Attended Module 1 (basic module): topics covered are “Professional role of SRC nursing assistants”, “Care on instructions in stable situations” and “Accompaniment in everyday life”.
- Attended Module 2 (advanced module): topics covered are “Health promotion and prevention”, “Housekeeping” and “Care documentation and work organization”.
- 15 days internship Choice of: after Module 1, at same time as Module 2 or after Module 2

The SRC has a flow chart to guide the target population, namely people who want to work in the care sector and supporting family members of the patient; ideally for migrants to be integrated in the labour market.

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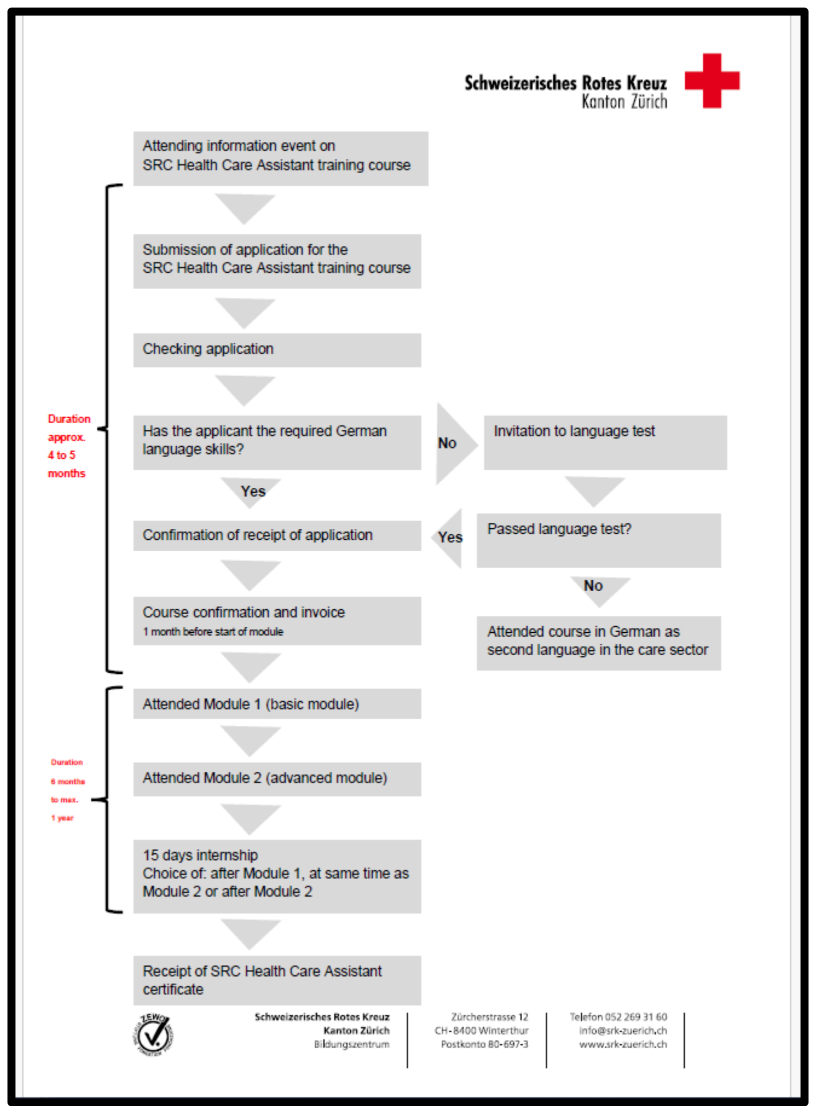
[46] In https://www.arbeitsagentur.de/vor-ort/zav/projects-programs/health-and-care/triple-win/india



Source:https://www.srk-zuerich.ch/sites/default/files/documents/7532_104-darstellung_verlauf_anmeldung_bis_zertifikat_ph_mit_logo_englisch.pdf

4.3 Cluster Two: Spain, Poland and Ireland

4.3.1. Spain

The Good Practice selected representing Spain is Wayalia[47]. This is an elderly care service designed to care for all elderly people who can continue to live in their own home or with their families but need assistance to perform basic tasks. It is the perfect alternative to a nursing home.

[47] See https://wayalia.es/

For that, it aims to train and professionalise long-term caregivers, responding to the needs of the different clients of the service, such as: illness, physical immobility, medication, memory work, etc. They have agreements with social entities and public institutions to facilitate access to training and entry into the labour market through long-term care.

In Waylaid, they are committed to quality home care, so they take very seriously the quality and professionalism of their services, because they know that directly influences the quality of life of the elderly person. All their caregivers are carefully selected and 100% face-to-face, through their extensive network of offices nationwide.

Waylaid Social accounts (see https://twitter.com/wayalia_es and https://www.facebook.com/wayalia/)

The reason for selecting this as a good practice is because of the balance between quality care service and the protection and training of its workers. They make a selection for each case and each family, training each worker individually so that they can provide a service according to the assigned family. In addition, they provide training in rights and duties, as well as facilitating the inclusion of migrants in the world of work, including making contracts for social integration, which is one of the ways of administrative regularisation.

Waylaid is a company committed to professionalizing long-term care, and for this reason, they have a large staff that is continuously trained in different subjects, even on demand. Even so, they certify people in different subjects, such as: Rights and duties as workers; Home help for dependent people; Senile dementia; Alzheimer's disease; Individualized follow-up; Crane handling; and Diabetes. In addition, if the people they care for have any specific typology, they also train them for those specific cases.

4.3.2. Poland

The best practice selected is the one developed by VCC Foundation[48]. It was not chosen because of its wide range of training opportunities, but because they adapt to the reality of people who want to work or are working in the care sector. Moreover, they offer material in different languages, giving training materials in the participants native languages, making the content of the material more accessible to migrants. In addition, they work in five (5) main blocks, which are in line with the programme's ethics and proposal and could be a good example for the e-learning training that the programme wishes to propose.

Psychological aspects 1.1 Basic concepts of psychology (introduction to psychology, basic concepts, psychopathology including the period of involution, cognitive processes, emotions and motivations, language and communication, personality). 1.2 Psychology of the elderly (biological, mental and social aspects of old age and aging, problems of the elderly, needs of the elderly, motivating the elderly to be active and independent in life). 1.3 Elements of therapy for the elderly (basic therapeutic orientations, elements of individual therapy, elements of group therapy, selected therapeutic techniques). 1.4 Personal development of the caregiver (interpersonal training, communication, assertiveness, creative problem-solving, supervision and support)
Social competencies 2.1 Fundamentals of sociology (introduction to sociology, basic concepts, social microsystem, social macrosystem, social pathologies, local community). 2.2 Social functioning of the elderly (relations with the environment, family as a group and social institution, functioning of an elderly person in the social environment, social policy)
Caring competencies 3.1 Fundamentals of geriatrics and gerontology (somatic and character changes in the aging process, disabilities and handicaps of the elderly, mental diseases and disorders of the elderly, prevention of diseases of old age and early diagnosis). 3.2 Care of the elderly (problems and needs of the elderly, personal hygiene and cleanliness of the environment, principles of nutrition of the elderly, hygienic treatment and care of the elderly, prevention of circadian functioning). 3.3 Methods and techniques of psycho-pedagogical work (dialogue, coping with stress techniques, organization of leisure time, bibliotherapy, art therapy, music therapy, choreotherapy, animal therapy, folk therapy, crisis intervention, terminal care and its forms).

[48] See https://vccsystem.eu/system-certyfikacji/new-competences/lista-new-competences/opiekun-osob-staszych/

3.4 Elements of rehabilitation and gymnastics (elements of anatomy, physiology of aging, elements of exercise therapy, gymnastics for every day)

3.5 Organization and planning of work (methodology of work of the caregiver, diagnostics, short-term goals, long-term goals, creation of work programs, cooperation with the family, cooperation with specialists, creation of documentation of work with an elderly person)

3.6 First aid (observation of basic parameters of life, recognition of threats to life, treatment and preventation of fainting, resuscitation of fainting, recovery of the elderly person).

Legal competencies

4.1 Legal basis for working with the elderly (basic legal concepts, social welfare provisions, social insurance provisions with special emphasis on retirement, disability and health benefits, family law and guardianship and civil law provisions, support institutions and organisations, state obligations towards the elderly, state institutions, non-governmental organisations)

IT Competencies

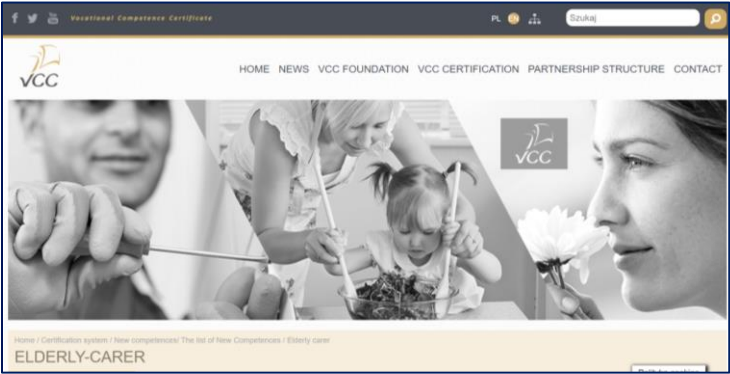
5.1 Web browser (browsing websites, playing multimedia content, searching for content on the Internet, searching for content on a website, searching for content in subject catalogs, saving documents and websites, printing content from a website, completing forms)

5.2 E- mail (e-mail management) using a web browser, viewing messages, sending messages, receiving messages, managing addresses, using an e-mail program).

5.3 Internet communication (Internet messaging, voice calls, video conference calls).

In terms of duration, they propose the following:

- 69 hours of theory
- 69 hours of practice
- 30 hours of IT
- 60 hours of an industry-specific foreign language.



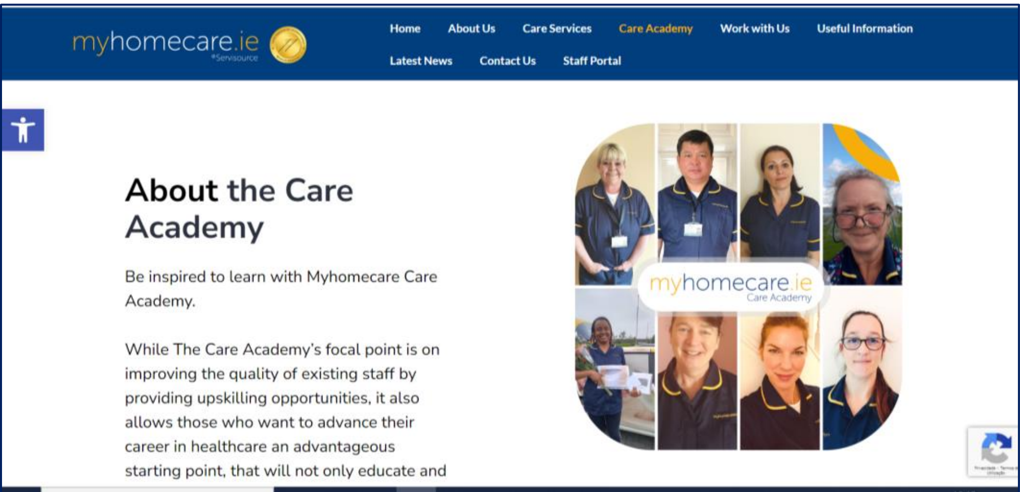
VCC Foundation Website (Website: https://vccsystem.eu/en/certification-system/new-competences/the-list-of-new-competences/elderly-carer/)

4.3.3. Ireland

The Good Practice selected in Ireland is My Home Care Academy. The Academy is the one-stop shop for aspiring Carers, offering training and career progression support and guidance. The Care Academy also offers the opportunity for those with experience requiring QQI Level 5 accreditation in healthcare courses to be subsidised.

This good practice was selected because it fulfils all the thematic requirements that VET CARE consortium defined as appropriate for the care sector, as well as the opportunity to obtain the official qualification for professional employment. They also function as a placement agency, offering continuous training to their internal staff. As a company, such as in Spain, have a good balance between quality of service and labour rights.

Besides it is a HSE (Health, safety and environment) recognised national supplier of homecare in Ireland.



Website of the My Home Care Academy (source: https://myhomecare.ie/care-academy/)

The Training Courses Available to Frontline Staff are the following, as described in the My Home Care website:

Care Skills QQI Level 5 The purpose of QQI Level 5 Care Skills is to equip the learner with the knowledge, skill and competence to care for clients in a safe and hygienic environment. After successfully completing this course you will be qualified to work as a healthcare assistant, carer and care worker in an HSE registered healthcare setting.
Care of the Older Person QQI Level 5 The Care of the Older Person component is a QQI Level 5 Minor Award which is designed to provide the learner with the knowledge, skills, and competencies to support and meet the needs of older people and to care effectively and to a high standard using the best practice while adhering to current legislative and regulatory requirements.

Dementia Awareness Training The Dementia Care & Awareness training course will look at how dementia is now both a national and global concern and why there is a need to develop awareness and understanding of the facts pertaining to dementia. This course will explore the neurology of dementia, the various forms of dementia and best practice in dementia care.
Basic Life Support BLS (Basic Life Support) for Healthcare Provider Course is for medical, para-medical and allied healthcare professionals. The skills taught include adult and pediatric CPR including two rescuer scenarios, use of bag valve mask and barrier devices, management of foreign body airway obstruction (FBAO) and use of Automated External Defibrillator (AED).
Infection Prevention & Control This infection Prevention & Control course aims to deliver to staff the simple and more effective knowledge and practices to reduce healthcare associated infections (HCAIs) in their workplace.
Intellectual Disabilities Training Our online Intellectual Disabilities Training course is designed for people who wish to work in the area of intellectual Disability, employers in the intellectual disability area would favour job candidates with this module completed.
People Moving & Manual Handling This course is for individuals working in the Healthcare and Homecare Industry and aims to provide the theory and practice of safe patient moving & handling.
Children First Children First promotes the protection of children from abuse and neglect. It sets out how to report concerns about a child to Tusla social work departments, and what organisations need to do to keep children safe.

4.4. Cluster Three: Italy, France and Belgium

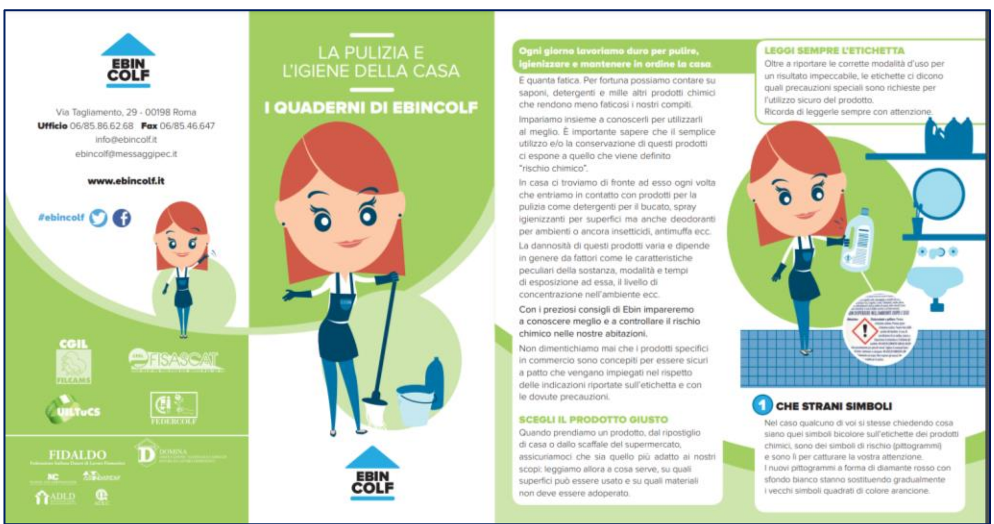
4.4.1. Italy

The Italian best practice is a slightly different proposal, considering the ones from France and Belgium that are described in the following sections, since it is represented by a certificate rather than a proper training course.

The EBINCOLF certificate is offered by the national bilateral body of the same name which, on top of being an observatory on the state of care work in Italy, it also promotes training and professional qualification initiatives at various levels, cooperating with local administrations.

The certificate addresses three different professional profiles, namely domestic workers, care workers and babysitters. In the exam regulation, these three professions share the same code of conduct, while the test itself is tuned to the professional figure(s) that the examinee indicated when applying for registration, according to the specific competences that characterise each profile. The document can be

obtained by passing a written, an oral and a practical test and the examination can be taken free of charge, which is a point in favour on the accessibility side. Moreover, the manner in which the test is conducted is well described in the shared regulations, together with the subject areas tested in the examinations, which are thorough and exhaustive. Even if the applying criteria can be considered strict[49], this certification can be a worthwhile way to validate the skills acquired during one's professional experience and improve employment finding chances.



Example (source: https://ebincolf.it/wp-content/uploads/2017/10/EbinColf_BROCHURE_PuliziaIgieneCasa.pdf)

4.4.2. France

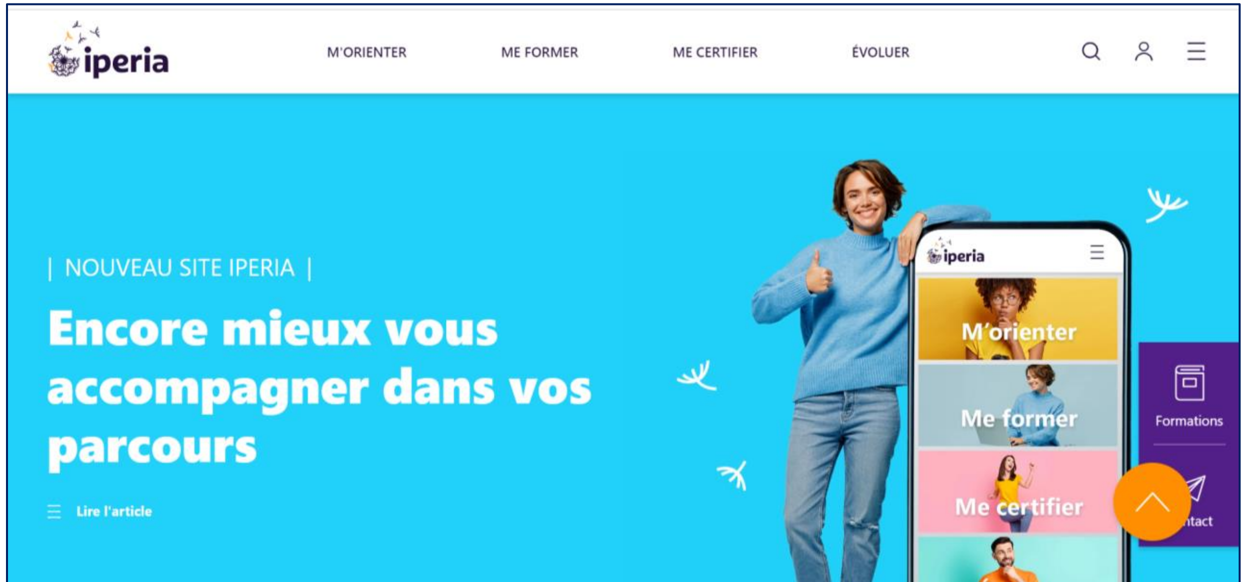
The best practice chosen for France is a training course offered by IPERIA, a CSO that works since 1994 for the promotion of recognition and validation of domestic professions, not only in the LTC sector but also in home assistance and childcare.

At the end of the course the trainee receives a level 3 title of Long-term care assistant, which is the equivalent to EQF 5. The training is divided in 7 main blocks that can also be taken individually and that explore a wide array of subjects within LTC, such as: management of the professional activity with private employers; prevention and safety at home; home and laundry care with eco-responsible practices (this green approach was a positive peculiarity of the French practice); personalization of one's approach to the assisted person, according to their autonomy level and disability; support in daily activities; maintaining social life; healthy and safe nutrition.

[49] The applying criteria include: basic knowledge of the Italian language (which is also a fundamental requirement to get a residence permit, namely A2 level); proven training, carried out in the last three years, which has enabled the achievement of knowledge, skills and competences in the task covered by the certification; work experience in good standing of at least 12 months, even if not continuous, in the last three years and in the tasks covered by the certification.

Each of the described areas is further detailed into sub-modules, granting a thorough approach to the different subjects; the course develops through more than 300 hours and includes both taught classes and assessment sessions. No specific applying requirements were noted but, since the course is taught in French, basic language skills should be possessed by the interested trainee.

The level 3 title "Long-term care assistant" (equivalent to EQF 5)is divided into 7 skill blocks, which can be validated individually. Each of the blocks is specifically known and implemented to support the learner in their professional development.



Website (source: https://www.iperia.eu/en/)

4.4.3. Belgium

Following thorough research across institutions in all 3 administrative communities, the option chosen is the one offered by Bruxelles Formation, which is a public body in the Belgian Capital region. This is in fact the French-speaking public institution that administers professional training in the Brussels area, also in cooperation with local organisations.

Their training option foresees a fairly long commitment, with a 21 months' duration that includes internship activities together with individual and collective monitoring, on top of the regular taught classes. The subjects concerned are varied and articulated as well, ranging from deontology to written and oral communication, hygiene and comfort care, social institutions and services, observation methodologies, nutrition, assistance with daily activities, psychology, health education and delegated nursing activities.

In this specific case, it is interesting to examine the necessary prerequisites to access the course. The trainee must be an unemployed job seeker without an upper secondary education certificate; moreover, they need to participate to a previous 80h caregiver targeted course plus an information session. These criteria show an intent to reach parts of the population that may come from disadvantaged situations and/or environments, scoring an important point towards an inclusive training offer.

Website (source: https://www.bruxellesformation.brussels/)

4.5. Cluster Four: Greece, Bulgaria and the Netherlands

4.5.1. Greece

The Lifelong Learning Center of the University of West Attica was founded in 2018 through the integration of two well-known institutions, the Technological Educational Institute of Athens and the Technological Educational Institute of Piraeus, both of which are public. The Lifelong Learning Center's mission is to support active and empowered citizens in economic and social life. It aims at enhancing cooperation with society, scientific, and professional organizations to offer quality education, professional training, and further education in its areas of operation. Furthermore, it seeks to foster strategic cooperation at national, European, and international levels. The center provides educational services outside the formal education system such as initial and continuous VET, specializations, and upskilling training.

The type of Training Program is a non-formal training program, taught in Greek, looking at the following themes:

- Well-being
- Physical health
- Mental health

- ❖ Identification and knowledge of the care workspace
- ❖ Emergency preparedness
- ❖ Health information for care worker purposes
- ❖ Awareness of professional profile for being a care worker
- ❖ Awareness of personal profile for being a care worker

Website (source: https://kedivim.uniwa.gr/)

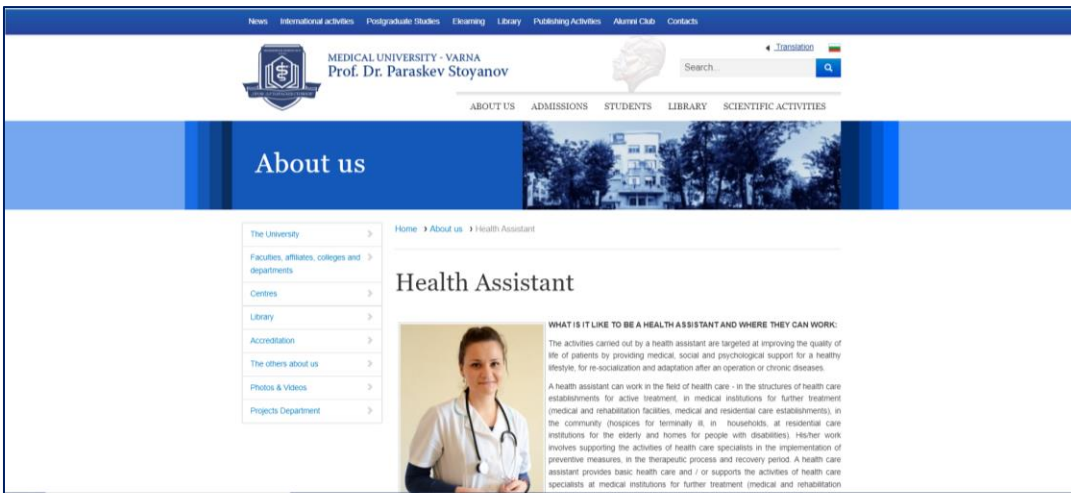
Concerning the description of each topic approached in the Training Program, it is divided into four theoretical sections and one practical section, which include the following:

- module one: basic principles for providing care at home
- module two: providing care
- module three: promoting health in sickness
- module four: creating a safe living environment
- practical training in personalized care and health support.

The total duration of training is 100 hours (blended), with 58 hours of e-learning asynchronous and video and 42 hours of presential laboratory training.

4.5.2. Bulgaria

The Medical University of Varna, founded in 1961, is a public university offering a comprehensive range of academic and professional titles in the fields of medicine and healthcare. Since 2013, the Vocational Training Centre at Medical University-Varna has been providing training programs in the professions of Healthcare Assistant, Caregiver, and Assistant to the Doctor of Dental Medicine.



Website (source: https://www.mu-varna.bg/EN/AboutUs/Pages/zdrawenasistent.aspx)

The themes approached are the following:

- Physical health
- Mental health
- Emergency preparedness
- Health information for care worker purposes
- Awareness of professional profile for being a care worker
- Awareness of personal profile for being a care worker

Concerning the description of the Curriculum Content (Syllabus), the "Caregiver" certification prepares a person to help medical workers improve the quality of life of patients. Caregivers offer medical, social, and emotional care to ensure patients follow healthy lifestyles, recover from surgery, or manage long-term illnesses. They practice in different health care facilities and in the community. Caregivers follow the guidelines set by medical professionals to address the basic needs of the patients, including their physical and socio-psychological needs.

Regarding the topics approached in the Training Program, they deliver:

- Providing medical, social, and psychological support
- Ensuring a healthy lifestyle and rehabilitation
- Assisting patients with basic living needs such as nutrition, hygiene, movement, and psychosocial comfort

In terms of duration, the number of hours of synchronous and asynchronous training is divided as following:

- Total: 660 hours (200 theory and 460 practice)
- Period: 9 months, full-time (Saturday-Sunday)

4.5.1. The Netherlands

MBO Utrecht provides training and further education for individual workers as well as for healthcare organizations. Their approach is to address the learning requirements of the professionals and to ensure that the development route is in sync with their requirements and time frame, offering flexible learning solution.

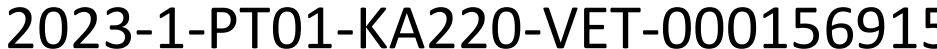
In the Netherlands, Secondary Vocational Education takes up to 4 years, and can comprise 4 levels: level 1- assistant training, level 2- basic vocational training, level 3- professional training, level 4- middle-management training. Students from the age of 18 must pay tuition or course fees, which are set every year by the government. Students over the age of 18 are usually eligible for a student grant and a public transport student concession card[50].

Themes:

- Physical health
- Emergency preparedness
- Health information for care worker purposes
- Awareness of professional profile for being a care worker
- Awareness of personal profile for being a care worker

Description of the Curriculum Content (Syllabus):

[50] https://www.government.nl/topics/secondary-vocational-education-mbo-and-tertiary-higher-education/secondary-vocational-education-mbo#:~:text=Pupils%20who%20have%20successfully%20completed,higher%20professional%20education%20(HBO).



The training program aims at preparing for care and welfare, provided at level 2 of MBO (secondary vocational education) with a BBL learning pathway (block or day release), where practical training takes up at least 60% of the course. The program is funded by the employer.

Description of Each Topic Approached in the Training Program: Topics include:

- Part-time work (20-28 hours a week contracts) and course attendance
- Trainee responsibilities vary based on the institution/academy

Number of Hours of Synchronous and Asynchronous Training:

- Duration: 1 year for a level 2 certificate
- Practical Training: 20-28 hours per week (>60%)

Website (source: https://www.mboutrecht.nl/opmaat/opleidingen/helpende-zorg-en-welzijn/)

5. Conclusions

In Europe, public spending on care is higher when it is a responsibility of the public bodies and/or government. According to the Geneva Association (2014), countries were organized by clusters namely: (i) Northern cluster (comprising the Netherlands, Sweden and Denmark); (ii) Central European cluster (Austria, France, Belgium and Germany); (iii) Southern and Eastern European cluster (Italy, Spain, Portugal, Estonia, Hungary, Czech Republic, Poland, Slovenia and Switzerland). In fact, the countries in the Northern cluster have a high public spending and low family responsibility for care, when compared with "the Central European cluster by average expenditure and average family responsibility and the Southern and Eastern European cluster by low public expenditure and high family responsibility"[51].

In the VET CARE clusters by partners aiming at identifying 12 (twelve) good practices in formal and non-formal training programs for care workers, the consortium looked for different social welfare systems and public policies. All countries share the same trends of aging population and lacking qualified care workers, having to develop training programs and/or public policies aiming to fill this gap. Indeed, since "the mid-1980s that industrialised nations faced mainly common problems in organising long-term care for older people: funding limitations, inadequacies of existing services systems, heavy reliance on family care, limited knowledge and planning and lack of cohesive national policies"[52]. Cultural and social characteristics of the countries also impact on the ability to develop public policies, in which care is a social right and not a family obligation. When looking at the twelve (12) countries, it is possible to conclude that a VET holistic care training program would be of advantage to integrate and include migrants that represent the main working force in the care sector. This program would bring into account already acquired knowledge and integrated into practical activities, underpinned by the philosophy of learning-by-doing that frames VET.

One of the highlights is the high number of informal care workers in Portugal, which need to be properly addressed in terms of training and public funding. Despite Germany having a compulsory insurance contribution for LTC, in the near future there will be no financial capacity to answer the demands for care at public level. Germany faces the challenge of recruiting enough staff for LTC outside the country, while facing a high growth as well in public spending in the area. Switzerland faces the same issue regarding increasing of healthcare costs. VET CARE consortium needs to bring on board the financial capacity of public bodies and private answers, bringing together content and time spending for reaching a qualification that answers the care sector demands.

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[51] In https://www.genevaassociation.org/sites/default/files/research-topics-document-type/pdf_public/ga2014-health31-verbeek-oudijkwoittiezegginkputman.pdf

[52] In https://www.researchgate.net/publication/282852584_Comparative_Research_on_Social_Care_The_State_of_the_Art , p. 19

A common factor in all twelve (12) countries is the need to increase the valorization of the care workers profession and salary/wage to attract staff and keep it while Europe is aging. Nonetheless, it is possible to say that the initiative to facilitate access to qualified jobs in the area of care is growing, and that the informal idea of care work is changing towards a greater professionalisation. For example, in Spain, it even been regularised at the legal level, and initiatives are being promoted to ensure the labour rights of domestic workers. Even so, we cannot deny the interrelationship between care work and migrants, especially women, who for various reasons, such as difficulties in obtaining academic accreditation, lack of job opportunities, among others, end up working in the sector. Taking this in account, facilitating the regularisation of their administrative situation should go hand in hand with the professionalisation of care, as this is not possible without labour rights or contributions. In fact, this has also been one of the factors for the VET CARE consortium include good practices based on their experience in the inclusion of migrants in the world of work, and in the case of Poland in particular the provision of training materials in different languages.

It is highlighted that there is a general need for professionalised care workers, a necessity which has to go hand in hand with a progressive decrease of irregular care services and an improvement of the attractiveness of the profession. Actions at a national and European level are being undertaken and the collective discourse is spreading awareness on both the ageing of the European population and the importance of recruiting new workforce in this field, granting also a generational change.

The good practices collected in the VET CARE report point out that countries in EU are moving into this direction, since they promote an approach to the LTC sector that is mindful, both in terms of rights and duties, holistic, considering different aspects of both the assisted person and carer’s health, and based on skills development and continuous learning.

In conclusion, and when collecting and analysing data on formal and informal training programs, looking at the twelve (12) countries, specific themes are visible in the LTC training such as language proficiency, physical health, emergency management, professionalization and psychological aspects. However, the training approaches are different, because the education systems and their approach differ across Europe. The twelve (12) best practices collected are a support for the development of the e-learning course and toolkit of VET CARE project and aim to contribute for the improvement of the quality of LTC training in Europe, as well as a possible standardization of the curriculum for LTC. The idea of VET CARE consortium is also to contribute for transferable knowledge, giving the option of having a similar curriculum in many languages as possible, approaching cultural and linguistic issues, which allow to provide a better integration into society.