LONG-TERM CARE SERVICES IN 4 EUROPEAN COUNTRIES

Labour markets and other aspects

Edited by
Karsten Krüger & Erik de Gier

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(Editors)

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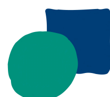

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PRESENTATION

There is no doubt that one of the major challenges that most developed economies will face in the next decades is demographic ageing. Europe is not an exception and in the context of the current economic crisis, the risk of social exclusion of elderly people is probably higher than in the last 30 years, particularly in Southern Europe countries where fiscal consolidation is the main objective of most governments.

At the beginning of 2010, Dr. Karsten Krueger proposed to the Scientific Committee of XREAP (a network of more than 150 researchers from 4 Catalan Public Universities founded in 2006) to organize a joint workshop with Radboud University in order to discuss the situation of the long care services sector in different European countries. The aim of the workshop was not only to bring together original research papers that could cast some light on long-term care services but also to exchange ideas between Spanish and Dutch undergraduate students in the field of Economics and to involve potentially interested stakeholders such as training institutes and public authorities.

Although it was not the first international event organized by XREAP (for instance, during August 2011 we have co-organized the annual meeting of the European Regional Science Association with more than 1000 delegates), it was going to be our first event with a very active role for undergraduate students and, at the same time, with a clear focus on policy advice, so I had to say that we were all a bit worried about our capacity to achieve these two objectives. However, and thanks to the efforts of Dr. Karsten Krueger and Prof. Erik de Gier and to the collaboration of other institutions such as ICPP, IES Bonanova, Corporació Parc Taulí and, of course, the Dutch and Catalan Goverment, we are really happy with the obtained results. During two days, more than 40 people took a very active role during the workshop. We counted with the participation of seven keynote speakers, several student's presentations, a round table with seven experts, and two technical visits, but, perhaps, the most visible proof of the success of the workshop is this electronic book.

In a world where academics are only recognised if they manage to publish in top-ranked journals, on behalf of the XREAP network, I want to thank all participants in the book for the efforts dedicated to this project. One of the aims of our network is to advance in the dissemination of knowledge and, in particular, to promote the cooperation between different research groups from a multidisciplinary perspective (although we cannot forget most of us are economists) and I think that, as the workshop, the publication of this electronic book is a new opportunity for us to go beyond the usual dissemination

actions that, for sure, will be followed by others in the future. I am sure that the readers of the book would learn a lot and enjoy your contributions that have already helped me to improve my perspective on this relevant policy issue. So, thank you again for your contributions and congratulations for this excellent book!

Dr. Raul Ramos

XREAP's Scientific Secretary

AQR-IREA, University of Barcelona

INTRODUCTION

By Karsten Krüger and Erik de Gier

One of the European Union's major concerns is its ageing population, and the need to develop a social and economic strategy able to meet this demographic challenge. One of the key issues is "*who should care for elderly and dependent people in the future*" (EUROFOUND 2006a: V). This question goes to the core of the European Social Protection system, which has "*the aim, among others, of ensuring the access for all, to high quality care*" (European Commission 2008: 1).

But it is difficult to define exactly what care and care services for dependent people means. Traditionally a distinction has been made between health care and social care "*partly on account of their origins but also due to the fact that interest groups have sought to maintain these boundaries*." (EUROFOUND 2003: 3). For several reasons, these boundaries are blurred and a more integrated perspective comes up advocating the concept of long-term care, defined by the OECD as *"the organisation and delivery of a broad range of services and assistance to people who are limited in their ability to function independently on a daily basis over an extended period of time"* (OECD Health Division 2008: 1)

Long-term care systems are characterised by the diversity of the providers, of the institutional and organisational settings, and of the sources of funding. With regard to social care, the EUROFOUND study of "Employment in social care in Europe" (2006a) made a rough distinction between waged carers and non-waged carers, establishing the following classifications:

Waged Carers:	▪ Traditional formal carers ▪ Mixed economy carers ▪ Independent formal carers ▪ Personal assistant carers
Non-waged carers	▪ Voluntary Carers ▪ Family informal carers ▪ Non-kin carers

The classification does not include undeclared waged carers (often immigrants) who play a highly significant role in certain countries.

However, this brief and probably incomplete list of carer types indicates that long-term care systems have complex configurations, combining different types of formal care with a wide range of informal care.

The long-term care systems of the EU-member states are under pressure from four quarters:

a) The improvement in the health of European populations has increased life expectancy. The over 65-year and the over-85 age groups have grown considerably in recent decades and will continue to do so in the future. Inevitably, this raised and will raise the demand for care for older people.

b) The family structure has changed all over Europe, towards a model characterised by smaller double breadwinner families. And as female members have traditionally taken responsibility for family care, the growing incorporation of women in the labour market increases the demand for formal carers.

c) The EU population in working age is decreasing, thus raising competition for labour between different economic sectors. This can be mitigated, but not resolved, by immigration. "*Low paid, low status, and high rates of turnover and burnout make it difficult to attract workers to the care sector and to keep them in their jobs*" (EUROFOUND 2006b: 1).

d) The retrenchment of the welfare state since the 1990s and the increasing public budget restrictions in EU-member states have made the funding of high quality national care systems even more difficult.

The multiple demographic changes exert pressure on the care service sector to respond to the increasing demand for professionalised care services. There is a lack of qualified labour to satisfy this demand, and there are strong public budget restrictions as well. *"To grasp why care is becoming increasingly problematic for states and societies, one must only note there has been a change in the context of care. The demographic and financial factors have acted as pressures, increasing the demand for care whereas the social factors, in particular changing norms about family and kin responsibilities and the role of women, have contributed to a transformation of the conditions under which care has been traditionally organised. All of these together have acted to effectively*

decrease the supply of care at a time when the demand is rising" (Daly & Lewis, 2000: 288-289). A major trend in the attempts to meet these challenges is the search for a new combination between institutional, home and community care.

The problem of providing high quality care service is related on the one hand to the increase in the demand for care, and on the other to the labour shortage. *"Social care is labour intensive, resulting in significant shortages of staff in the most countries"* in Europe (EUROFOUND 2006c) But at the same time, long-term care is one of the sectors in which the most employment is created. The OECD – Health data statistics show the following rates of civil employment in long-term care services for the countries examined in this book:

Table 1
Share of civil employment in long-term care services

	2000	2008
Finland	14.01	15.23
Germany	9.98	11.48
Netherlands	13.53	15.94
Spain	5.38	6.33

Source: OECD-dataset: Health Care Resources

This book brings together articles by authors from four European countries (Finland, Germany, the Netherlands and Spain) which reflect trends in the search for new combinations between institutional, family and community agents to provide high quality long-term care services. The articles also show the diversity of the national landscapes of care services as well as the variety of possible solutions.

The book is the fruit of a Dutch-Spanish seminar organised by the XREAP and Radboud University, held in Barcelona in October 2010 to discuss the situation of the care service sector, the respective labour markets, and the policy strategies needed to adapt the long-term care sector to the challenges outlined above. The organisers decided to publish the presentations in an electronic book and also to include other articles on the issue written by German and Finnish researchers and practitioners.

The book is divided into two parts: the long-term care labour markets in Germany, the Netherlands and Spain, and articles about specific issues on long-term care services that can diminish future labour market problems in countries where labour market will become tight as service quality, the use of information and communication technologies, and the implementation of network principles to organise care provision.

The articles in the first part, entitled "Long-term care service labour markets", examine the different political strategies proposed to achieve an adequate equilibrium between the different types of care services;

Two articles – written by M. Guillén & C. Bolance & R. Alemany, and by K. Krüger & E. Jiménez – discuss the impact of the 2006 Promotion of Personal Autonomy and Care of Dependent People Act on the Spanish care system and more specifically on the labour market. One of the law's aims was to strengthen the professionalisation of the long-term care services, which is characterised by a high degree of family care, and to expand the formal care labour market. As the above table shows, this labour market segment still has a high potential for growth compared with the other European countries. The new law can be interpreted as an attempt to redress the relation between formal and informal care in favour of the professional care services.

Both articles mention the unequal implementation of the legislation in the different Autonomous Communities of Spain. The article by Guillén & Bolance & Alemany applies an economic perspective to discuss proposals for refining the management of the care system, means-tested co-payments, and the development of an insurance market for long-term care services. From a sociological perspective, the article by Krüger & Jiménez discusses in more detail the limited impact of the law in the labour market, arguing that it has reinforced the option of informal home care, in consonance with trajectory of the Spanish welfare system. It is argued that the legislation's recognition of the family carer and of the disposition that family carers should be paid for carrying out these tasks in relation to the degree of the dependency is a step forward in the recognition of the unpaid home work. However, as there is no strict control of the use of the benefits paid for family care, it is not clear whether the informal care services are really provided by relatives or by undeclared paid care workers.

The third article, written by E. de Gier, provides an insight into the current state of the Dutch long-term care labour market, which is characterised by a high rate of civil employment and by the likelihood of a future labour shortage. Due to the general future labour shortages, the long-term care sector in the Netherlands faces a double problem: a) to attract new labour and b) to retain experienced carers. This double problem can be partially resolved by adequate human resource strategies, but it must be accompanied by a rebalancing of formal and informal care, which means a greater role for self-help among the dependent persons, their families and the community. E. de Gier advocates the development of a mixed strategy to improve the employability of the workers and the empowerment of the patients/clients. In another words, the Dutch care service labour market requires a rebalancing of the relation between formal and informal care, in favour of informal care.

A similar problem of labour shortage is facing the long-term care sector in Germany, as M. Evans describes in the fourth article. The author starts with an analysis of the employment structure, mentioning the considerable growth of long-term care employment and the high rate of part-time work and marginal occupation in this sector. She then draws out the future labour market situation. The Statistical Federal Office forecasts an increase in the need for fully employed care professionals from 2005 to 2025 of between 19.5% and 27.3%. There are serious doubts that this demand can be satisfied. This situation calls for integrated concepts and design in the social health economy, providing <good work> in the long-term care sector. The article backs improving working conditions to raise the attractiveness of long-term care employment.

The fifth article, written by S. Dörpinghaus & M. Evans, focuses on a specific segment of the long-term care labour market in Germany – low-qualified occupations – and a specific aspect, the return of women to professional employment in the health economy. Within the general increase in employment in long-term care and the forecast lack of qualified employees, the authors indicate that helper qualifications and low-level entry qualifications will exert displacement effects. Currently, these work places offer scarce opportunities for personal and professional development, but a systemic management of re-entry, specifically for the increasing group of women who have abandoned their professional career at least once, these jobs can offer new employment prospects in the health economy.

A similar perspective is provided by N. Tuset & A. Pujol's article on the (re-)entry into the job market of unemployed women who participated in health and social care courses between 2005 and 2006. More than 90% of the students on these courses were women. The educational level of the students was quite low and the average age was above 39 years. The study analysed a specific time period on a vocational training program in which more than 29.500 persons participated between 2005 and 2009. The success rate, in terms of entry into the job market, was around 23,6%. The authors also advocate adding flexibility to the programs so that participants can re-enrol once they have found work, calling for a more systemic approach to management and the design of lifelong learning courses aimed to improve professional development in the long-term care economy.

The second part, on organisation and quality in the long-term care sector, includes three articles from Finland, Germany and Spain:

The article by N. Rodriguez & M. Puig analyses the quality of home care services based on a case study combining quantitative and qualitative data. The case study was carried out in the Catalan health region Vilafranca del Penedès. The areas studied were health in general, the provision of help with activities of daily living of dependent persons over 74, and care burden among relatives. One key finding was that informal carers tend not to provide the care required by the dependent elders, and that from the nursing perspective greater emphasis should be placed on the systemic detection of needs. The study highlights the need to achieve an adequate balance between formal and informal care.

The article by R.G. Heinze & & J. Hilbert & W. Paulus discusses the household as a central place of long-term care, and the need to use information and communication technologies to improve services. The basic assumptions are that the households have been, are and will be central locations for care services. But the household and the family structure have changed considerably in recent decades towards a model comprising smaller, older and more unstable units. This does not imply a reduction in intergenerational support but a different spatial dimension. Different generations tend to live less in the same household, the same house or the same location: multi-local cross-generational solidarity becomes predominant. This produces new coordination needs.

Part of the solution may lie in the use of IC-technologies, but according to the authors the deployment of these technologies for home care is slow in Europe. They give various examples for IC-technology development in this area in Germany, such as <Social Alarm Systems>, <Home-Tele-Services>, <Telehealth Monitoring> and <Ambient Assisted Living> or <Ambient Intelligence>. The different strands of IC-technology development offer many opportunities to support living at home in old age. At present, the problem regarding technological development is to define whether technology is considered as a real support for the elderly in their quality of life.

Last but not least, the article by I. Laitinnen and K. Aarva describes the experience of the City of Helsinki in modernising their long-term care services based on a network approach. They start from the assumption that the dramatic rise in care needs and carer demands cannot be satisfied by traditional organisation of services. Increasing electronic service will not be enough. The operating methods and models of long-term services must change towards a networked, low hierarchy model, facilitating constructive development of a network culture and forms of mutual and multiple learning. The City of Helsinki started to consider a new strategy in 2005 and in early 2009 approved a new strategy for promoting service innovation and new ways to provide services. The <value network> is a policy for strategic coordination of multi-providers in a cooperative network, which both produces and distributes value. In the centre of the networks stands the customer needing shared services, care, and assistance. The article described the efforts to promote the network approach in the City of Helsinki, analysing first the problems and opportunities in its implementation and then discussing practical solutions for improving the network. The study is based on documentary research, but also on a large series of interviews and workshops.

The book provides information about a range of strategies to meet the common challenges of ageing societies in the area of long-term care. The articles reflect different strategies to redress the balance between formal and informal care at the societal level, focusing on the issue from the perspectives of lifelong learning, quality assurance, and work organisation. As such, the book contributes to European and national debates about the future of long-term care services as an integral part of the transition to an ageing knowledge society. This challenge is approached not from a pessimistic costs perspective, but as an opportunity for positive societal development.

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CARE SERVICES LABOUR MARKETS

The Spanish Long-Term Care System – a Case Study

by Montserrat Guillén, Catalina Bolancé and Ramon Alemany

Introduction

In December 2006 the Spanish parliament approved the so called Law of Dependence, which was enforced in 2007. The law established a public long-term care (LTC) system and granted new rights to citizens in need of personal assistance. The law was recognized as a fourth pillar to the Spanish welfare system. Since then, the Spanish general budged has assigned increasing levels of funds for citizens needing LTC, and those funds have been set independently of public health funds. The Law of Dependence in Spain provides support for all individuals from age 6, but citizens who are 65 or older are in fact much more prone to need some form of long term care. Wittenberg et al. (2002) and Guillén et al. (2007) discuss the issue of whether living longer necessarily means that individuals will have a longer active life or whether, on the average, they will need support for a longer period of time. In addition, there are contributions to the discussion on the role of public and private LTC insurance by Feder et al. (2007), Brown and Finkelstein (2008), de Crasties (2009), Gleckman (2007) and Bolancé et al. (2010). The demographic situation in Spain imposes an alert due to the increasing number of elderly people, which will possibly increase the demand for long-term care services. The absence of a well structured public network for formal care in Spain inspired the debate that finally lead to the instauration of the current system.

Before the law has been passed, several forms of social protection have already existed in Spain. There were programs and social services for the elderly such as a network of public residences, day centres, food and care services, and similar facilities. Mainly local authorities and NPOs played an active role in providing care to dependent people, mostly elderly. Citizens with little economic resources, living alone and in need of LTC were a priority, but there was no specific subsidy linked to the need of LTC for which citizens could apply. In fact, the public health system was effectively providing assistance to people in need of LTC who had scarce resources, but this created a burden for medical facilities and implied an inefficient use of hospitals.

The Spanish system recognizes the right to receive support in case of dependence. Emphasis is out on need of support, not on disability or handicap, while budged allocated to social protection in Spain is among the very small in Europe. However, a

strong advertisement campaign when the law was enforced did not create awareness, but reinforced the belief that the state is a strong safety net.

In the new Spanish law, the concept of dependence is defined as "a permanent state of a person, as a result of ageing-related processes, illness o disability and linked to the absence or loss of physical, intellectual or sensorial autonomy that requires the assistance of a third person or support of any kind to perform basic daily life activities, or, in the case of people with intellectual disorders or mental illness, of other types of help for personal autonomy". Namely, a person is considered dependent situation if three circumstances occur:

1. The person suffers physical, psychological or intellectual limitations that permanently reduce his or her capabilities.
2. Basic daily life activities (BDLA) cannot be performed autonomously.
3. The person requires assistance or care by a third party.

We note that BDLA are the most basic tasks that allow someone to cope with a minimum of autonomy and independence, these tasks are: personal care, basic domestic activities, essential mobility, to recognise persons and objects, to keep orientation, to understand, to execute orders and simple tasks.

The previous definition of dependence is similar to that used in most European countries (Germany, France, United Kingdom, Portugal, Italy, ...) (see Albarran, et al., 2009)

The type of support that is guaranteed to any individual that is recognized to be dependent by this new Spanish legal framework is in part chosen by users. Dependent individuals can receive cash or service, but, even if priority has been given to service provision, most citizens currently prefer to receive cash.

The new LTC public system set up in Spain in 2007 recognizes the right to receive support in case of dependence and puts strong emphasis on the need to assistance, rather than just on disability or handicap. However, the Spanish budged allocated to LTC is among the most limited budgets in Western Europe, which means that even after the reform, the public system does not cover all social protection needs connected to LTC in a sufficient way. According to Eurostat, in 2007 LTC expenditure in Spain was

about 0.74 % of its GDP. Since the public LTC system was implemented in Spain, in general the Spanish society is deceived with the outcome because of insufficient funds (see more information on EU countries in Holdenrieder, 2006, Solé-Auró and Crimmins, 2008, Fernandez et al. 2009 and Reimat, 2009). A strong advertisement campaign following the enforcement of the Law created general awareness of the problems linked to longevity, but it also reinforced the role of the state as a strong safety net that slowly seems to be weakening. One of the pictures used during the launch of the Spanish System is shown in Figure 1. The advertising campaign showed the way the new system was presented to citizens as an expression of love and care from others and the support of specialized institutions.

Figure 1
Picture from the campaign on the LTC system in Spain in 2006

The Spanish system is based on the principle of universality, equity and non-discrimination. There are three levels of public responsibility for protection: minimum (general in Spain), enhanced (by an agreement between the central government and a given regional government) and supplementary (provided only by the regional government). A Territorial Council has been created in order to lower the discrepancies or inconsistencies in different regional autonomous communities. The system is funded by the general budged, but the law mentions the possibility of establishing means-tested co-payments, which have not yet been implemented.

One of the key issues in any LTC protection system in Spain is how the level of needs requiring support is defined, that is, how to classify any individual applying for care into one group. This is usually done by means of a scale. Once the applicant's situation has been assessed by experts, he or she is either assigned to one of the three possible degrees of dependence or denied eligibility. Below we describe how the Spanish dependence system assigned to individuals to a given degree of dependence. Afterwards we address the allowances, or public subsidies that currently exist in Spain.

The Spanish scale of dependence

A scale called Baremo de Valoración de la Dependencia (BVD) has been legally established in Spain after the system was established. The scale measures an individual's inability to perform daily life activities by means of a scale from 0 to 100 points. The scale used in Spain puts a lot of emphasis on the intensity of support needed and the tasks for which assistance is required. In fact, the system has already been changed after the first three years and there are still doubts that it is consistently being applied by all regions. There is also a controversy regarding the role played by the evaluation of inability to perform instrumental daily life activities. To explain the calculation of BVD we use data from a Spanish survey. Moreover, after that we extrapolate some results for the Spanish population.

Information from the survey EDAD 2008 which stands for Survey of Disabilities, Personal Autonomy and Situations of Dependence (Instituto Nacional de Estadística, INE) is analyzed. This survey was conducted in 2008 and it was a huge statistical instrument that involved more than 220,000 respondents. The statistical accuracy and ability to represent the Spanish population is guaranteed. We identified 26 variables in

the survey questionnaire that inquire about each DLA that are then used in the BVD scale to measure dependence severity. When a respondent indicates that he or she has a difficulty to perform a specific daily life activity (DLA), then he or she must indicate whether the difficulty is moderate, severe or total. According to the law, we assigned a coefficient value of 0.90 for moderate difficulty, 0.95 for severe difficulty and 1.00 for total inability to perform that particular DLA. In practice, a medical team decides the level of difficulty.

We also identified individuals with disorders when performing IDLAs (instrumental daily life activities), because the BVD scale has some particular coefficients for those individuals who have a difficulty in performing tasks due to some cognitive or intellectual challenges. Inability to perform any of the following four activities is considered sufficient to have a disorder in IDLA: difficulty to pay attention when listening or looking, significant difficulty to learn to read, to write, to count (or calculate), to copy or to learn to handle devices, major difficulty to perform simple tasks without help or supervision and major difficulty to perform complex tasks without assistance and without supervision.

The number of points given by the BVD scale is obtained by adding the severity coefficient times the weight assigned on the scale to that particular task for every existent ADL or IADL. The current weights (as approved on July 12th, 2010) are given in the Table 1.

Using the BVD, there are three severity degrees in the Spanish LTC evaluation system (see, Esparza 2010) and two levels in each degree. A person is eligible in:

- Degree 1, if support is needed once a day (Level I: 25-40 points, Level II: 40-49 points)
- Degree 2, if assistance is to be provided two or three times per day (Level I: 50-64 points, Level II: 65-74 points)
- Degree 3, if assistance is demanded several times during the day (Level I: 75-89 points, Level II: 90+ points)

Table 1
Weights for BVD calculation in Spain 2010 by age group.

	No IADL			With IADL		
Type of activity	7-10	11-17	18+	7-10	11-17	18+
Cannot pay attention by looking or listening				3.106	3.23125	3.08
Cannot learn to read, write, count (or calculate), copy or learn how to handle devices				3.106	3.23125	3.08
Cannot perform simple tasks without help or supervision				3.106	3.23125	3.08
Cannot perform complex tasks without help or supervision				3.106	3.23125	3.08
Cannot maintain the body in the same position without help or supervision	4.4	4.4	4.07	1.21	1.21	1.1
Cannot change body position without help or supervision	3.6	3.6	3.33	0.99	0.99	0.9
Cannot walk or move around the house without help or supervision	13.4	13.4	12.3	13.2	13.2	12.1
Cannot walk or move around outside the house without help or supervision	14.3	10.725	9.9	14	10.5	9.674
Cannot move using transportation as a passenger without help or supervision		1.7875	1.65		1.75	1.6125
Cannot drive without help		1.7875	1.65		1.75	1.6125
Cannot wash or dry him/herself without help or supervision	9.6	9.6	8.8	8.7	8.7	8
Cannot take care of his/her body without help or supervision	3.2	3.2	2.9	2.2	2.2	2
Cannot use the toilet (urination) without help or supervision	6.44	6.44	5.92	3.04	3.04	2.8
Cannot use the toilet (defection) without help or supervision	9.66	9.66	8.88	4.56	4.56	4.2
Cannot dress or undress him/herself without help or supervision	12.9	12.9	11.9	12.6	12.6	11.6
Cannot eat or drink without help or supervision	19.3	19.3	17.8	10.9	10.9	10
Cannot organize or do the shopping or carry the goods without help or supervision			2			2
Cannot prepare meals without help or supervision			3.6			3.6
Cannot do household chores without help or supervision			2.4			2.4
Cannot follow medical prescriptions without help or supervision	1.6	1.6	1.45	6	6	5.5
Cannot avoid danger in daily lie without help or Supervision	1.6	1.6	1.45	6	6	5.5
Cannot show feelings. respect or care to others				0.464	0.4084	0.3424
Cannot establish or maintain family relationships				0.464	0.4083	0.3423
Cannot establish or maintain relationships or sexual partners				0.464	0.4083	0.3423
Cannot establish or maintain a relationship with friends. neighbours. acquaintances and colleagues				1.392	1.225	1.027
Cannot establish or maintain a relationship with subordinates. equal or senior				1.392	1.225	1.027

Source: Baremo de Dependencia, Ministry of Health, Spain (2010)

With data from the survey we estimate the population that is 65 or more years ago in each degree of dependence at 2008, the results are presented in Table 2. We emphasize that the estimated number of women in need of care is more than double the number of men. In total there are nearly one million individuals 65 or older with some degree of dependence.

Table 2
Population in each degree of *dependence*

	Men	Women	Total
Degree 1	123,087	292,736	415,823
Degree 2	71,148	190,458	261,607
Degree 3	74,560	204,563	279,123
Total	268,796	687,757	956,553

Source: EDAD (2008) and own analysis

Public allocations in the Spanish system

Once an individual becomes eligible, he or she receives a personalized plan and can choose between assistance in kind or in cash, if he or she prefers to be cared at home and this is indeed possible. Not all degrees and levels are funded. According to the reform, public funding was expected to gradually expand until 2016, depending on the available budged. Today only those having dependence level with severity of degree 2 or more are eligible. It is likely that budget restrictions will hinder the full implementation of the law at all levels of dependence, and that the categorization of dependence entails some level of moral hazard. Monthly allocations of funds for 2009 are shown in Table 3

Table 3 indicates that someone who is eligible to receive LTC support from the public system can obtain up to 833.96 euros in cash as a monthly payment for the services received or 520.69 euros monthly for family care, if he prefers that relatives take care of him. In that case, an extra sum of 162.49 euros is given monthly to cover the social security taxes, and the training and education of the person that is employed as the family care-giver.

Table 3 LTC allocations in Spain in 2009				
Monthly maximum (minimum)[(a)] allocation in euros				
Degree and level		Service	Family care	Personal assist
Degree 3	Level II	833,96 (266,57)	520,69	833,96
Degree 3	Level I	625,47 (181,26)	416,98	625,47
Degree 2	Level II	462,18 (103,20)	337,25	
Degree 2	Level I	401,20 (70,70)	300,90	
(a) The minimum amount that a person in that level should receive. (b) An additional sum of 162.49 euros is assigned for training and social security contribution of the care worker.				
Source: Ministry of Health, Spain (2010				

The maximum public support allowance is gradually lowered depending on the severity level of dependence. Currently, the minimum possible allowance is 70.70 euros monthly for people with a severity degree 2, at level I. We should note that once a person is placed into one of the above categories (except for the highest level), if there are signs of deterioration, he or she can apply again to be reclassified.

Who is being funded

In 2010, the number of people receiving some form of allocation was 614,750. In fact the form of service may be multiple, so 7,468 got a prevention plan; 74,775 got tele-assistance; care at home was supplied to 78,968; a care at day or night centre unit was assigned to 39,312 users; residential care was provided to 114,263; supplementary service allocation was given to 50,803 and supplementary cash allocation for family care was allowed to 357,599 Spanish citizen. Allocation for family care is by far the most popular form of support from the public system.

Only 709 allocations for personal assistants were given in Spain, as this is restricted to very severe cases, especially of young people for whom a hope of new therapies is envisioned and who want to follow educational programmes.

Therefore, the total number of allocations was 723,830 in 2010.

The only way to reduce the number of allocations in the future, as the number of elderly people grows steadily given the demographic shape of the Spanish society, is that the Health System reinforces prevention and early medical reports. Control of scores is also

recommended. For instance, medical and social evaluation teams should be homogeneous and qualified all over the country. There is an urgent need for monitoring, clarifying vague concepts that persist in the scoring scale and urgent emphasis is put on prevention.

Campaigns to promote awareness of people towards a healthy living are essential, but expenditures will only be reduced if assistance in form of the provision of services and the reduction of allocations in cash is clearly implemented. We also point out to the need for promoting partnership and complementarity between public and private funding.

Discussion about the Spanish system

There is a strong debate in Spain about the sustainability of the long-term care system. Concerns are rising about the equity of decisions in all the Autonomous Communities about who is and who is not eligible. This poses many problems to the political and social success of the Law, as there is a lot of criticism in the media. Inequality is possible if people living in different areas would benefit from different allocations and services simply because his or her Autonomous Community dedicates a lot more budged to social programmes. And this is indeed the case, because the development of social care networks and institutions has been much different from one Community to another and has thus created room for perverse comparisons between Spanish citizens, who would in principal claim equal rights.

As many experts recommend, health and social services must reinforce prevention to extend duration of active life among the elderly. In previous analysis we have seen that three factors influence the increase of lifetime LTC cost in the last decade, namely the increase of longevity, a longer duration in the state of dependence and price of care services. Social policies should be devoted to reduce the length of time spent in a state of dependence by promoting active life and they should also dictate rules for the market to provide efficient services with a price evolution in line with inflation.

Social protection should not set priority on moderate dependence and non-eligible who still need care. The very extreme cases of lifetime LTC cost exist, which makes it reasonable to focus on the most severe situation and some form of compulsory insurance be imposed. Establishing public LTC systems such as the Spanish case aimed

at severe cases and make people understand that it can only been an efficient risk mitigating tool if targeting the large costs is a good strategy. The welfare system and pensions should take care of more frequent and with relative low cost cases.

There are features of the Spanish case reform that have remained beyond the scope of this article. One of them is who more control on the assessment scores given to applicants of the public system can be put in place, so that medical and social teams should be homogeneously qualified and evaluations peer reviewed. There is an urgent need for monitoring existing deviations in some regions between the expected number of eligible and the final number of allocations given. Clarifying vague concepts in the scoring scale is necessary, as well as understanding how, why and when should the official score weights be changed. There are opinions in favour of removing the three level score for dependents, so that every point given in the measurement scale is linked to some kind of proportional allocation. The main drawback for this proposal is that some services, unlike cash, cannot be assigned proportionally. Indeed, one person either gets one form of service care or not, for instance, a residence. Another disadvantage is that not having a limited number of severity levels makes it more difficult to design public policies because it is difficult to identify worst classes. Another suggestion which ahs been made in the past is the introduction of means-tested copayments, but then this can lead to moral hazard because wealth can be transferred to third-parties in order to obtain public subsidies. In fact this can have a deterrence effect towards extending private insurance, similar to the phenomenon observed in the United States with the existence of Medicare, where the market for private LTC coverage has remained small.

The LTC insurance market in Spain is still very immature. The possibility to deduct LTC insurance premiums from taxes in conjunction with pension plans has been pointed out as a key driver and it has already been permitted to a very limited extend. Currently, market premiums are still expensive. For instance, a 1,000 monthly annuity in the event of full dependence is priced at about 265 euros for a man and 492 euros for a woman aged 50. The market tends to reject this sort of product and would prefer some alternative where at least part of the cumulated insurance premium could be passed on to heirs if no dependence annuity has been received. Otherwise, consumers feel that money going into LTC insurance premiums is lost savings.

Economic recession periods do not favour the development of LTC insurance, but the decrease of house prices shows that if this is the only form of savings then it can be very

vulnerable to economic fluctuations. In fact, some traditional forms of savings subject to market or liquidity risk may not be a good option when protecting against the possibility of having to face high lifetime LTC cost.

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The New Care Service Act: frustrated labour market expectations.

by Karsten Krüger and Eduardo Jiménez

Care services in the Spanish welfare regime

Act on the Promotion of Personal Autonomy and Care of Dependent Persons

The Act on Promotion of Personal Autonomy and Care of Dependent Persons (LAPAD – the acronym comes from the Spanish: La **L**ey de Promoción de la **A**utonomía **P**ersonal y **A**tención a las Personas en Situación de **D**ependencia) was approved by the Spanish Parliament in December 2006. The Act itself established that it would be implemented in successive phases until 2015, giving priority to beneficiaries with the highest degrees of dependency. Starting from the first year (2007), people with an acknowledged dependency falling within the two levels of the third (the highest) degree would receive benefits. In the second phase (2008-2009), the Act would apply to people with an acknowledged dependency falling within the second level of the second degree. The third phase (2010-2011) would provide benefits to those with a dependency falling within the first level of the second degree. From 2010-2013, the Act foresees the inclusion of dependent people at the second level of the first degree, after which it will be applied to everybody else with an acknowledged recognized dependency in the period 2014-2015.

The Act is currently in its third phase of implementation, coinciding with a period of serious economic crisis. The measures taken by the Spanish government to reduce the public deficit have also had an impact on the implementation of the LAPAD, for instance eliminating the principle of retroactivity in benefit funding. This means no benefit will be paid for the period between application, acknowledgement of the dependency and approval. But even before these government measures there was a public discussion about the difficulties involved in implementing the law, its funding problems and the negligible impact it has had on the labour market compared to the forecasts made while it was being drawn up.

Various evaluation reports have criticized the way the LAPAD has been applied. The most criticized aspects are:

- The Act has been implemented in different ways in the different Autonomous Communities.
- The differences between Communities in sharing public funding of benefits are considerable.

- The delay in recognizing care needs and the corresponding entitlement to benefits and the effective provision of services.
- The LAPAD established that benefit must be provided in the form of services and that financial benefits would be the exception, but the real situation shows that financial benefits is the norm rather than the exception.

In the second quarter of 2010, coinciding with the beginning of the next implementation phase, there was much discussion in the press about the implementation of the LAPAD and its problems. The main topics were:

- Public funding of care services: When the Act was approved the budget situation of the central state and the Communities was very different from the situation in 2010. Caused by the worsening of the financial situation for the central state and the Communities have emerged opinions advocating a slowing down of or a moratorium on the Act's application (see Azua 2010 and Prieto 2010).
- Problems in managing public care services at municipal level starting with requests for recognition and ending with provision of the services due to the lack of specialized professionals (see Masreal 2010).

Assessments and criticisms of the new care system lead us to the conclusion that the Act was full of good intentions but falls down in its application due to the realities of the social and political situation.

From our point of view, there are two other highly important aspects:

a) The Act hasn’t had the forecasted impact on the formal Spanish Labour market but reinforced the informal and paid family care.

b) The way the Act is applied differs greatly among Communities. This could imply that it is no longer possible to speak of a homogeneous welfare regime in Spain. This would have implications for policy design, but also at the level of theory should this first impression be confirmed.

The following article will analyse the ways in which the Autonomous Communities have implemented the LAPAD and its impact on the labour market looking for the

relationship between the regional configuration of public care services and the socio-economic reality of each region. The aim is to see the new configuration of the Spanish care labour market and if the Communities have implemented the act according to their own particular contexts.

As point of departure we take the theory of welfare regimes complemented by the familiarism approach developed by Saraceno and others. According to this approach, Spain belongs historically to the group of Mediterranean welfare regimes that are characterized by the exclusive use of family solidarity to solve social problems. We ask: a) if the LAPAD brought about enough significant changes in the Spanish welfare regime to cause a paradigm change, and b) if the Act is an example of the fact that the Spanish welfare regime is internally highly differentiated in different regional welfare systems.

The Spanish welfare regime and care services

The LAPAD was a response to social needs, long discussed in Spanish society and related to two socio-demographic facts that can be observed in all member states of the European Union (EU). First, life expectancy is increasing, which means there are more and more elderly people who need care. Second, the family structure has changed considerably, mainly due to the increasing incorporation of women into the labour market. In other words, the type of European family that existed after World War II (the male breadwinner contributing income from work outside the home and the mother working as a housewife) is in backward movement. This has a high impact on all European welfare regimes but is especially relevant in Mediterranean welfare regimes like the Spanish one that have traditionally been based on family solidarity. The system cannot be maintained any longer based exclusively on family care (provided by women) and needs to resort more and more to external support (from both the formal and informal labour markets).

These and other social and demographic trends induced the state to create stable regulatory frameworks with regard to care services for dependent people. It was for this reason that the new Act created the "System for Autonomy and Care for Dependency" (*Sistema para la Autonomía y Atención a la Dependencia* – SAAD) in which all public administrations must participate and cooperate (see LAPAD 2006: 37)

The LAPAD is a project to change the pathway of the Spanish welfare regime with policy strategies traditionally in line with Mediterranean welfare regimes. According to Moreno (2006), the traditional Spanish welfare regime is essentially based on the role of the woman/wife as the pillar of social assistance in families. The increasing incorporation of women into the formal labour market has caused a substitution effect that means that first mothers and spouses are replaced by other female relatives who carry out these family social assistance tasks, and later by (informal) care workers (see Moreno 2006:6).

In an initial phase we see the transfer of personal care responsibilities from housewives to other female relatives, e.g., the grandmother becomes responsible for childcare, and other care areas fall to other available female relatives such as sisters. Moreno called this *intra-family substitution*. The second phase sees the informal commoditization of care services using the low-cost manpower of immigrant care workers, which in many cases is equivalent to the hidden labour market. Central, regional and local governments in Spain have observed the expansion of this emergent private market with caution, but also with a certain amount of relief as this trend saves the public administration money, allowing them to invest in other areas. This kind of (informal) commoditization of family care can be considered as a particular response of countries with Mediterranean welfare regimes to the changes in society described earlier (see Moreno 2006:9). The use of (illegal) immigrant manpower implies that quality criteria are not a priority in the family's choice of care providers.

The passing of the new law in 2006 can be interpreted as an attempt to enter a third phase in the transfer of care responsibilities: the professionalization of services strengthening the role of public and private organizations and thereby stimulating the expansion of the third sector. This implies (i) formalizing the informal labour market and (ii) increasing the funds allocated to social services, assuming that manpower in the formal labour market is more expensive than in the informal labour market. And it seems necessary to add (iii) an increase in the costs of care services on the basic assumption that care needs will grow due to the increase in life expectancy and the numbers of elderly.

The new Act is therefore an expression of the political will to change the trajectory of the welfare regime. According to a report by the 'Economic and Social Council of Spain' (Consejo Económico y Social España – CES 2010), after three years of applying

the law, the new system has meant the beginning of a change in the social protection model based traditionally on families, with an important burden for families and for women in particular (see CES 2010:616). As we will see, however, the new law does not signify a break with the traditional model but its adaptation to new social realities accompanied by the increasing internal heterogeneity of the welfare regime.

In order to evaluate the impact of the new law on the trajectory of the Spanish welfare regime we also use a concept proposed by the European project '*Multilinks*' for assessing social policies. It suggested the concept <familiarization/de-familiarization> to characterize social policy regimes oriented towards families, distinguishing four types:

a) Familiarism by default: there are no public alternatives to family care and financial support.

b) Supported familiarism: there are policies to support families so they can maintain their intergenerational responsibilities.

c) Optional familiarism: the state provides some kind of support so that families can choose between financial support to provide the care themselves or use an external care provider.

d) De-familiarization: state regulations are based on the individualization of social rights regardless of the family situation. In the case of social welfare services and health, it provides only access to external services (see Saraceno & Keck 2008).

This scheme can be re-interpreted in the following sense: the difference between familiarism by default and supported familiarism is the degree of economization of family benefits. Supported familiarism implicitly recognizes the social and economic value of family solidarity and partially rewards it. The difference between familiarism types (a) and (b) on the one hand and (c) and (d) on the other is the growing degree of professionalization of the care services resulting in better quality. Another effect should be an increase in economic service costs, assuming that a growing degree of professionalism increases costs, e.g. care workers' wages. On the other side of the scale are the benefits that a growing professionalization could provide to quality of life, for

both the dependent person and their family, without forgetting the socio-economic benefits brought by the creation of jobs.

As regards the analysis of what impact the new law has had on the Spanish welfare system, this scheme enables the Act and its implementation to be classified. The new law foresees financial benefits in exceptional cases and prioritizes external care services integrated into the social systems, which can be either public or public-private services. So far it has formally backed the de-familiarization of services, which would break away from the pathway of the Mediterranean welfare regime in Spain. However, this legal provision is linked to the development of the social service systems in the Autonomous Communities. Therefore, depending on the development of the network of services in the Communities, the law might also follow options (b) or (c). If the traditional welfare regime trajectory is followed, it can be expected that implementation of the law will show a tendency towards option (b). If the regime becomes more flexible, option (c) can be expected. The decision to de-familiarize care services means a radical change in the paradigm of the Spanish welfare regime. It was also, therefore, the least expected, and the implementation of the new law in the Autonomous Communities must be analysed in greater detail.

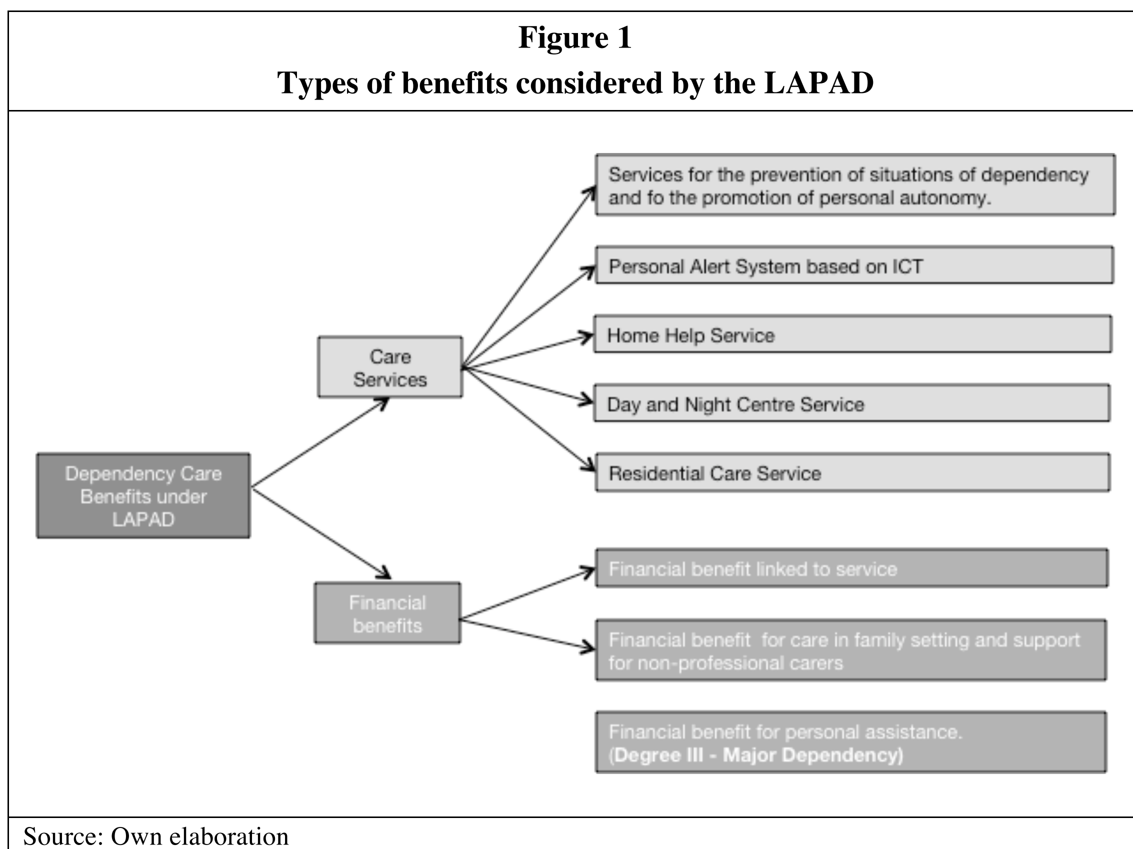
We propose carrying out a triple analysis in order to cover different aspects of the impact of the implementation of the new law. First we analyse the evolution of the LAPAD at national level, with special emphasis on the comparison between the forecasts in the preparatory phase of the law and its real impact, especially on the labour market. Then we carry out a regional analysis focusing on (a) the regional development of the system, what we call an internal evaluation; and (b) the regional system development taking certain socio-economic variables as references, which will enable us to assess whether the regional systems developed in line with their specific needs or whether it depended more on the political will of the autonomous governments.

The structural elements of the SAAD[1]

The law distinguishes between services and economic benefits, giving priority to the provision of services through regional networks of social services composed of public and public-private care centres managed by the various Autonomous Communities. It is stipulated that in exceptional cases and when the conditions are met, beneficiaries may receive economic benefit to pay for non-professional care workers.[2]

The law stipulates that the regional social service networks should provide different services such as the prevention of situations of dependency and the promotion of personal autonomy, teleassistance, professional home care, day and night centres, and residential care.

Figure 1
Types of benefits considered by the LAPAD



Source: Own elaboration

1 The Spanish acronym for <System for Autonomy and Care for Dependency>

2 The Act does not determine any criterion of exceptionality except that homes should be fit for providing the service.

Access to both services and financial benefits depends on the beneficiaries' degree and level of recognized dependency and their own economic resources establishing three degrees of dependency: moderate dependency (degree I); severe dependency (degree II); and major dependency (degree III).

The law contemplates a distribution of the respective competences at three levels: central state, Autonomous Communities and municipalities. In other words, for the effective development of the law it is necessary for all the public administrations involved to participate and cooperate. We will not go into more detail here about the distribution of competences and the regulatory development of the law in the different autonomous regions. However, it is clear that any evaluation of LAPAD implementation must consider two aspects: the temporal dimension analysing general development at state level and the regional dimension analysing the differences between Autonomous Communities. The objective of the analysis is to find out to what extent the regional configurations of the SAAD correspond to the real needs of the elderly in the respective Autonomous Communities and what trajectory the Spanish welfare regime is taking.

General implementation of the new Act

In the description of the LAPAD provisions, we have highlighted that financial benefits as well as the use of a family care worker is considered by the Act as exceptional, with priority being given to the provision of services through the regional social service networks. Only in exceptional cases may beneficiaries receive financial benefits to be attended by non-professional care-workers.

Table 1
Applications, official evaluations, acknowledged beneficiaries entitled to receive services, and services; accumulated data from 01/04/2010

	Applications	Evaluations	Beneficiaries entitled to services	Services
Spain	1,258,567	1,144,999	796,986	546,610

Source: SAAD, consulted on 15/04/2010 at http://www.imsersodependencia.csic.es/estadisticas/saad/index.html

According to the law, however, the specific configuration of the system is dependent on the development of public social services in each region. In other words, the Act itself leaves open the possibility that the anticipated action taken with regard to exception could become the norm in day-to-day practice, depending on the degree of development of these regional and local networks.

Table 2
Evaluations in April 2010 and projections made in the White Paper on Care Services by degree and level of dependency*

Evaluations			Projections in White Paper for 2010		Dif
	Nº	%		Nº	Nº
	1,141,999	100%		1,246,429	-104,430
Degree III	*468,764*	*41.05%*	High dependency	*223,457*	*245,307*
Degree II	*328,222*	*28.74*	Severe dependency	*420,336*	*-92,114*
Degree III & II	**796,986**	**69.79%**	**TOTAL**	***643,793***	**153,193**
Degree I	227,172	19.89%	Moderate dependency	*602,636*	-375,464
No degree	117,841	19.32%			

Source: SAAD consulted on 15/04/2010 at http://www.imsersodependencia.csic.es/estadisticas/saad/index.html and Libro Blanco (2005)
* Note: Each degree is divided into two levels by applying a scale agreed by the Territorial Council of the SAAD for its later approval by the government via Royal Decree. But we consider here only the aggregated levels.

By the beginning of April 2010, more than 1.2 million people had claimed benefits under the LAPAD and 1,141,999 official evaluations had been made as to the degree of dependency of the applicants. Of these, 796,986 evaluations recognized applicants as having dependency Degree II or III, entitling them to receive help at this stage of implementation of the LAPAD.[3] At the beginning of April 2010, 546,610 people had received some benefit under the terms of the law. As some beneficiaries are entitled to receive more than one type of benefit, the following data show more benefit awards than beneficiaries. A study comparing actual evaluations of degrees of dependency with the projections in the White Paper (Ministry of Labour and Social Affairs 2005) shows

[3] The data shown in Tables 1 and 2 are accumulated figures since 01/01/2007. The following tables contain data from which cases of death, revisions, etc. have been eliminated.

that the projections underestimated the real number of people with severe dependency (see Table 3). The number of evaluations acknowledging Degree III is considerably higher than those predicted by the White Paper. The number of evaluations acknowledging Degree II, however, is lower than projected. One explanation lies in the fact that those with an acknowledged dependency of Degree II Level 1 could receive benefits only from 2010 onwards. Nevertheless, projections for high and severe dependency have in fact been exceeded by over 23%. The number of evaluations recognizing Degree I is considerably lower than projections made in the White Paper, which is explained by the fact that these people cannot receive benefits until 2013.

Table 3
Type of benefits recognized by the LAPAD

	Nº	%
Dependence prevention & promotion of individual autonomy	4,033	0.63
Teleassistance	63,928	10.02
Home care	70,328	11.03
Day & night centres	32,978	5.17
Nursing home care	109,076	17.10
Financial benefits linked to services	44,060	6.91
Financial benefits linked to family care	312,624	49.02
Financial benefits linked to personal care assistance	700	0.11
Total	**637,736**	**100.00**
Ratio: benefits /beneficiaries	1.17	

Source: SAAD, consulted on 15/04/2010 at http://www.imsersodependencia.csic.es/estadisticas/saad/index.html

The data on types of services show that financial benefits for family care workers predominates. The data indicate that grants represent 56.1% of all benefits and are not therefore the exception but the norm in the new care system. And about 49% of all benefits are financial benefits for family care. Thus far it is noteworthy that the LAPAD stipulation that benefits should generally be provided in the form of services has not been met. Consequently there is no paradigm shift in the Spanish welfare regime towards commoditization of care services. Family care workers remain the pillars of the system but are now partially recognized and encouraged by the state. The Spanish welfare regime appears to have evolved since the Act was passed towards an optional familiarism in which most beneficiaries opt for financial benefits. However, this finding

depends on whether families really have a choice. Where there is an insufficiently developed regional or local infrastructure to provide services on demand, we cannot talk about optional familiarism but rather supported familiarism.

Impact on the labour market

The preparatory reports for the LAPAD included various predictions about its impact on the labour market. The White Paper considered two aspects of this:

- The creation of new jobs in the public and private sectors
- The integration of those workers totally or partially excluded from the labour market as they have to carry out (unpaid) care services (see White Paper 2005: 637)

To estimate the employment potential, the unpaid time devoted to care services has been taken as a reference. Based on an analysis of dependency statistics, the White Paper concluded that in 1999 there were 1,279,392 people caring for family members as opposed to 391,060 professional care workers. Of these family care workers over half spend more than 30 hours a week on care (646,770 family care workers). In other words, there was an enormous potential to convert this family care into professional care work. Considering that not all work would be full-time, the creation of around 300,000 jobs was forecast for the period 2005-2010 (see Table 4).

Table 4
Forecast net creation of employment by the new national care service system 2005–10

Year	Forecast creation of full-time jobs	Forecast creation of part-time jobs	Forecast new jobs
2005	7,870	5,463	13,333
2006	41,231	28,622	69,853
2007	77,604	53,871	131,475
2008	125,987	87,458	213,445
2009	168,759	117,150	285,909
2010	195,039	135,393	303,432

Source: Libro Blanco 2005: 655

The reality, however, has shown that these forecasts were exaggerated and have not come about despite the fact that data on social security affiliates show an increase in employment in care service sectors: in the area of nursing homes (NACE 87), 54,300 jobs were created between 2005 and 2010, and 61,200 jobs in the area of social services without accommodation. Instead of the 303,432 new jobs forecast, only 115,500 jobs were created by 2010, which amounts to only 38.1% of the employment forecast.

In both sectors, the greatest growth took place between 2005 and 2007, when both show annual growth rates higher than 5%. The nursing-home sector continues to show considerable employment growth until 2010, while the social services without accommodation sector has grown more slowly between 2007 and 2009, but showing a very high growth between 2009 and 2010.

It would therefore appear that the first implementation phase of the LAPAD affecting people rated dependency Degree III has had a positive labour market impact. The same is true for the second phase affecting those evaluated at Level 2 of dependency Degree II. But the impact is blocked from 2008 coinciding with the financial and economic crisis, which produced a considerable increase of unemployed people.

Table 5
Evolution of employment in the care service sectors
(in thousands at the first quarter of each year)

Year	Social services with nursing homes (NACE 87)	Social services without accommodation (NACE88)	All NACE
2000	137.4	98.8	15,119.3
2001	142.0	102.1	15,866.3
2002	146.8	105.6	16,335.8
2003	163.1	117.3	16,923.6
2004	170.8	122.8	17,600.4
2005	182.1	131.0	18,492.7
2006	193.9	139.4	19,400.1
2007	203.6	146.5	20,069.2
2008	191.2	150.8	20,402.3
2009	237.1	155.6	19,090.8
2010	236.4	192.2	18,394.2
Δ 2010-05	54.3	61.2	-108.5

Source: own based on quarterly data from: Series retrospectivas realizadas con matriz de paso: Ocupados por ramas de actividad CNAE 09 2 dígito.. www.ine.es consulted *18/05/2010*

These data indicate that the care service sector has withstood resisted the economic crisis, showing continuous growth of around 6% compared to 2005. It is noteworthy that both sectors have shown still a substantial growth from 2002 onwards, i.e. that means before the approval of the LAPAD was approved. And after its approval, the employment growth in these sectors has slowed down. One interpretation of this may be that the economic crisis (or the way in which the Act has been implemented) has adversely affected the sectoral growth. However, between 2008 and 2010, employment growth in both service sectors speeds up again their employment growth. This trend is s

Table 6
Evolution of employment in the care service sectors
(1st quarter 2005 = 100)

Year	Social services with nursing homes (NACE 87)	Social services without accommodation (NACE88)	All NACE
2000	75.45	75.42	81.76
2001	77.98	77.94	85.80
2002	80.62	80.61	88.34
2003	89.57	89.54	91.52
2004	93.79	93.74	95.17
2005	100.00	100.00	100.00
2006	106.48	106.41	104.91
2007	111.81	111.83	108.52
2008	105.00	115.11	110.33
2009	130.20	118.78	103.23
2010	129.82	146.72	99.47
Δ 2010-05	29.82	46.72	-0.53

Source: own based on quarterly data from: Series retrospectivas realizadas con matriz de paso: Ocupados por ramas de actividad CNAE 09 2 dígito. www.ine.es consulted at *18/05/2010*

But the greatest impact of the new law is observed in the area of family care workers. Since the implementation of the law until April 2010, 312,624 people have been acknowledged as entitled to receive financial benefits for family care. However, this financial benefit does not have a one-to-one correspondence in the special agreements with social security to which family care workers have access. Only 119,524 family members have been covered by such an agreement, i.e. 38.2% of the 312,624 potential

family care workers. That leaves a fairly wide range of care worker recruitment to the informal labour market.

Table 7
Beneficiaries of family care and formal non-professional care workers

	(1) Agreements with non-professional care workers	(2) Beneficiaries of financial benefit for family care	(3) Difference between agreements and beneficiaries	(4) Formal coverage rate (1/2 as a %)
TOTAL	**119,524**	**312,624**	**-193,100**	**38.2%**

Source: SAAD consulted on 15/04/2010 at http://www.imsersodependencia.csic.es/estadisticas/saad/index.html

In summary, the analysis of the relationship between the recognition of rights to care services and the labour market indicates a strong positive correlation, but also showed that the impact on labour markets has not been as forecast. Naturally one of the factors that has diminished the potential impact is non-compliance with the law. The Act considered financial benefit as an exceptional measure, but awarding 312,624 people the right to receive financial benefits for family care contradicts this legal disposition and as a result reduced its impact on the labour market. In addition, this figure is well below the number of family care workers who, as estimated in the White Paper, spend more than 30 hours a week on care duties (646,770 family care workers). Therefore the act has not created the number of jobs predicted.

To a certain extent this implies a consolidation of the Mediterranean welfare regime and the role of women (as family care workers) as the pillars of the care system. However, financial benefit for family care is not paid directly to care workers but to beneficiaries. Due to the total lack of control over the use of financial benefit, as reflected in the fact that only 38% of potential family care workers are registered with social security,[4] there

[4] The new law offers the possibility that family care workers can be covered by special social security agreements to access certain social benefits similar to other employed people. Thus far the new care act creates a new segment between the formal and informal labour markets by formalizing the family care labour market. The formal recognition of the figure of the family care worker can be

is a considerable margin for real use of the benefit. One possibility, and a logical evolution of the Spanish welfare regime, would be the recruitment of informal care on the hidden labour market. Gathering data from Social Security and the SAAD on employment in the care service sector, we see about 404,000 formal jobs (56.9%), 120,000 recognized family care workers (16.7%) and potentially 193,000 informal care workers (26.9%). It seems that the new Act has restructured the labour market introducing a third segement of the paid family care workers besides the professional and the informal care workers.

The regional implementation of the new care system

The analysis of the implementation of the new care service system at regional level will be done in two steps. First we will assess the system from an internal perspective focusing on its evolution from 2008 onwards, taking as reference points the months of June and December for 2008 and 2009 and April for 2010. We apply this procedure on the following indicators: the beneficiary rate and the rate of financial benefit for family care.[5] Unlike the SAAD, which calculates coverage with reference to the total population of the Autonomous Communities, here we take the population aged over 64 as a reference. This group represents more than 75% of the beneficiaries under the new Act. In doing this we take better account of the differences in ageing among regions. We then assess the new system from an external perspective, comparing implementation in the different Communities by crossing internal indicators with regional socio-economic indicators.

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interpreted as a step towards formal recognition of the value of unpaid work done by female family members.

5 A temporal analysis of the relation between services and financial benefit is not possible because the official statistics for 2008 and 2009 included the category of benefits without specifying the type of benefit that in certain months and in certain Communities had considerable weight. This invalidates any analysis of the evolution of this relationship.

Beneficiaries

The first analytical step refers to the number of beneficiaries in the different Communities. We choose these data as a starting point because the number of applications and recipients show a strong correlation at least for April 2010. The data show high heterogeneity.[6] The following table shows that there are two main sections:

a) A group of Communities whose rates and growth rates in percentage points are higher than the rates for Spain as a whole: Andalusia, Cantabria, Castile-La Mancha, Catalonia, Murcia, La Rioja and the Basque Country. This is a group of Communities that is mainly governed by the PSOE (Partido Socialista Obrero Español – The Spanish Socialist Workers Party) alone or in coalition with other parties.

b) A group of Communities with lower rates compared to Spain as a whole: Asturias, the Canary Islands, Castile & Leon, the Valencian Community, Extremadura, Galicia, Madrid and Navarre. Most of these regions are governed by the PP (Partido Popular – People's Party) alone or in coalition with another party. Within this group, Navarre can be considered an exception because in June 2008 it had a higher beneficiary rate compared to Spain as a whole, whereas the other Communities within the group show lower rates. Hence Navarre is the Community with the lowest growth rate in numbers of beneficiaries of all the regions.

Apart from these, there are four Communities[7] that do not fall into either group:

a) Aragon, Ceuta & Melilla and the Basque Country have higher beneficiary rates than the average of all regions but lower growth rates.

b) The Balearic Islands have a lower beneficiary rate compared to the average for all Communities but a higher growth rate.

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[6] Although the data range has expanded in the course of two years from 0.009 to 0.117, the variance coefficient has decreased from 52.7% to 30.2% over the same period.

[7] Spain is organized into 17 Autonomous Communities and two Autonomous Cities (Ceuta and Melilla). For statistical reason, Ceuta and Melilla are treated here together as one administrative unit.

Table 8
Beneficiary rate as a % of population ≥ 65
(classified from lowest to highest rates from data for April 2010)

	June 2008		April 2010		
	Rate	Distance from the Spanish average	Rate	Distance from the Spanish average.	Rate of growth
Madrid	0.0127	-0.0181	0.0567	-0.0457	0.0440
Canary Islands	0.0145	-0.0163	0.0627	-0.0397	0.0482
Asturias	0.0204	-0.0104	0.0669	-0.0355	0.0465
Valencian Com.	0.0086	*-0.0222*	0.0710	-0.0314	0.0624
Galicia	0.0253	-0.0055	0.0790	-0.0234	0.0537
Castile & Leon	0.0226	-0.0082	0.0810	-0.0214	0.0585
Balearic Islands	0.0087	-0.0221	0.0859	-0.0165	*0.0772*
Extremadura	0.0255	-0.0053	0.0937	-0.0087	0.0682
Navarre	0.0506	0.0198	0.0937	-0.0087	0.0431
TOTAL	***0.0308***	0.0000	***0.1024***	0.0000	***0.0716***
Basque Country	0.0316	0.0008	0.1026	0.0002	0.0710
Ceuta & Melilla	0.0525	0.0217	0.1034	0.0010	0.0509
Aragon	0.0466	0.0158	0.1052	0.0028	0.0586
Catalonia	0.0294	-0.0014	0.1152	0.0128	0.0858
Castile-La Mancha	0.0368	0.0060	0.1164	0.0140	0.0796
Cantabria	0.0390	0.0082	0.1287	0.0263	0.0896
Murcia	0.0308	0.0000	0.1322	0.0298	0.1014
Rioja	0.0542	0.0234	0.1390	0.0366	0.0848
Andalusia	0.0670	*0.0362*	0.1734	0.0710	0.1064
Highest difference	0.0584		0.1167		

Source: own based on data from SAAD and INE

Naturally all Communities showed an increase in the number of beneficiaries in the course of the implementation of the LAPAD, i.e. the successive integration of beneficiaries classified in the first period as Degree III and later as Degree II, first at Level 1 and later at Level 2. The fact that the regions with the lowest rates in June 2008 showed a higher rate of growth than the others indicates that the distance between the different regions has been shortened taking as reference a) the Spanish average[8] and b) the variance coefficient.

[8] While in June 2008 the beneficiary rate for Valencia was only 28% and Andalusia 217% compared to the average rate for Spain, in April 2010 Madrid was 55% and Andalusia 169%.

In June 2008, the Communities with the greatest positive difference compared to Spain were Andalusia (0.0362 percentage points), La Rioja (0.00234) and Ceuta & Melilla (0.0217). In April 2010 these differences had widened, with Andalusia (0.0710 percentage points) and La Rioja (0.0366) being those regions whose rates showed the greatest distance from the Spanish rate, while the third region is currently Murcia (0.0298)

The Communities with the highest negative differences compared to Spain in June 2008, on the other hand, were the Valencian Community (-0.0222 percentage points), the Balearic Islands (-0.221), Madrid (-0.0181) and the Canary Islands (-0.0163). In April 2010, however, the Balearic Islands were only -0.0165 percentage points from the Spanish average, while Madrid (-0.0457) and the Canary Islands (-0.0397) were still far away although the gap is closing. The Community with the third highest negative distance is now Asturias (-0.0355).

Communities that in the summer of 2008 already had higher rates compared to the average of all Communities tend also to show higher beneficiary rates than the Spanish average in April 2010. Although the rates for the Basque Country, Ceuta & Melilla and Aragon have worsened compared to the Spanish average, they still remain above it. Navarre, however, which in June 2008 showed a higher rate than the Spanish average (0.0506 % and 0.0308% respectively), has a lower rate compared to Spain (-0.0087 percentage points) in April 2010. In fact it has the lowest beneficiary growth of all the regions. Then again, all those regions, which had a rate below the Spanish average in June 2008 also have a lower growth rate compared to the whole Spain, with the exception of the Balearic Islands.

Family care workers

Family care workers are a key factor in developing the new care system. The high percentage of financial benefit for family care work undoubtedly reduces the potential impact of the LAPAD on the labour market. The data on rates and growth rates of financial benefit for family care again confirm the consistency of the above-mentioned two groups of Communities in respect to the implementation of the LAPAD.

Table 9
Rates of financial benefit for family care workers as a % of population ≥ 65 (classified from maximum to minimum in April 2010)

	June 2008		April 2010		
	Rate	Distance from the average	Rate	Distance from the average	Growth rate
Madrid	0.0000	-0.0024	0.0068	-0.0334	0.0068
Canary Islands	0.0000	-0.0024	0.0144	-0.0258	0.0144
Valencian Com.	0.0001	-0.0023	0.0166	-0.0236	0.0165
Asturias	0.0016	*-0.0008*	0.0243	-0.0159	0.0227
Galicia	0.0006	-0.0018	0.0308	-0.0094	0.0302
Castile & Leon	0.0000	-0.0024	0.0312	-0.0090	0.0312
Extremadura	0.0021	-0.0003	0.0315	-0.0087	0.0294
Balearic Islands	0.0020	-0.0004	0.0319	-0.0083	0.0299
Basque Country	0.0077	0.0053	0.0395	-0.0007	0.0318
Spanish Average	**0.0024**	**0.0000**	**0.0402**	**0.0000**	**0.0378**
Catalonia	0.0001	-0.0023	0.0491	0.0089	0.0490
Navarre	0.0023	-0.0001	0.0522	0.0120	0.0499
Aragon	0.0035	0.0011	0.0534	0.0132	0.0499
Castile-La Mancha	0.0017	-0.0007	0.0539	0.0137	0.0522
La Rioja	0.0044	0.0020	0.0640	0.0238	0.0596
Cantabria	0.0041	0.0017	0.0682	0.0280	0.0641
Ceuta & Melilla	0.0328	0.0304	0.0689	0.0287	0.0361
Murcia	0.0026	0.0002	0.0718	0.0316	0.0692
Andalusia	0.0086	*0.0062*	0.0758	0.0356	0.0672
Highest difference	0.0328	0.0328	0.0690	0.0690	0.0624

Source: Own based on data from SAAD and INE

Communities in the first group have higher rates of family care workers and higher growth rates compared to Spain and the average of the Communities, with the exception of the Basque Country, which has lower indicators. The second group of Communities has both indicators below the Spanish rates and the average rate of all Communities. Here the exception is Navarre, which has both indicators higher. Three of the four Autonomous Communities that are not in either group show similar behaviour compared to the data for beneficiaries. The exception is Aragon, which in this section has similar indicators to the first group, i.e. higher compared to Spain and the average of all Communities.

Taking the months of June 2008 and April 2010 as references, we can observe the same distribution of the Communities between the two main groups, with the exception of four. On the one hand we have the block formed by Asturias, the Balearic Islands, the

Canary Islands, Castile-Leon, Extremadura, Galicia, Madrid and the Valencian Community, which have lower rates of financial benefit for family care in relation to the population over age 64 compared to the Spanish rate in both months. And on the other hand there are regions such as Andalusia, Aragon, Cantabria, Ceuta & Melilla, La Rioja and Murcia with higher rates in both months compared to the Spanish average.

In June 2008 the Basque Country has a higher rate than the Spanish average, but in April 2010 it is slightly lower. Castile-La Mancha, Catalonia and Navarre, however, had lower rates of financial benefit for family care compared to the Spanish average in June 2008, but in April 2010 they were higher.

Current situation

To complement the temporal analysis we will now describe the current situation of care system services taking the beneficiary rate and the rates of financial benefit in relation to total benefits as references. The aim is to detect and describe the differences between Communities in the path taken by the Spanish welfare system in this area of social policy.

Table 10 shows that all Communities except Madrid have a financial benefit rate of over 50% of the total number of benefits. However, there are major differences between the Communities. On one side there is Madrid, which with 20.9% has an unusually low rate, and the Basque country, which with 51.6% has the second lowest rate of all the regions; and on the other there is Murcia, whose system is almost exclusively focused on financial benefits (94.4%). Excluding Madrid, the maximum difference in the financial benefit rate is 42.8 percentage points, indicating that the configuration of care systems differs greatly from one Community to another.

We get a better picture of the current situation by crossing two indicators: (i) the rate of beneficiaries in relation to the population over age 64 indicates the coverage of care needs, and (ii) the rate of financial benefit as a proportion of overall benefits is considered an indicator of which kind of familiarism the regional system is oriented towards.

Table 10
Financial benefits in April 2010
(number and % of recipients of financial benefit and coverage rate of the population ≥ 65; classified from maximum to minimum by overall benefit rates)

	Beneficiaries of financial benefits and % of these in relation to all services		Coverage rate of financial benefit in relation to the population ≥ 65	Distance from the Spanish coverage rate at April 2010
	Nº	%	%	Percentage points
Madrid	6,668	20.9%	0.0072	-0.0387
Basque Country	17,431	51.6%	0.0426	-0.0034
Valencian Com.	15,886	53.9%	0.0190	-0.0269
Canary Islands	4,010	56.0%	0.0147	-0.0312
Asturias	6,926	61.7%	0.0292	-0.0167
Andalusia	96,390	61.9%	0.0787	0.0328
Cantabria	7,380	63.7%	0.0682	0.0223
TOTAL	**357,393**	**65.4%**	**0.0459**	**0.0000**
Galicia	20,604	67.1%	0.0337	-0.0122
Extremadura	9,498	68.3%	0.0454	-0.0006
La Rioja	4,370	70.2%	0.0754	0.0294
Castile & Leon	28,129	70.6%	0.0490	0.0031
Castile-La Mancha	21,508	71.9%	0.0588	0.0129
Balearic Islands	5,105	74.3%	0.0340	-0.0119
Catalonia	71,686	78.6%	0.0589	0.0130
Ceuta & Melilla	1,280	85.5%	0.0776	0.0317
Aragon	18,431	85.7%	0.0698	0.0239
Navarre	7,190	87.5%	0.0661	0.0201
Murcia	14,901	94.4%	0.0755	0.0295
Highest difference		*73.4%*	*0.0715*	*0.0715*

Source: Own based on data from SAAD and INE

Based on data from April 2010 four large groups of Autonomous Communities can be distinguished:

a) A group of Communities with a low beneficiary rate and a financial benefit rate below 50%. This is actually the group of Communities characterized by familiarism by default, which shows, nonetheless, a tendency towards supported familiarism.

b) A group of Communities with a beneficiary rate slightly higher than in the previous group but still below the Spanish average, and with a financial benefit rate of

between 60% and 80%. This group is characterized by a strong tendency moving from familiarism by default towards supported familiarism.

c) A group of Communities with a beneficiary rate above the Spanish average and a high financial benefit rate, certainly higher than in the previous group. It is characterized, therefore, by supported familiarism.

d) A group of Communities with a beneficiary rate higher than (or equal to) the Spanish average and a financial benefit rate below the Spanish average. In this case we can speak of a tendency towards optional familiarism.

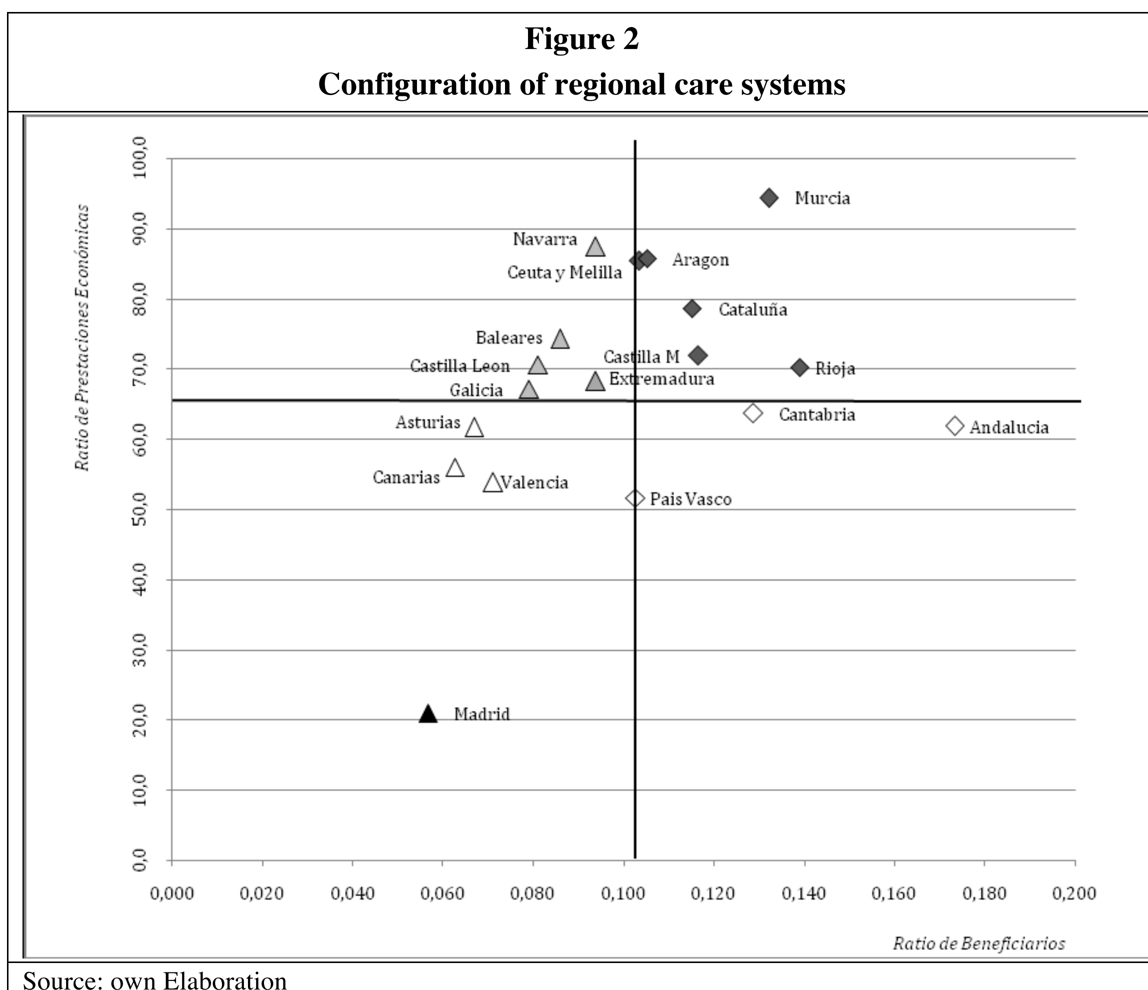

Figure 2
Configuration of regional care systems

Source: own Elaboration

This indicates that the Spanish welfare system is internally diverse, which makes it very difficult to design general strategies for social policies applicable in all Autonomous Communities.

Regional diversification of the Spanish care system in response to socio-economic needs?

The configuration of the current regional care systems measured by the beneficiary rate among the population over age 64 and the rate of financial benefits indicates internal diversification of the Spanish welfare regime. There is one group which retains the logic of the familiarism by default system with outbreaks of supported familiarism, a second group which can still be classified as familiarism by default but with a marked tendency towards supported familiarism, a third group of supported familiarism, and a fourth group which is in between supported familiarism and optional familiarism.

The differences between Autonomous Communities in June 2008 could be justified even though they began to implement the LAPAD in different ways, but we can observe that these initial differences have characterized the Act's implementation over time. In this second part of the analysis we examine whether the regional settings of the SAAD are related to the socio-economic conditions of each community. It is well-known and well-shown that socio-economic situations are heterogeneous among Spanish Communities and therefore an analysis must be carried out to discover whether these differences in socio-economic conditions could account for the differences in the implementation of the LAPAD. To give an example: it can be assumed that in a region with a high ageing ratio but a low degree of urbanization it will be more expensive to create and maintain a care service system and that there will probably also be a shortage of qualified workers to provide the services.

The aim is to determine to what degree the regional development of the SAAD depends on the regional socio-economic context or the political will of the respective governments. We propose a socio-territorial approach to analyse the parameters that could affect the regional implementation of the LAPAD. The goal is to see to what extent regional socio-economic conditions influenced the regional configuration of the care systems. We develop a set of variables taking as reference the total population of the region and the population over 64. We ruled out the surface area as a reference, although we do think that the territorial density of the population over 64 should have an influence in shaping the services of the department. However, the variables developed for each Community show such a high degree of disparity (e.g. the variance coefficients) that it cannot be used to establish correlations. We have therefore limited our analysis to the following variables:

- The ageing rate: the ratio of the population over age 64 in relation to the total population in the region.[9]
- The urbanization rate of the elderly: the percentage of the population over age 64 living in municipalities with more than 10,000 inhabitants[10];
- The rate of potential family care workers: the ratio of women between ages 45 and 64 to the total population and alternately to the population over age 64 in the Community[11];
- The company rate: the number of socio-health companies for the population in the Autonomous Communities and alternatively for the population over age 64;[12]
- Company density: the number of socio-health companies per sq. km[13];
- The rate of social and health employment: the number of social security affiliates in the social and health sectors for the population over age 64 in the Community[14];
- The density of social and health workers: the number of social security affiliates in the social and health sectors per sq. km[15].

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[9] Source: INE (National Statistics Institute): Revisión del Padrón municipal 2009. Datos a nivel nacional, comunidad autónoma y provincia. Por Comunidades Autonomicas. www.ine.es and Padron Municipal - Población por CCAA y tamaño de los municipios - 01/01/2010. www.ine.es .

[10] Source: Informe 2008: Las Personas Mayores en España Tomo II.

[11] Source: INE: Revisión del Padrón municipal 2009. Datos a nivel nacional, comunidad autónoma y provincia. Por Comunidades Autonomicas. www.ine.es and Padron Municipal - Población por CCAA y tamaño de los municipios - 01/01/2010. www.ine.es .

[12] Source: INE: Directorio central de empresas: Empresas por CCAA, actividad principal (grupos CNAE 2009) y estrato de asalariados. www.ine.es

[13] Source: INE: Directorio central de empresas: Empresas por CCAA, actividad principal (grupos CNAE 2009) y estrato de asalariados. www.ine.es and Anuario Estadístico de España: Territorio – Extension superficial de las CCA y provincias. www.ine.es

[14] Source: Seguridad Social - Afiliados último día del mes por CCAA. Provincias y Sección de Actividad. www.seg-social.es.

[15] Source : Seguridad Social - Afiliados último día del mes por CCAA. Provincias y Sección de Actividad. www.seg-social.es and Anuario Estadístico de España: Territorio – Extension superficial de las CCA y provincias. www.ine.es.

- The living standard: we take as a reference first the retirees' living standard measured by pension income, and second the household living standard measured by household expenditure per person.[16]

Table 11
Regional ageing and urbanization rate

	Ageing rate	Urbanization rate
	Inhabitants ≥ 65 as a % of regional population (2009)	Inhabitants ≥ 65 in municipalities of ≥10.000 inhabitants as a % of inhabitants ≥ 65 in the region (January 07)
Castile & Leon	0.224	0.463
Galicia	0.219	0.572
Asturias	0.218	0.824
Aragon	0.196	0.594
Extremadura	0.190	0.354
Basque Country	0.189	0.811
Cantabria	0.184	0.649
La Rioja	0.180	0.558
Castile La Mancha	0.176	0.429
Navarre	0.173	0.496
Spain	0.166	0.726
Valencian Com.	0.164	0.796
Catalonia	0.163	0.801
Andalusia	0.148	0.740
Madrid	0.144	0.952
Balearic Islands	0.137	0.797
Murcia	0.137	0.936
Canary Islands	0.130	0.849
Ceuta & Melilla	0.108	1.000

Source: own based on data from INE and Informe 2008: Las Personas Mayores en España Tomo II.

[16] Sources: For the average income of the retirement pension, the data for the year 2009 were consulted at : INE – Pensiones contributivas del sistema de la Seguridad Social. Serie 1994-2009 - Pensiones e importe medio por clase de pensión, CCAA, periodo a base de los datos del Boletín de Estadísticas Laborales. Ministerio de Trabajo e Inmigración, www.ine.es.
For the expenditure of the households by persons, the provisional data of the year 2009 of the INE were used: Encuesta de condiciones de vida 2010. Resultados provicionales. www.ine.es.

As far as the application of the LAPAD is concerned, we consider that the following two variables are highly relevant: a) the ageing rate and b) the urbanization rate of the elderly. The former is an indicator of the potential demand for care services. We assume that the higher the ageing rate the higher the demand for care services. The latter is an indicator of the service-providing facilities that build up an infrastructure of public, public-private and private social services to meet this demand. We assume that it is easier to create and maintain this infrastructure in urban areas than in rural areas.

The data in Table 11 clearly show a strong negative correlation between the ageing rate and the urbanization rate: The Communities that have a higher urbanization rate than Spain as a whole tend also to have a lower ageing rate. The exceptions are Asturias and the Basque Country, which have a higher ageing rate as well as a higher urbanization rate. Ceuta & Melilla, because they are cities, have ageing and urbanization rates that are very different from other regions. For this reason we exclude them from the following analysis.

Beneficiaries

The following table shows that the beneficiary rate has a weak correlation with the ageing rate, but a medium negative correlation with the urbanization rate of elderly people. The Spanish mainland Communities with the highest urbanization rates tend to have lower current beneficiary rates. Therefore it can be assumed that Communities with lower beneficiary levels tend to have higher rates of socio-health employment in general and even more pronounced rates in relation to the elderly population. The correlations between the beneficiary rate and the other socio-economic variables are generally weak or very moderate. The exceptions are the two social health employment rates. The beneficiary rate has a strong correlation with both social health employment rates in relation to the total population in the region, and a moderate correlation with these rates in relation to the elderly population. In those regions with a higher social health employment rate, the beneficiary rate tends to be higher. This trend apparently contradicts the earlier trend. The explanation probably lies in the fact that all the trends are moderate. However, we should emphasize again that the two social-health employment indicators also include health employment, which probably significantly

distorts them. As far as the company rate is concerned, we can observe a moderate correlation. But as in the case of the employment rate, these rates also include the health sector, which distorted the correlation.

Table 12
Correlation between the beneficiary rate and other socio-economic variables

	Ageing rate	Urbanization rate	Family care worker rate Women aged 45-64/ total population	Social health employment rate / population (1)	Social health employment rate / population ≥ 65 (2)	Company rate (NACE 87)	Company rate (NACE 88)	Company rate (NACE 87+88)	Average pension (2009)	Household expenditure (2009)
Correlation	0.10	-0.37	-0.16	0.49	0.06	0.05	0.19	0.17	-0.03	-0.11

Source: Own based on data from SAAD and INE

In short, there is no discernible pattern relating the beneficiary rate to the socio-economic variables chosen with the exception of the social-health business rate. However, as mentioned before, these three variables do not really reflect the development of the care services sector because they include the health sector. Another exception is the urbanization rate, where the beneficiary rate tends to be lower when the urbanization rate becomes higher. But, as we said before, it must be the urbanization rate that determines the ratio of beneficiaries. However, it seems that the political aspect is the determining variable, as shown by the examples of the Canary Islands, the Valencian Community and Madrid. These regions are governed by the PP alone or in coalition with other political forces and have the lowest beneficiary rates of all regions and at the same time very high urbanization rates. Finally, pension income does not seem to influence the recognition of beneficiaries.

Rate of financial benefits for family care

The correlation between the rate of financial benefits for family care and the urbanization rate, unlike the relationship between the urbanization rate and the financial

benefit rate, is practically non-existent. But there remains a strong negative correlation between financial benefits for family care workers and the average pension income.

Table 13
Correlation between the rate of financial help for family care and the socio-economic variables

	Ageing rate	Urbanization rate	Family care worker rate Women aged 45-64 / total population	Social health employment rate / population (1)	Social health employment rate / population ≥ 65 (2)	Company rate (NACE 87)	Company rate (NACE 88)	Company rate (NACE 87+88)	Average pension (2009)	Household expenditure (2009)
Correlation	-0.14	**0.03**	-0.25	**0.06**	**-0.36**	-0.39	-0.07	-0.26	-0.37	-0.18

Source: Own based on data from SAAD and INE

Moderate negative correlations between (i) the rate of socio-health employment by people over age 64, (ii) the care company rate (with residences) and (iii) the average pension, and the rate of financial benefits can be seen. Also the rate of all care companies has a medium negative correlation with the rate of financial benefits for family care. The rate of social-health companies without accommodation, however, shows no correlation.

Political guided implementation

In short, this analysis of the relationship between beneficiaries, financial benefits for family care and social-economic indicators shows that the regional application of the LAPAD does not correspond to the characteristics of a socio-economic environment. This leads to the following tentative conclusions:

a) The regional development of the care systems depends more on the political than the socio-economic environment. Examples are the Canary Islands, the Valencian Community and Madrid, which are governed by the Popular Party alone or in coalition with another party and which have low performance indicators with no correlation to socio-economic indicators. The Balearic Islands seem to confirm this

hypothesis as they show very high growth in the beneficiary rate, which could be related to the change in government from the conservative Popular Party to a coalition government led by the Socialist Party.

b) The configuration of the regional systems with high rates of financial benefits for family care indicates that the LAPAD has not produced a paradigm shift in this part of the Spanish welfare regime but has maintained a high degree of familiarization in the care services. However, the law has brought about a change from familiarism by default to supported familiarism in the Balearic Islands, Navarre, Murcia and Aragon, where the rate of financial benefits exceeded 70% in 2010, and optional familiarism in other regions which have more moderate rates. The exception is the Community of Madrid, which combines one of the lowest beneficiary rates with an almost exclusive orientation towards the provision of services.

We also observed correlations between the configuration of the SAAD and the level of pensions as well as household expenditure per person. These correlations do not include the beneficiary rate, but only the rates for general financial benefits and financial benefits for family care:

a) There is a medium negative correlation between the regional pension average and the rates for financial benefits in general and financial benefits for family care. This means that Communities with higher pension incomes tend to have more services than financial benefits.

b) We observe a positive correlation between the regional average pension and coverage of social service employment for the total regional population and a strong positive correlation with the coverage of social service employment for the population over age 64. This means that Communities where retirees have a higher income level tend to have better coverage of social services employment.

c) There is a strong positive correlation between the regional average pension and the company rate and also the service sector with accommodation as well as the sector without accommodation, and therefore also with the whole. This means that in regions where retirees have a higher income level, there are more companies that provide care services.

The three results are consistent. Regions with a higher average level of pension income and a higher level of household expenditure have better care service infrastructures in terms of employment and companies. This makes it easier for these regions. Given the fact that these differences in living standards between Autonomous Communities still exist when the new Acts has been approved, it can be concluded that living standards and therefore the existing infrastructure have had a decisive influence on shaping the care service system, and this has brought about lower financial benefit rates in these communities. However, the overall development of LAPAD rates measured in beneficiaries does not maintain a correlation with the living standard, which again confirms the theory that political ideology influences the implementation of the LAPAD. This is why the rate of financial benefits in these Communities is lower compared to the other regions. But the general application of the LAPAD – measured in beneficiary rates – does not show a correlation with living standards. This again confirms the hypothesis that political ideology influences the application of the care service act.

Table 16: Correlation of the SAAD with socio-economic indicators of the Autonomous Communities

	Beneficiaries with benefits as a % of pop. ≥ 65	Financial benefits	Financial benefits for family care	Ageing Rate of the Autonomous Community Population ≥ 65 as a % of total autonomous community population	Degree of urbanization	Health and social services employment per total population	Health and social services employment per population ≥65	Company ratio per inhabitant ≥ 65*1000 (NACE 87)	Company ratio per inhabitant ≥ 65*1000 (NACE 88)	Company ratio per inhabitant ≥ 65*1000 (NACE 87+88)	Family carer rate (1) (ratio women aged 45-64 /total population ≥ 65	Density of family carers (4) (ratio No-employed aged 45-64/total population ≥ 65	Average pension (2009) (€ month)	Annual household expenses goods and services (2009)
		%	%	%				Nº	Nº	Nº			In €	In €
Spain	**0.0702**	**0.560**	**0.490**	**0.166**	**0.789**	**0.0079**	**0.0472**	**0.653**	**0.634**	**1.287**	**0.124**	**0.065**	**754.06**	**11.801.37**
Andalusia	0.1272	0.472	0.454	0.148	0.797	0.0056	0.0378	0.522	0.612	1.134	0.118	0.074	693.53	10.724.76
Aragon	0.0815	0.854	0.653	0.196	0.683	0.0099	0.0504	0.943	0.564	1.508	0.124	0.056	780.79	11.821.40
Asturias	0.0474	0.591	0.492	0.218	0.865	0.0087	0.0396	0.920	0.380	1.299	0.148	0.081	903.27	12.055.94
Balearic Islands	0.0458	0.725	0.681	0.137	0.836	0.0045	0.0327	0.406	0.619	1.025	0.120	0.057	683.40	12.750.10
Canary Islands	0.0262	0.560	0.550	0.130	0.894	0.0039	0.0302	0.458	0.374	0.832	0.121	0.073	708.27	10.046.51
Cantabria	0.1070	0.637	0.637	0.184	0.673	0.0077	0.0418	0.536	0.675	1.211	0.135	0.075	784.35	11.488.46
Castile & Leon	0.0694	0.640	0.408	0.224	0.562	0.0099	0.0444	0.895	0.423	1.318	0.127	0.066	731.42	11.436.32
Castile-La Mancha	0.0819	0.564	0.517	0.176	0.545	0.0084	0.0477	0.730	0.331	1.061	0.109	0.066	702.46	9.890.11
Catalonia	0.0749	0.674	0.562	0.163	0.814	0.0100	0.0614	0.853	0.755	1.607	0.123	0.056	777.76	13.152.04
Valencian Com.	0.0353	0.539	0.469	0.164	0.829	0.0027	0.0328	0.437	0.423	0.859	0.124	0.065	691.18	11.214.03
Extremadura	0.0664	0.623	0.433	0.190	0.492	0.0054	0.0341	0.559	0.540	1.098	0.118	0.071	642.06	9.146.30
Galicia	0.0502	0.654	0.599	0.219	0.686	0.0065	0.0265	0.333	0.526	0.860	0.133	0.065	629.85	11.010.85
Madrid	0.0346	0.197	0.184	0.144	0.942	0.0058	0.0747	0.722	0.885	1.606	0.126	0.059	892.78	13.701.88
Murcia	0.0800	0.851	0.809	0.137	0.955	0.0108	0.0346	0.253	0.517	0.770	0.109	0.061	664.36	10.301.16
Navarre	0.0755	0.788	0.623	0.173	0.547	0.0047	0.0722	0.625	1.562	2.187	0.123	0.058	849.52	13.654.47
Basque Country	0.0825	0.447	0.416	0.189	0.803	0.0125	0.0644	1.021	1.157	2.178	0.140	0.071	938.44	13.584.20
La Rioja	0.1074	0.530	0.450	0.180	0.633	0.0121	0.0355	0.431	0.673	1.104	0.120	0.057	719.75	11.139.70
Variance coefficient	**39.8%**	26.1%	26.7%	17.0%	19.9%	39.3%	33.4%	37.6%	48.3%	33.5%	8.0%	11.9%	**12.5%**	**12.0%**

Source: Own based on data from SAAD and INE

The diversified modernization of the Spanish welfare regime

In our analysis, we examined first the impact of the new act on the Spanish care labour market and second whether the regional configuration of the care service systems is due to the specific characteristics of each region. This leads to the following tentative conclusions:

a) The impact of the new Act on the labour market in terms of the creation of employement laid considerably behind the forecasting made in the preparation of the act. This diference is probably linked to the unfulfilling of the legal disposition of the act, which gives priority to services instead to financial benefits. However, the care labour market is one of the sector, which best resist the serious financial and economic crisis.

b) The orientation of the SAAD towards financial benefits, especially for family care, introduces a new aspect in the labour market analysis as it recognizes part of (female) work in the home as paid work through special social security arrangements for family care workers. This is creating a new labour market segment in the care sector: the family labour market. However, the low level of controls made on the use of financial benefits in combination with the low rate of family care workers affiliated to social security seems to indicate an informalization of care services. We therefore observe increasing labour market segmentation depending on the degree of formalization of work: informal family care, formalized family care, informal care services (informal or hidden labour market) and formal care services.

c) The development of regional systems depends more on the political will of the regional governments than on the socio-economic environment. The best examples are the Canary Islands and the Communities of Valencia and Madrid, governed by the Popular Party alone or in coalition with another party. The Balearic Islands seem to confirm this hypothesis given the high growth in the beneficiary rate after the change of government from the conservative Popular Party to a coalition led by the Socialist Party.

d) The configuration of the regional systems with, in general, high rates of financial benefits, especially for family care, indicate that the new Act has not brought about a paradigm shift toward professionalization in this part of the welfare regime. The

Spanish welfare regime maintains a high level of familiarization of care services. However, the Act has brought about a change from familiarism by default to an optional familiarism in those Communities where financial benefits exceeds 70% of all benefits, and opens the possibility of evolution into an optional familiarism in those Communities that show a more moderate rate of financial benefits combined with a high beneficiary rate. The exception is the Community of Madrid, which combines one of the lowest beneficiary rates with an almost exclusive orientation towards services. Therefore Madrid can be considered as the paradigm of a Community that follows the logic of the familiarism by default.

e) The development of regional care service systems – measured by the rates of general financial benefits and financial benefits for family care – has been dependent until now on the level of material well-being of the older population in the Communities. Higher living standards – measured in pension income – had contributed to the development of better infrastructure services in terms of employment and business structure even before the new Act was approved. This means that in these Communities the care systems tend more towards services than in other communities. However, we must insist that the overall development of the LAPAD – measured by the ratio of beneficiaries – has no correlation with living standards. This again confirms the hypothesis regarding the strong influence of political ideology on the implementation of the LAPAD.

f) The way the new Act is applied indicates a double trend in the Spanish welfare regime: a) a gradual abandonment of the traditional model of familiarism by default for a model of supported familiarism with higher state involvement, and b) a greater diversification of the Spanish welfare regime, which could lead to a situation where it would be difficult to continue talking about a single Spanish welfare system, but about an internally diversified regime. Statistical data available from the SAAD covering the period from June 2008 to April 2010 shows the existence of three blocks of Autonomous Communities with different implementation processes. The first block shows higher rates than the Spanish average, and the growth of these rates is also generally higher. The second block shows rates below the Spanish average, also with slower growth. Then there are the communities that cannot be included in either of these two blocks. It can also be seen that the differences between Autonomous Communities have remained stable in the course of the

implementation of the LAPAD and that the gap between Communities tends to become consolidated over time.[17]

g) These results suggest that the Spanish welfare regime tends towards internal diversification. We do not want to reduce it to two distinct models, but to a continuum of sub-models which at one end has the Community of Madrid opting for a low level of state involvement and delegating services to families following the traditional lines of the Spanish welfare regime, and at the other end Andalusia, which has the highest coverage rate of all the regions, combined with a relatively low rate of financial benefits. Above all, the differences between regions regarding the rate of financial benefits indicate that we cannot speak only of two sub-models. There are some regions opting for a gradual shift towards a model of supported familiarism (those with a high rate of financial benefit for family care) and others opting for a model of optional familiarism (with lower rates of financial benefits). However, the public budget constraints imposed by the current government as a measure to combat the financial crisis could again alter the scenario, as is also reflected in public debate.

In the introduction we asked to what degree the LAPAD had brought about changes in the Spanish welfare regime. We reject the idea that it has caused a paradigm shift in social policy in the sense of having provided a step towards formal commoditization, i.e. greater professionalization of the care services. Our analysis indicates that familiarism by default tends to disappear in the medium term, and therefore we have limited the changes in the regime to two options: a) supported familiarism and b) optional familiarism.

In fact we observe supported familiarism in most regions, and optional familiarism seems even more of a long-term policy option now that it is faced with severe budget restrictions. Also it seems a viable option only in those Communities, which even

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[17] This trend is accompanied by a gradual reduction in the percentage differences between the regions in respect to the Spanish ratio or the variance coefficient. But at the same time it slightly increases the numerical difference between maximum and minimum rates. For 2008, it would be possible to explain these regional differences by their different capacities to respond in time to the passing of the Act, but this does not explain the regional differences still existing at the beginning of 2010.

before the new Act was passed had an infrastructure of care services, but even in these cases we noticed no decisive steps in this direction.

To complete this brief survey of the evolution of the care service system, we look at the future implications of the two predicted system trajectories. Both will mean changes to the previous care service system. Supported familiarism implies the economization of the system in the sense that it encourages family care work, while optional familiarism opens the way towards greater professionalization of the system.

Both trajectories will require sufficient financial resources that involve greater investment than the familiarism by default model. It can be assumed that, due to professionalization, optional familiarism will need even more financial backing. The step towards optional familiarism also requires a basic infrastructure to provide services to dependent persons, which includes specialized enterprises and qualified human resources.

	Supported familiarism	**Optional familiarism**
Characteristics	Economization	Professionalization
Precondition	− sufficient financial resources	− sufficient financial resources − basic infrastructure − human resources
Effect on the sector	− low growth of formal services − high level of family care and informal care	− moderate growth of formal services − high rate of family care and informal care
Effect on the labour market	− low professionalization level − low qualification level of care workers − low salaries − unstable labour conditions	− increasing professionalization − increasing qualification level of care workers − increasing salary levels − more stable labour conditions in certain aspects
Effect on the system	− low cost system − low service quality	− moderate cost system − moderate service quality

Taking the current Spanish situation as a starting point, it can be anticipated that supported familiarism will have only a limited impact on the formalization of the care service sector and on employment due to the high rates of financial benefits for family care and the low level of checks on their use. Based on our analysis, we can conclude that Communities offer a high rate of financial benefits due to their lack of basic service

infrastructure, but the orientation of their care systems towards financial benefits in turn hinders the development of an infrastructure of public and private services.

However, the optional familiarism model can provide a moderate growth of formal services, probably not in the residential sector but in the service sector without accommodation (day centres and home services). As we suggested earlier, it is more likely that optional familiarism will develop in those Autonomous Communities that already have a basic infrastructure.

In the case of supported familiarism, the impact on the labour market would be consolidate a low level of professionalization with low-skilled carers (family care workers and care workers in the informal labour market). This model will be characterized by a minor segment in the formal labour market with moderate wages and a major segment in the family and informal labour market with low wages. Working conditions tend to be very unstable.

In optional familiarism regimes, the formal segment of the labour market will be more important and implies a higher degree of professionalization of the sector in general and higher levels of qualification. However, the informal segment of the labour market remains strong with unstable working conditions. The system as a whole, however, will have higher wage levels and more stable working conditions.

In short, the supported familiarism regime is a low-cost, low-quality care service system, while the optional familiarism regime is characterized by moderate costs and moderate quality of care services with a margin for upward development that means higher costs and better quality of services. It should be noted that in the optional familiarism regime, families opting for services normally do not refrain from providing care to their family members, but complement professional care services with care tasks of higher emotional significance.

Given the current budgetary constraints of the Spanish central state, autonomous regions and municipalities, it can be expected that the Spanish welfare system will follow the path of supported familiarism, i.e. the system involving low cost and low quality of services. In this case the key to system development is the family care workers and their qualifications. This implies a) that the political authorities have to improve monitoring of financial benefits and must insist that, where possible, family care workers should become part of the special social security agreement. This also

means b) that the system should provide flexible training to family care workers to give them the skills to do the job. Due to the fact that family care workers are mostly women over age 40, a group characterized by their low level of participation in the labour market, a set of measures to solve the above-mentioned problems could be a) to improve the socio-economic situation of these women as regards in face of retirement, b) to open up opportunities in the formal labour market by introducing flexible mechanisms to recognize professional experience, and c) to contribute to the training of qualified human resources, which are necessary for the transition to optional familiarism.

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The Intricate and Uncertain Future of the Labour Market in the Dutch Health Care Sector, more in particular as regards long-term care

By Erik de Gier

Introduction

Seen from a comparative perspective and in hindsight, Dutch labour market policy has performed extremely well since the 1990s. After experiencing high unemployment figures above the level of 10 percent of the active labour force in the 1980s, from the 1990s onward figures went down substantially towards 5 percent or even lower. This low unemployment level has been maintained until today despite the advent of the Great Recession in 2009. This development has taken the Netherlands into the relatively small league of best European performers, traditionally consisting of the Scandinavian countries such as Denmark and Sweden. At this moment, the Dutch unemployment figure hovers somewhere between 4 and 5 percent.

Already in the 1990s in the Dutch economy problems arose with overheated labour markets in which available demand and supply didn't always match easily. Apart from quantitative shortages there were also substantial qualitative mismatches. To some extent, the Great Recession has eased these problems temporarily. However, it is foreseen that in a few years from now the Dutch labour market will experience comparable problems to the 1990s. The main reason for this is the revived growth of the economy in combination with massive exit from the labour market of the baby boom-generation in the upcoming years. Particularly those sectors of the economy where the labour market population contains many baby boomers will be hit.

One of the most important sectors in this respect is the Dutch health care sector. In this sector the average age of the workforce is comparatively high, that is above 47 years. Additionally, the ongoing ageing process of the Dutch population will spur additional demand of health services, both in a quantitative and a qualitative sense. But there are also some other relevant drivers, which induce the demand of health services, such as medical and technological developments and socio-cultural developments.

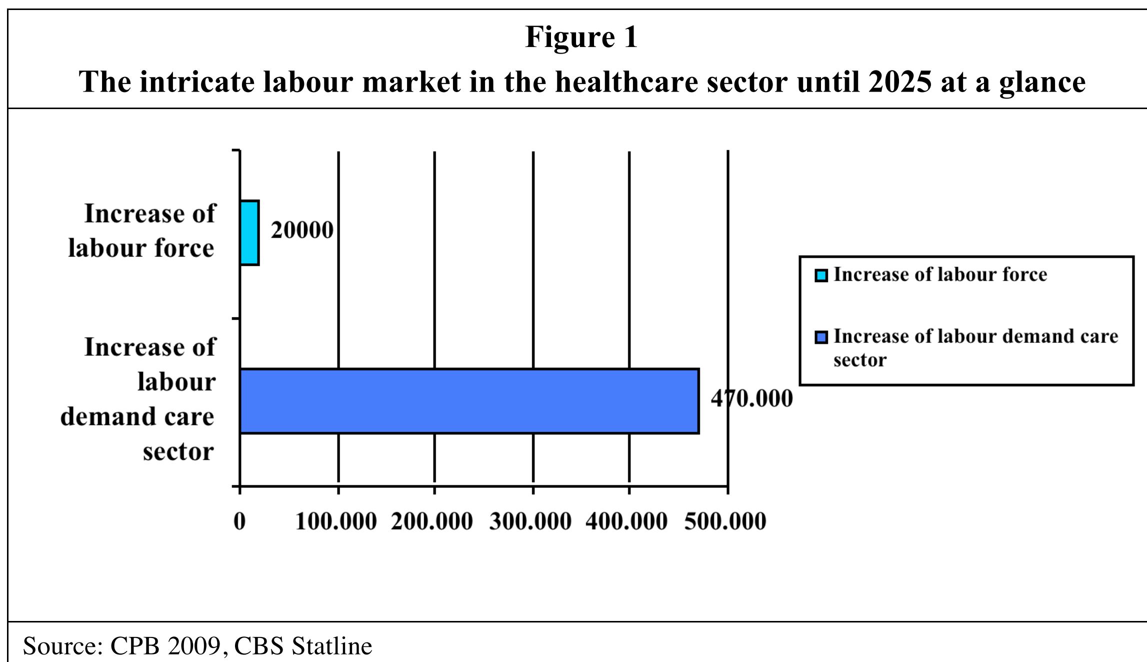
The main question to be answered in my contribution is how the health care sector could cope satisfactorily with this enormous challenge and what kind of impediments has to be overcome at both the national institutional level and the organizational level.

In the first part of my contribution I will elaborate on the main quantitative and qualitative aspects of this issue. Subsequently, in the second part I will shift my attention towards possible solutions. Finally, I will draw some conclusions.

The intricate Dutch health care labour market: quantitative and qualitative developments

According to a recent authoritative labour market prognosis there will be a shortage of approximately 470.000 workers in the Dutch health care sector in 2025. At the same time, the total increase of the Dutch labour force will not exceed 20.000 workers in the same period, 2009). This dramatic gap, illustrated in Figure 1, demonstrates the XL-size of the problem at once. First of all, it shows that the level of participation of the active Dutch labour force between 20-64 years is very high on average if compared with other European countries. It is actually above the level of 75 percent (77 percent in 2009), which is the objective of the in 2010 reformulated EU-Lisbon Strategy (European Commission, 2010). This implies that attempts to increase further labour market participation of the Dutch working population will not be easy and moreover, is definitely not going to solve the whole problem. Therefore, other solutions have to be looked after, such as productivity increases (Berkhout & Van den Berg, 2010).

Figure 1
The intricate labour market in the healthcare sector until 2025 at a glance



Source: CPB 2009, CBS Statline

Perhaps the numbers in Figure 1 are somewhat overstated. It depends to a large extent on which pre-suppositions the computations are based. However, it is quite certain that the Dutch health care labour market will have to master serious labour shortages, both in a qualitative and quantitative sense in the years to come.

Currently there are about 700.000 paid care workers, mainly nurses and home care aids. If we take a broader definition of care workers, including also staff dedicated to the well being of clients and patients, the number of care workers increases towards 1.3 million workers. Currently, this equals about 15 percent of the whole Dutch working population. In addition, informal workers, such as family members, neighbors and other volunteers, traditionally administer the bulk of care work. At this moment, there are 3.7 million informal carers that at least supply some care.

A closer look at the formal care labour market shows the following facts: Workers in the care sector are mainly female and work overwhelmingly part-time. Their average age is above 40 years. If we make a subdivision between cure and care labour markets, then the care labour market is the most aged. Additionally, the best-educated employees work in the cure sector, which entails hospitals and the less-educated employees work in the care sector made up by a number of caring institutions and residential homes for the elderly.

In a qualitative sense there is evidence that care workers are generally satisfied about the content of their work. However, growing work pressure is increasingly perceived as a problem. This is caused by almost continuous processes of rationalization of the work and the work organization in health care institutions. With respect to the future, 50 percent of the care workers expect a further increase of work pressure (Menzis 2010). The background of the continuous rationalization processes is the drive of many health care institutions to save costs and to increase productivity. On the long run rationalization will probably also go at the expense of traditional craftsmanship and professionalism of care workers and will equally reinforce neo-taylorist tendencies in the health care sector.

Another interesting fact is that on the average employees in other sectors are less positive about working in the healthcare sector than care workers themselves. For example, 90 percent of the care workers perceive the content of their jobs as nice and attractive, whereas only 57 percent of the remaining part of the working population has the same opinion. Also with respect to other work aspects, such as suitable working times, sufficient influence on the content of and planning of work and room for new initiatives in the work carried out, the remaining part of the working population is less positive on working in the care sector than the current care workers (Prismant and Motivaction 2009).

Asked for the most important bottlenecks in current care work employers experience as most important: recruiting staff (52%), managing work pressure (46%), lack of staff availability because of leave or holidays (41%), ageing staff (41%), absenteeism due to illness and/or employment of disabled people (33%) and wage costs (33%) (Prismant 2009).

To sum up, there is a huge future labour market problem in the Dutch care sector. The increase of future demand of health care services because of mainly demographic reasons, cultural developments and medical technological developments cannot be paralleled by a sufficient increase of labour supply in this sector. In addition, there rises not only a quantitative problem in terms of a big gap between demand and supply of labour. Likewise, a qualitative problem becomes visible that may also reinforce the quantitative problem. Continuous rationalization of work processes and work organization in healthcare organizations may go at the expense of the attractiveness of working in the care sector. This is particularly detrimental if we compare the care labour market with other competitive labour markets in the services sector. For example, the labour market in the educational sector is in many aspects comparable with the care labour market. Also in the educational sector the ageing process of the working population will put a high pressure on future demand of labour in this sector. In the short term many baby boomers will exit this sector and will have to be replaced by younger cohorts. In a context of tight labour market in the future competing for scarce labour supply between sectors will focus mainly on the quality of work. If the quality of work in the educational sector will be perceived by workers as more attractive than in the care sector many workers may decide not work in the care sector but in the educational sector.

How to solve the future labour market shortages in the care sector?

In this paragraph I will discuss which proposals have been put forward recently to solving the future labour market issue in the Dutch care sector. In addition, I will widen the scope to a broader array of possible measures and policies that might contribute to solving the problem.

By the end of 2009 on behalf of the government a group of experts related to the care sector published a report about the expected future shortages on the care labour market

and how to deal with it (Zorginnovatieplatform 2009). The group proposed four types of HRM-measures with respect to health care institutions.

First of all, health care institutions need to invest in life long learning. By this is meant effective and adequate continuing training and development of staff. The approach to be chosen needs to be flexible in order to prevent a potential clash between broad competences-oriented training and narrow job-oriented training.

As will be the case with the other measures proposed by the expert group, the responsibility for organizing of and investing in life long learning will not be uniquely an employer responsibility. Also the employee himself has to take some part of the responsibility to make the HRM-policies a success as well as relevant national, regional and sector actors such as the Ministry of Health, trade unions, professional organizations and training institutions.

The group of experts recommends to specify investment in life long learning into the following four more specific activities in behalf of all actors involved:

- Monitor staff needs of healthcare organizations systematically to coordinate it with trainers.
- Collaborate on improving the study and sector results of the initial healthcare training
- Invest more in traineeships
- Invest in training and development of employees
- Utilize experience through accreditation of prior learning routes

Secondly, the group of experts recommends using employment terms to benefit from diversity among employees in the care sector. As a matter of fact, this recommendation anticipates the increase of the need of flexibility on the employees' side. Differences in age, family situation and value patterns of workers require more flexibility with respect to employment terms, such as working hours, training and the size and quality of the job.

More specifically, the experts recommend:

- Remuneration in line with the market, combined with a scope for differentiation

- Harmonization of school and kindergarten opening times with the working and studying hours of parents
- To make leave-saving schemes more flexible
- To focus on the usability policy for all age groups, including working and learning of older age groups
- Establishing well-defined career paths for care and nursing staff

Thirdly, the experts recommend optimizing the work structure. This implies the structuring of work in accordance with the needs of individual employees by means of self-scheduling, self-management, reordering of duties, job differentiation and proper working conditions.

Finally, the experts recommend a fourth type of HRM-measures called policy-driven recruiting, particularly focused on workers working outside the healthcare sector. For example, deliberately focusing policies on target groups that are currently underrepresented in healthcare, such as ethnic minority groups may contribute to an increase of the supply of care workers. More in particular, the experts recommend:

- To revamp the healthcare sector's image and name as an area of employment
- To invest in creating knowledge for recruitment and selection
- To put energy into further strengthening regional collaboration

Summing up, the group of experts of the Zorginnovatieplatform puts forward a number of recommendations almost completely directed at the supply of labour to solving the future labour market shortages in the care sector. The experts realized that this would only solve part of the problem. Apart from more deliberate HRM-policies directed at current and future care and nursing staff also other measures have to be taken, mainly in the context of discouraging future demand of health services (cf. also Givan 2010).

Currently, it turns out that the Netherlands is already spending 3.8 percent of BBP on long-term care. If compared with a number of other European countries and the EU, this is by far the most. Only Sweden is spending a comparable amount of public money on long-term care. On average the EU spends in 2010 1.3 percent on long-term care.

Moreover, it is forecasted that the public cost of long-term care in 2060 will rise in the EU to 2.4 percent on average and in the Netherlands to 8.1 percent (Gradus & Van Asselt 2011; European Commission 2009).

The main difference between the Netherlands and countries such as Germany, France, Belgium and Denmark is that the collective Dutch healthcare system includes less incentives stressing personal responsibility and in addition offers less individual choices. For example, the German system for long-term care, the so-called ' Pflegeversicherung' (1995) is mainly focused on living at home of the elderly as long as possible. At the same time the Pflegeversicherung contains strong incentives towards informal home care by family members and therefore evades a big claim on professional care (Gradus & Van Asselt 2011).

The experts of the Zorginnovatieplatform refer in this respect to matters as adapting the existing legal health insurance scheme, prevention, independent living of patients, labour-savings innovations and a more outstanding role for informal care. Interesting in this respect are calculations made by the experts of the long-term effect of alternative solutions. These calculations are summarized in Table 1.

Table 1
Example calculations of the long-term effect of alternative solutions

The more than 900.000 part-time care workers work on average 2 hours longer each week	Creates 75.000 additional jobs
Older health care workers retire 2 years later on average	Produces equivalent of 50.000 additional jobs
Increase of share health care labour market from 13% to 15%	Produces equivalent of 175.000 additional jobs
Annual increase of productivity of 1%	Produces equivalent of 115.000 additional jobs
Increase of independent living reducing with 10 % entitlement of health care insurance (AWBZ: Exceptional Medical Expenses Act)	Saves 90.000 jobs
Total number of jobs produced	Approximately 500.000
Source: Zorginnovatieplatform 2009	

At least in theory these computations demonstrate that the forecasted shortage on the care labour market by 2025 of approximately 470.000 workers is solvable by a

combination of intelligent supply and demand oriented policies. However, at the background rises another big potential issue, which will probably complicate the resolution of the future labour market shortages in the health care sector. This concerns the question of rising costs and who is going to pay for these.

Increasing costs of healthcare and its possible consequences

Until today the largest part of healthcare delivery in the Netherlands is financed by public means. As a rule, patients are obliged to pay premiums for the two existing collective health care regulations ZVW (health care insurance) and AWBZ (long term care insurance and excessive medical expenses)[18]. The ageing process and the expected growth of chronic diseases of the elderly will contribute to further increases of premiums. Likewise, medical-technological developments and socio-cultural developments will put further upward pressure on health insurance premiums. Finally, also the package of HRM- and labor market measures as proposed by the Zorginnovatieplatform will contribute to a further increase of the costs of collective health care in the Netherlands. Therefore, a more fundamental question with regard to how much money Dutch society is willing spend on future health care has to be answered urgently.

Despite the fact that health and the quality of healthcare by a majority of the Dutch population are estimated as the most important private and public goods it can be expected that there are limits to permanently rising health care premiums. For example, instead of contracting more collectively paid workers in the healthcare sector as well as increasing the supply of health care services, also a scenario of privatization of a substantial part of the current collective health care system is a real possibility. If that occurs future access and the average quality of health care provisions will become

[18] Currently the AWBZ-premium individual earners have to pay amounts to approximately 12 percent of gross personal income. In order to contain a further growth of this premium the government excluded a few years ago home care from the AWBZ and decentralized it to the municipal level by means of a new regulation (WMO). As a consequence, home care became less expensive because from that moment on less professional and therefore cheaper workers deliver home care. Another relevant cost containment policy of the Dutch government is the reinforcement of demand steering over supply steering by stimulating the usage of personal budgets by patients and clients.

strained, at least potentially for large groups in Dutch society. As a consequence, social inequality could rise (De Gier 2010a).

In order to prevent the incidence of this unattractive future scenario the Dutch advisory National Health Care Council (RVZ) has suggested recently a big cultural change in the coming ten years encompassing a structural move from 'sickness and care' towards 'health and behavior' (RVZ 2010). In particular, the council anticipates the expected strong increase of chronic diseases between 2010 and 2020 and proposes that both care supplier and patients jointly manage this problem. More concretely, the RVZ perceives:

- A substantially increasing, but principally changing health care demand
- An increase of medical treatments and knowledge about this by the general public
- A critical healthcare consumer and citizens searching for health
- At the same time, a double break on this growth potential. This includes the care labour market as well as the budget available for heath care.

Other indications pointing into the direction of future privatization and reductions of public spending on health care are a number of reports produced on request of the government by responsible civil servants in which possible reductions of public health care spending up to 20 percent of total are put in a row (Rapporten brede heroverwegingen 2010). On the whole, three reports were produced on cure, care and mental health care. The authors not only paid attention to reducing public spending on health care, but also developed proposals with regard to a more efficient organization of long-term care. Taken together, all three reports propose:

- Reduction of public health care spending by increasing own contributions of the insured and limiting the supply of collectively financed provisions
- Reinforcement of privately financed health care
- Increase of self-management of clients and patients
- A further substitution between professional and informal care
- Increase of efficiency of the healthcare system and health care services (Rapporten brede heroverweging 2010).

Despite the fact that the current government didn't explicitly formulate specific quantitative targets yet with respect to reducing public health care spending in the short term it can be expected that the proposals put forward by the RVZ and the civil servants will largely be implemented in due course.

A viable alternative approach

Seen the enormous future challenge for the Dutch care labour market it seems sensible to search also for solutions of this issue outside the narrow domain of in-company HRM-policies. Contrary to most other labour markets the care labour market can also be considered as a combination of a formal and an informal labour market. Traditionally much of the care work is not only accomplished by paid employees, but also by a large group of informal carers. Theoretically both labour markets could be enlarged or diminished. The basic idea behind it is a sort of communicating vessel. At the same time, patients and clients themselves could carry out a larger part of the care work by enlarging their own personal responsibility. In that case, a more outstanding role for self-help, all or not with support of modern technology and/or professional support, becomes important (De Gier 2010b).

The basis of the alternative approach is the idea that both workers and clients/patients need to dispose of the right combination of capabilities. Capabilities are individual skills and competences that allow workers and clients to participating in an acceptable way in society. In case of workers this points towards optimizing the employability and in case of clients and informal carers this deals with empowerment.

Employability can be realized by the implementation of active labour market policies and the implementation of transitional labour market policies oriented on the whole lifetime professional career. It contains, for example, the following aspects: work security instead of job security, education and training, mobility, making so-called 'good transitions' on the labour market from unemployment to employment, quality of work, working smarter, age-specific HRM-policies, work-private provisions.

Empowerment, on the other hand, offers the right conditions to informal carers and clients to carry out caring activities more effectively and to get a better grip on their own personal situation and environment. Empowerment entails amongst other aspects: care-ability of informal carers and clients, volunteer-ability, self-care of clients, remote

care with the support of modern technology (internet and videophone), new family networks and care of elderly people for the elderly.

There is evidence that both the formal and the informal care labour markets will be tight in the future. For example, the number of available informal carers will shrink because of demographic and formal labour market reasons. Traditionally, the bulk of informal care is given by women, which mostly carry out paid part-time work. In the context of future labour market shortages the official active labour market policy of the Dutch government also implies stimulating women to making transitions from part-time work to full-time work. As a consequence, less room remains for giving informal care by women. Therefore, other categories of citizens, such as the elderly, have to be stimulated to substitute at least a part of the informal care role of women. Another and perhaps smarter solution is to link organizational HRM-policies of caring institutions with taking care by these institutions at the same time of the informal carers and self-helpers in the direct context of these institutions. Apart from dovetailing professional care work and informal care work, part of the organizational HRM-policies could in that case also become available to the linked informal carers. For example, available training facilities of health care institutions would also become accessible to informal carers and voluntary workers.

Conclusion and debate

There is evidence that the future Dutch care labour market in 2025 will be extremely tight from a quantitative viewpoint. This is caused by demographic and economic developments.

This problem will be reinforced by an increasing pressure on the quality of work and working conditions in this sector. Particularly, continuously increasing work pressure will become a problem. Moreover, traditional professional craftsmanship of care workers will erode. Put into perspective, working in the care sector will lose some of its attractiveness in comparison with working in other parts of the services sector. As a consequence, attracting new and replacing labour supply will not be the only problem the care sector will meet. Also, retaining the existing work force seems to become problematic, mainly because of increasing work pressure and the loss of traditional craftsmanship of caring professionals. Instead, neo-taylorist tendencies will contribute

to the development of a so-called ‘Fordist model of medicine’. Therefore, it is recommended by experts to develop timely competitive strategic and comprehensive HRM-policies, of which lifelong learning programs have to be an important part. This will not fully solve the issue. Additional policies will be required, combining labour market and HRM-policies with a substantial discouragement of healthcare services demand.

Discouragement of healthcare services demand in principal is a delicate matter. Either it could focus primarily on productivity increases, privatization of healthcare and increasing own contributions in case of services of entitled persons or, alternatively, it could focus primarily on a smart and dynamic exchange of the formal and the informal care labor market. This includes a larger role of self-help of clients and patients. In the first case the risk of increasing social inequality in Dutch society will be evidently larger. In the second case, there is a need of developing comprehensive employability and empowerment policies of workers, informal carers and patients/clients themselves. Also, support of appropriate medical technological devices and appliances is required.

In sum, it turns out that the Dutch care labour market is in fact an expression of a delicate and dynamic demand and supply balance of formal carers, informal carers and self-caring of patients and clients. An ageing and shrinking labor force, which results in a gradual decrease of labor supply, doesn’t exclusively cause this. Another important factor is the ageing of the population itself that will generate a further and at the same time more diverse and complex demand of healthcare services. In 2010 there were 2.5 million citizens over 65 years of age and 640.000 over 80. In 2025 these numbers will have risen to 3.7 million people over 65 and 910.000 over 80.

In the near future this demand and supply balance will lead to a further substitution of formal carers by informal carers and likewise, to a re-institutionalization of the role of the (extended family) in Dutch society. Already at this moment the number of informal carers by far exceeds the number of formal carers. In 2010 there were about 700.000 formal care workers, which equals approximately 8 percent of the total Dutch working population and 3.7 million informal carers. In 2025 the number of formal carers has to rise from currently 15 percent until 22 percent of the whole working population. Considering the already tight labour market in the Netherlands, the question is if this will be feasible. Therefore, it becomes extremely important to increase both the

employability of care staff and the empowerment of patients, clients and informal carers.

Increasing the employability of care personnel entails the following:

- Permanent investment in lifelong learning activity
- Introduction of new and more horizontal forms of work organization
- A re-valuation of professional craftsmanship of care workers
- Introduction of innovative management and leadership styles, work organization and work processes
- More attention to the work-life balance of both formal and informal care workers

Subsequently, empowerment of informal carers as well as of patients, clients and informal carers can be realized by:

- Prevention of chronicle diseases of the elderly
- A more intensive and extensive use of positive financial incentives
- An increase of supply of combined formal and informal care
- Extensive use of supportive and labour saving applied technology
- Systematic attention in HRM-policies of health care institutions to the involvement and development of informal carers
- On the long run a cultural shift from “sickness and care” towards “health and behavior” (RVZ 2010)

At the background remains the risk that nor the proposed trade-off between formal and informal care will not solve the whole problem. If that happens to be the case the risk of a dual labour market in the care sector will rise as well as the risk of a social division in the supply of care. In that case privatization and higher own contributions will become more predominant.

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“New Work” in the health economy[*]

By Michaela Evans

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Introduction

A look in the past shows: The healthcare industry is the "secret hero" of the reorganization of the German economy to a service and knowledge economy. Altogether, investments into the health care system are regarded as one of the most effective instruments of economic development. Work and employment in the healthcare industry do not only contribute to value creation but provide a supply and health infrastructure which protects the manufacturing conditions of other economic sectors. About five million people are currently employed in the German health economy. This sector has a turnover of about 260 billion € (own calculations: Institute for Work and Technology, 2010). Future prognosis assume further revenue and employment profit in the upcoming years. Development drivers are particularly the demographic change as well as the increasing demand for health-related products and services and the medical technological progress.

At present, problems and strategies for attractive and future safe employment in the health economy are discussed in various ways in the scientific community and the world of media. The spectrum of topics reaches from qualified employees in care and medicine to necessary reforms in education of central health professions. Reports about insufficient working conditions or use of "temporary work" in health service are other topics being discussed.

Challenges for labor market and personnel policy

For the health economy special challenges arise, since:

- Competition for qualified employees will increase both within the health economy as well as in competition to other industrial areas,
- increasing demand for health-related work is already confronted with a deficit of qualified employees,
- demographic development leads to an increasing staff age,
- structural radical changes require customizations of professional qualifications,
- qualificationary and competence based needs are accompanied by a differentiation and specialization in health-care related jobs,

- partially unsolved roles contribute to functional assignments and other job perspectives,
- having partly unsolved roles, function assignments and professional prospective trends the consequence.

For a social health economy, particularly the interaction of regional supply design, securing the supply of specialists and qualification development is a main focus. In order to promote the health care sector as a source for social innovations the question at hand is how employment and qualification contribute to the interaction of scientific, technological and organizational progress.

The search focuses especially on strategies that contribute

- to secure sufficient future workforce in the sector as a whole as well as in institutions and regions,
- to provide tailored qualifications to meet current and future challenges in Medicare,
- to promote a mixed skill and skill-oriented use of labor and thus contribute to greater job satisfaction, quality and cost,
- to keep professionals of the health industry on the job as long as possible to allow a life phase-oriented work environment,
- to attract new target groups in the labor market to work in the industry and offer them interesting qualification, employment and income prospects,
- to identify potential design challenges in the industrial relations system in order to find conditions and constraints in implementing the previously mentioned points.

A particular challenge of the modernization process is to take patients and users of health related products and services along and to put them at the center of innovation activity.

Data and facts for the occupation in health professions

- From the year 2000 until 2009 the "health and care professions" have shown an increase of 13 percent in socially insured employment. Every tenth socially insured employee works in a health profession. The share of part-time employment in the "health and care professions" is currently about 32 per cent. The analysis of the employment effects shows that a not insignificant part of the occupation growth during the last years can be led back to the increase of part-time jobs and marginal occupation. Part-time jobs increased by 60 per cent, marginal occupation by 34 per cent between 2000 and 2009. Altogether, in June 2009 862.000 people had marginal jobs in the health and nursing sector, further 239.000 were employed part-time.
- The high importance of part-time employment for women can also be seen in the health and nursing sector. So the share of the women in part-time employment in all part-time employed ones was about 86 per cent in the service sector in June 2009. In the health and nursing sector the share with 92 per cent is even higher and thus reflects the high importance of women in this line of business (Federal Agency for Work 2010).
- Particularly in the area of home care the marginal occupation plays currently an important role (Federal Agency for Work 2010). The development of part-time job and marginal occupation has to be analyzed critically from a perspective of the social health economy. Although new job (re-)entry possibilities can arise in the health economy (e.g. being created for women after the family phase). There exists, however, the danger on the other side that health work transports precarization, decrease in professionalism and decrease in qualification into the health economy.
- The employment situation of the health economy is still indicated by sex specific disparities. About 83 per cent of the industry's workforce is female. It is therefore an important employment field for women. There are vast differences in the share of female occupation between single professions and occupational groups, though. While for example the women's share in the profession "receptionist" is about 99 per cent, it is considerably lower in the technical and

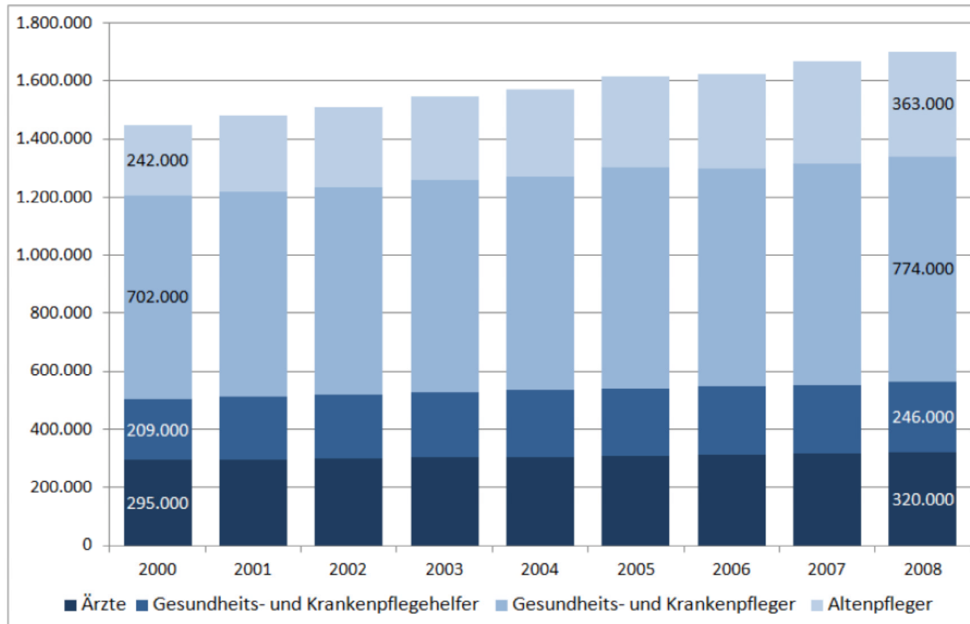
manual oriented health professions (e.g. tooth technology) with about 56 per cent.

- Despite the partial trend towards the "feminization" of work (e.g. medicine), there are deficits in the health economy, for example concerning female career courses or the role of women in leading positions (Sewtz 2008).
- The report of the advisory council of experts (2007) shows, that the age distribution of employees in the area of "health and care" with a social insurance is heterogeneous. Only 10 per cent of the employees in the health sector are "55 or older", at present 15 per cent is "younger than 25 years". Furthermore a decrease of employment can be seen at the "25 to 39-year", among other reasons this one can be explained with parental leaves (Federal Agency for Work 2010).
- Particularly female re-entrants and job returners represent one interesting target group and resource of employment, which until now is hardly noticed by the facilities. (Federal Agency for Work 2010). A considerable need for action stands out from the perspective of the social health economy here in view of exact labor market strategies as well as of the design of family-orientated framework conditions (e.g. supporting benefits for caring members).

The analysis of the employment situation from the years 2000 until 2008 (Figure 1) shows a significant increase for both the medical staff, health and care nurses, care helpers as well as old people's nurses (Isfort/Weidner 2010).

For a subtly differentiated employment discussion of the health economy, the development of unemployment is of further importance. Unemployment declined by 30 per cent in the complete service sector of the health industry. The nursing sector alone shows an even steeper decline at about 32 per cent between 2005 and 2008. Another decrease of unemployment by about 6 per cent can be seen in the subsequent year. In the first half of 2009 8.200 nurses and midwives were unemployed. In the second half of 2010 this figure further decreased to 6.800. Overall this is a 17.0 per cent decrease and an unemployment rate of about 1.1 per cent. For "nurses and midwives", this can be described as a situation of full employment.

Figure 1
Employment by occupation (2000-2008)



Source: Isfort / Weidner 2010
Translation Note:
Ärzte -doctors;
Gesundheits- und Krankenpflegerhelfer -Health and Care Nurses;
Gesundheits- und Krankenpfleger - Health and Care Professionals;
Altenpfleger - Old people's welfare

For the profession of the "old people's nurses/geriatric care helpers" there is a different situation. 34.300 persons were unemployed nationwide in the 1st six months of 2009. Their number increased to 39.500 in the 2nd six months of 2010, which is an increase of about 15.1 per cent. On the basis of existing data no statements can be made about which qualification steps in the employment field "geriatric care" are affected by the outlined effects: The following considerations could be target of a deeper examination and will most likely play an important role:

- Due to increasing requirements of (multi-morbidity, chronic and degenerative syndromes, late entrance in the stationary old people's welfare) qualifications in health care and nursing geriatric care experts are increasingly under pressure to meet the same qualification standards. Partially a replacement of geriatric care experts with well qualified nurses and other healthcare professionals can be seen.

- A replacement of uneducated and unqualified employees in supporting jobs with higher qualified personnel is eminent. The increasing specialization and differentiation of health-care has contributed to this trend of qualification. This leads to a de-qualification of supporting jobs in health care. Lower level qualifications therefore do not automatically lead to employment.
- The facilities and enterprises of the healthcare industry are not prepared for the increasing distinction and specialization of the professions and qualifications in personnel progress, process and organization design. In principle, the available qualifications (care expert work, helper qualifications, care helpers) are needed. There is however uncertainty about concrete roles and possible areas of work in the specific institutions
- An unordered modernization to the facilities and enterprise is confronted with an unordered modernization of the vocational training and the qualification development of the healthcare industry. This problem grows even stronger because of a "missing match" in the organization of supply and demand of available health qualifications on the regional labor markets.
- Current studies point out, that frequently nemployed persons often switch to the geriatric care profession (Voges 2002). It would have to be checked in detail whether different sorts of employment and deviations can be copied into dependence of professional previous experiences, the qualification step and the local/regional labor market situation in the operational/professional residence time.

Problems of the qualified employee extraction and safeguarding

The great interest of society concerning employment qualifications and demand for highly skilled personnel is due to the characteristics of the work being done in health care: Health care concentrates on personnel-intensive service whose availability and quality is vital to everyone.

The current debates do not draw any coherent picture of the future of the health work. Positive occupation forecasts for the work in medicine and care meet reports to acute difficulties of the qualified employee extraction. It is, that 50.000 nurses are missing

around in the old people's welfare currently (Pointed out to Employers' Federation care 2010). Moreover, they point out that the care defect has reached such a critical dimension in hospitals already (ver.di 2010) that even basic care benefits could not be guaranteed any more. Not included by the official statistics are around 70.000 to 100.000 East European domestic helpers perform care activities in German households (Isfort/Neuhaus 2010). Also has to be asked how the nationwide fall in the education numbers lets in view of the need for care work increasing socially explain themselves in the past (2000 to 2008) (Isfort/Weidner 2010)?

The statistical Federal Office in 2010 has presented a projection to the manpower requirements and supply in care professions up to the year 2025. Basis of the prognosis is the “Mikrozensus”. It illustrates the whole employment force according to profession, sector, qualification level, age and sex. First year of the projection is the year 2005. The forecast is based on subtly differentiated scenarios for the development of hospital cases and persons in need of care. Furthermore it is differentiated between specific hospital types and itinerant stationary care facility as well as professional flexibility. The result of the calculation forecasts an increasing need for fully employed care professionals between 27.3 per cent ("status quo scenario") and 19.5 per cent between 2005 and 2025 (" scenario diminishing treatment cases") (Afentakis/Maier 2010). The increasing demand for nursing staff develops differently: The “status-quo-scenario” shows a 48.1 per cent increase between 2005 and 2025 In hospitals the increase should even be 8.1 per cent higher. In 2018 the “status quo scenario” suggests an acute care staff shortage. The “scenario diminishing treatment cases” prolongs that shortage for three years until the year 2021. Up to the year 2025 55.000 to 112.000 fully employed care-workers would be missing.

The discussion about the deficit of well-qualified employees sometimes points in the direction of immigration of health care professionals to meet current and future demands. The results introduced here show, however, that the debate about securing professionals must be further differentiated. In light of criteria for a social health economy the question has to be answered how to organize a skill-mix that meets differentiated needs of regional health-care solutions.

Quick and general solutions for the qualified employee safeguarding in the health economy are not helpful for a long term solution:

- Subtly differentiated physical requirements and structures of supply also cause differences in the qualified employee demand. The question therefore is which qualified employees are needed with which qualifications in which areas in the future. Rhineland-Palatinate, Hessen or Bremen already work successfully with the instrument of the (regional) qualified employee monitoring. The regional analysis of the qualified employee demand also could be used in the social health economy to develop rationalized strategies of the qualified employee safeguarding and training.
- The idea of "expert work" also has to be analyzed critically against the background of the increasing relevance of marginal occupation and part-time jobs. , For the future it is important to target specific groups with certain qualification levels, and develop custom strategies for an employment perspective in the health economy.
- Data for the development of unemployment in the area of the "elderly care/elderly care help" provide first references to the fact, that a distorted situation on the labor market health is already there. Especially lower qualified employees are in danger of losing their jobs because of these qualification developments.

  A narrow understanding and a one-sided focusing on "expert work" could block the look for this development.
- In view of outlined employment structural radical changes questions of the trend in employment must urgently be connected with improvements of wage development and design. The increasing specialization of job outlines and the distinction of the qualification standards have clear influence on the development of work in central health professions which also yield changes in the pay structure, altogether. Social health economy should therefore address which distribution effects on basis of a citizen insurance are desirable and necessary

Design concept "good work" in the health economy

From the perspective of a social health economy turns patient orientation becomes a success criterion of the search for sustainable strategies and concepts of "good work". As a consequence it has to be asked what kind of consequences derive from improved working conditions for the employees, reformed educational programs, new professions and new distribution of work for the patients.

This requires an overcoming and uniting of till now mainly segmented profession and association political modernization strategies and the moving relationship of corresponding concepts with the innovation chances and ability of the line of business itself.

A social health economy needs an integrated concept and design offensive for work and training. At present, the area is presenting itself as an almost incalculable experimenting landscape.In many pilot schemes the topic is to work on aim group-specific occupation strategies, on solutions for "good work" or on new training concepts In connection with this the following facts are important:

- Regionalization is important: For a regionalized health care system and regional specific modernization solutions, small-shaped changes must also to be included in the supply events in its significance for the qualified employee demand. In connection with this, regional qualified employee monitoring already is in some federal states successfully been tested. The connection ability is decisive in the health economy to qualitative future trends according to an occupation sensitive "trend and innovation monitoring" here. A systematic training and occupation monitoring as well as the support of industry-wide cooperation and training combines of health care facilities can deliver important impulses at a regional level.
- Make attractive employer brands: Strategies against doctors and lacks of care are aimed both at a clear improvement in the working conditions and at a professional personnel progress and leadership. Needs of the colleagues as well as operational development strategies must be brought together more narrowly. In many cases, careful and treasuring dealing with the employees and a professional personnel progress are not part of the strengths of German hospitals and care facilities yet. Personnel management and development are frequently

discussed in view of occupation groups, the requirements for processes of the work routine too seldom connect to personnel progress. Facilities and enterprises of the health economy must market themselves as attractive employers (employer branding) in future. High gloss booklets are not the solution here, rather integrated and reliable concepts are necessary.

- Picking out "becoming more academic" and practice confluence as a central theme: The debate about "becoming more academic in the care" that exits since the 1990s years in Germany, considers in fact just a small amount of semi-academic people of conducting, teaching and searching, the real care practice is hardly touched by it all. In view of the variety and the specialization possibilities within the care, in future, on has to keep an eye on the interplay of different qualification and which effects arise from it also from a patient perspective.
- Strengthening patients and user orientation: In view of the renewal of working conditions and training the patient with his needs still proves to be a "blind spot" from the perspective of the social health economy. Till now, it is not cleared in health work, which effects a new job sharing, the current reforms in the professional educational system or technology use have for the supply quality from the patient point of view.
- Thinking further for a new job sharing: Segmentation instead of integration still determines the picture of a new, old job sharing. The traditional understanding of health-related work is concentrated often on the fulfillment of components of tasks while the look at the overall responsibility is missing. Not alone the professional conception of oneself but the readiness for the cooperative process management must form the basis of a new job sharing. The previous discussion is determined by pragmatic approaches largely. The interprofessional distribution of tasks is most important, particularly between medicine and care. Many contributions are interest conducted and spare a reflection of the consequences of such redistributions for the care and other health professions but also for the users of health services.
- Recognizing and working on tendencies in de-qualification: New and changed requirements and needs in the population as well as the diversity of performances also find their way in the development of the qualification profiles

of existing jobs and lead to the development of new professions and training offers. While these are representing an important step towards the professionalization of non-medical occupational groups on the one hand, critical voices also see a business management optimization strategy as result of a shortage and price increase of medical labor in the development. So it had to be analyzed critically, whether the delegation and substitution of activities leads in the end also to the creation of new professions, further educations and additional trainings, or perhaps to a cascade effect and thus in the end to de-qualified workers in health work. Furthermore the dividing work puts also new requirements on the re-integration of the activities. The danger, that interface problems are not restricted to sectors and facilities along the transactions, but could be accompanied by another "Taylorization" of health work and thus hit occupational groups in future, is absolutely to be taken seriously.

- Professional return and re-employment in an aim group orientated form: The prospective trends of the health economy in view of the forecast qualified employee deficit are particularly dependent on the re-integration of little courted working groups. The striking rejection of low-level entry qualifications for so-called problem groups of the labor market is just as little aim leading like undifferentiated and headed off multi-purpose solutions. Till now, particularly re-entrants are not systematically courted by the facilities as a target group. A deployment of labor suitable for qualifications as well as the systematic anchorage of the re-employment management is necessary in the operational staff and organization development. Moreover, it is imperative also in view of possible emotional and physical loads for the employees to examine the means and long-term usability of low-level entry qualifications in the healthcare industry critically.
- Work and technology use for "social innovations": The spectrum of the fields discussed currently ranges from documentation systems, primarily working replacing technology concepts (Paulus/Romanowski 2010) up to use of "care robots". The processing of interactive health information touches the future of work and training as well as use of telematics and telemedicine. To increase the accessibility and effectiveness of prevention measures in the social environment health services must more strongly adapt themselves to the individual

prerequisites, risk factors and setting of the users/patients. This requires a partaking and multi-disciplinarily working in the interplay of different occupational groups and competences.

The outlined priorities design areas for the future of work and training are not at all new. Anyway it is that the focusing on association and profession specific interests on one side or on business management economic interests on the other side is not enough though. Successful concepts of "good work" also should stand out, by taking the needs and claims of the patients into consideration, follow the train of thought and understand them as a starting point of the modernization.

The described occupation structural and professional area-related developments are expression of the articulation and assertiveness of interests in the health economy in the end, too. The development of a new job sharing and the specialization and distinction of professional education in the most important economy industry in Germany also must more strongly be analyzed. The look abroad shows that team-oriented decision and work processes can have thoroughly positive effects for the economical productivity of the facilities and for the patients. I view of a subtly differentiated situation, a mere assignment of corresponding concepts cannot be promising in the German health care system, however.

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Labour insertion after occupational training in the health and social care sector in Catalonia 2005 – 2006

By Núria Tuset Zamora and Anna Pujol i Picas

Introduction

This is a summary of the study carried out by the Catalan Public Employment Service (SOC) on labour insertion of unemployed workers who took part in health and social-care courses (Pujol, A. el al. 2010).

The long-term care sector is a priority for the SOC due to its potential for the job creation. Moreover, some features of these kinds of jobs match features of a large number of unemployed people registered with the SOC. Many of the new care jobs are associated withmedium-and-low skilled workers and, most of the people working in them are women. Approximately 24% of the individuals registered with the employment service have not completed compulsory basic education, 60% have only compulsory basic education level and approximately 50% are women

Active labour policy in this sector contributes to the following (see OECD 2009):

- professionalizing the sector, thereby distancing it from the simple identification with domestic work;
- homogenizing and establishing quality standards in service supplies;
- attracting more workers to the sector, which has a lack of candidates

The long term care sector is one of the New Sources of Employment, characterized by high employment potential and coverage of social needs. That is why public action is necessary.

The importance of this sector as a source of employment has increased thanks to the passage of recent laws in Spain and Catalonia such as *Law 39/2006, on the promotion of personal autonomy and care giving to persons in a situation of dependence* and *Law 12/2007, on social services of Catalonia*. Both of these laws recognize a set of universal rights for people that need care, so these laws will help to increase employment in this sector. It is possible to foresee future vacancies in the coming years. The table below shows a forecast carried out by *Programa per a l'impuls i l'ordenació de la promoció de l'autonomia personal i l'atenció a les persones amb dependència (PRODEP) per a Catalunya* (*Program to organize the promotion of personal autonomy and care of people with disabilities* (PRODEP) for Catalonia):

Table 1
Forecast of vacancies

	Forecast 2007	Forecast 2015	Increase of jobs
Domiciliary care	3,200	19,153	15,953
Nursing assistant in geriatrics	17,043	30,033	12,990
Personal assistant in disable people	70	4,380	4,310
Nursing assistant in disable people	4,483	9,383	4,900
Total	**24,796**	**62,949**	**38,153**

Table 2
Percentage of people working in the health and social sector

	2000	2001	2002	2003	2004	2005	2006	2007
EU-27	8.63	8.73	8.90	9.18	9.42	9.54	9.57	9.52
EU-15	9.50	9.58	9.69	10.06	10.36	10.51	10.52	10.51
SPAIN	5.28	5.14	5.40	5.78	5.69	5.98 [(*)]	5.98	6.04

Source: Eurostat
(*) Break in series

In the European Union, one out of 10 workers work in the health and social sector. In Spain only 1 out of 6 work in this sector, so Spain and Catalonia should increase its workforce here.

In conclusion, this sector is a special priority for the SOC because it is a new source of employment, and demand is growing, despite the recent public- expenditure restraint measures, and it has an important local component (services are hired mostly from the local area). In recent years, the SOC has been improving active employment policy by adapting it to the needs of the different sectors and territories.

Another reason that justifies making long-term care sector a priority is the high rate of return on government investment in the social sector (welfare state), as far as employment is concerned. According to the professor and director of the Spanish Social Observatory, Vicenç Navarro (2011):

"The same amount of public expenditure that creates 556.000 vacancies in physical infrastructures, creates 1.2 millions in welfare services. Public investments that provide 11 vacancies in physical infrastructures, provide 17 in the green sector and 23 in the social sector. Moreover, it is important to remember that social investments, on the whole, create employment for people who are most affected by unemployment and also provides services to a larger number of people."

This report focuses on the management of active labour policy by the SOC in the long term-care sector. As all previous information indicates that this is a growing sector, we can ask the following questions:

Are the long-term care programs managed by the SOC enough considering the potential of the sector?

What is the profile of the participants in the programs?

What partners does the SOC work with to implement the programs?

Does the intervention of the SOC contribute to improving the professionalization and quality of the sector?

To answer these questions, this study focuses on the following:

1. Determining which active employment policies have developed by the SOC in the area of long-term care between 2005 and 2009: New Sources of Employment program (usually implemented by town councils), vocational training, direct jobs creations, and program of recruitment in origin to contract people in their country of origin part of the long-term care workforce.
2. Determining the availability of long-term care training between 2005 and 2009.
3. Analyzing labour insertion results of participants in vocational training programs related to the long-term care sector, pointing out profiles that get better results and the factors that are associated with successful labour insertion:
    a) Quantifying and qualifying labour insertion, according to the characteristics of the students, labour contracts and employers.
    b) Establishing which factors facilitate successful labour insertion.

Active Labour Policy and professionalization of Care Work

New Sources of Employment Program (NJO)

The program *New Sources of Employment* had a specific line of grant money entitled for the stimulation of the demand of certain home-care services (care of the elderly, care of disabled people, child care, and others). The aim was not to broaden social-care services but to improve the purchase of home-care services within the regular economy and to seek new customers. This program was developed in collaboration with local associations and city councils, which issued a *service-cheque* to pay for part of the cost of the service.

Evaluation of the program (NJO) shows its efficiency to be remarkable – with an average annual budget of 1,114,509.96 € between 2005 and 2008, it contributed to the organization of the sector, working with local entities, private companies and local demand-. The program also contributed to certifying private companies working in the sector.

Vocational training program (FO)

The training of professionals in long term care has been carried out mostly through vocational training. The increasing number of participants in care training is shown in the table below:

Table: 3
Place in long-term care training managed by the SOC. Catalonia 2005-2009

Sex /year	2005	2006	2007	2008	2009	TOTAL
Women	2,848	3,566	3,898	5,083	10,383	25,778
Men	252	332	398	797	1,968	3,747
TOTAL	3,100	3,898	4,296	5,880	12,351	29,525
Inter-annual increase		25.74%	10.21%	36.87%	110.05%	
Increase compared to 2005		25.74%	38.58%	89.68%	298.42%	

More than 29.500 students have participated in the courses in the last five years. The sharp rise in participants in the 2009 is due to a change in the management of the courses, shorter training courses have been programmed in order to offer to a large number of unemployed people the chance to take part in the courses, taking into account the rise in unemployment due to the economical crisis. Along with the increase in the number of students in the sector, the participation of men has also double from 8.13% in 2005 to 16% in 2009

Furthermore, between 2008 and 2009 a pilot experiment was carried out, providing comprehensive education and training in long-term care.

Programs of support to the employment and local development

In the announcements for projects and actions for employment with local entities, long-term care services and those related to the "*Law of dependence*" have been considered as a priority area. Thus, specific projects on education, training and direct job creation have been developed, such as "workshop schools" (*escoles taller*) and "trade houses" (*cases d'oficis*).

As far as local development is concerned, and thanks to the line of subsidized studies and campaigns on development, many studies have been carried out. From a local basis, these studies focus on the development of the sector as an employment and social policy.

Job vacancies management, training and first reception in origin (SILO)

SILO is a service of the SOC and its aim is to help Catalan companies that need to hire workers from foreign countries. From 2007 to 2009, the SILO service has managed the hiring of workers from Latin-american countries in the health sector, such as doctors, nurses and geriatrics assistants.

Description of participants

The SOC, in collaboration with the University, carried out an evaluation of the all training courses in Catalonia in 2005 and 2006 (see Toharia 2005) with the purpose of evaluating the influence of training on the labour insertion of students. Out of this evaluation, a sample of students who followed care work training was taken to analyze the influence that training in care work might have on the labour insertion of this specific group of students. Following is a description of the participants in **training in care work (2005-2006) comparing them with the all students in other training courses.**

From 2005 to 2006, 6,994 students took part in care courses. There were seven different courses in care work, with the following percentages of participation:

- Nursing assistant in geriatrics (63.99%)
- Domiciliary care (10.41%)
- Nursing assistant in hospital care (7.12%)
- Alzheimer care assistant (5.00%)
- Assisted living jobs (5.00%)
- Caregiver in physical and mental disabilities (5.00%)
- Nursing assistant in mental health and drug addictions (2.27%)

Most of the students (91.71%) were women, whereas the proportion of women in all training courses was 60.2%.

The average age of students was 39.26 years, whereas the average age of all participants in courses was 33.60 years. A remarkably low number of young people carry out care work training - 17% of participants were between 45 and 49 years old and the predominant profile of participants in care work training was that of a woman between 30 and 54 years old (66.10%).

In terms of student nationalities, 78.7% of students were Spanish and 21.3% were from foreign countries (3 percentage points more than the average number of foreigners in training courses). Foreign participants nationalities in care work training were

predominantly: Equador (4.3%), Morocco (3.1%), Colombia (3.0%), Peru (2.4%) and Bolivia (0.9%).

In terms of the level of education level of the students, the average level was quite low, with a 37.5% of students not having completed compulsory basic education, 36.2% with compulsory basic education and 23.0% with higher secondary education. In terms of the level of education by nationality, 56.9% of foreign students had not completed compulsory basic education, while this percentage fell to 33% among students of Spanish nationality.

Most of the courses were of medium duration (between 251 and 500 hours) or long duration (more than 500 hours). A total of 71.06% of participants finished the courses successfully, although the percentage of success was lower in the courses of longer duration, as there was an increase in the number of students who failed to finish the courses.

Care work training courses were provided throughout most of Catalonia, thus 85.5% of participants received training in their own local area, and 62.1% in their own town or city.

Employment contracts and employers description

A follow-up of the labour insertion of the 6.994 participants has been carried by analysing their labour contracts in the period from the 1 July 2005 to the 4 of July 2009, shown in the monthly data file of the *Departament d'Empresa i Ocupació* of the *Generalitat de Catalunya* (Department of Enterprise and Employment of the Catalan autonomous government).

A total of 7.183 companies have hired the participants through 36,783 employment contracts, with an average of 5.1 contracts per company. The average number of contracts per participant was 5.3, indicating a huge employment turnover. Part-time contracts accounted for 38.1%. Contracts through temporary recruitment agencies accounted for 11.4%. In the follow-up period, 49.2% of participants were hired for a job in the long term care sector at least once. The most frequent placement was 'nursing assistant in hospital care' (33.7%).

Medium-size companies were the most common employers: 37.6% have between 10 and 49 workers, 25.3% between 1 and 10, and 19.5% between 50 and 199. The biggest number of contracts (44.0%) was provided by big companies (200 or more workers).

Description of employment contracts:

- Period: from 1/07/2005 to 4/07/2009
- No. of contracts: **36,783**
- No. of participants: **6,994**
- Turnover: **5.3** contracts / participant
- No. of companies: **7,183**
- No. of contracts / company: **5.1**
- Part-time contracts: **38.09%**
- Temporary recruitment agency contracts: **11.4%**
- Placements linked to the sector: **49.3%**
- Most frequent occupation: **Nursing assistant in hospital care (33.7%)**

Labour insertion of participants

The follow-up of labour insertion focused on the personal features of hired participants (sex, age, education, nationality, etc.) and the characteristics of the training course (speciality, length, etc.). Only contracts signed after participants joined a course have been taken into account. The follow-up lasted until 4 July 2009.

A total of 5,769 participants (82.5%) had signed at least one contract within the follow-up period and more than half of these participants were hired at least once with a permanent employment contract.

Insertion of participants in the labour market

- **82.5%** of participants have been recruited at least for one placement in the considered period
- **54.0%** of recruited participants have signed at least one permanent employment contract
- **50.5%** of participants have signed at least one contract for a placement linked to the sector
- **60.5%** of participants have signed their first or only contract within half a year of finishing the training course

The indicator 'successful insertion of the training-course participant into the labour market' has been defined, as a measure of quality of the insertion, as:

- Having signed at least one permanent employment contract
- Having signed at least one contract for a placement related to the long term care sector
- Having signed at least one contract within six months of finishing the training course

These three cumulative conditions are quite restrictive, but the definition of the indicator has taken into account the context of rapid insertion, given that:

- The long term care sector belongs to the *Nous Jaciments d'Ocupació* (New sources of employment), characterized by a high employment potential.
- The *Ley de Dependencia* (Dependence Law) is a stimulus for the sector.
- The labour force demand of the sector is higher than the supply.
- The follow-up takes place in a period of economic growth

A total of 23.6% of participants (1,650) were successfully inserted in the labour market. Of participants who finished their training course with a positive evaluation, **30.6%** were successfully inserted in the labour market.

Factors affecting the success and quality of labour insertion

Sex

Male participants had better results in successfully getting a quality job (65.9% of male participants compared to 57.8% of female participants), as defined above, but female participants got a long- term care related job more frequently than men (51.7% of women compared to 39.2% of male).

Chart 1
Successful labour insertion of participants by sex

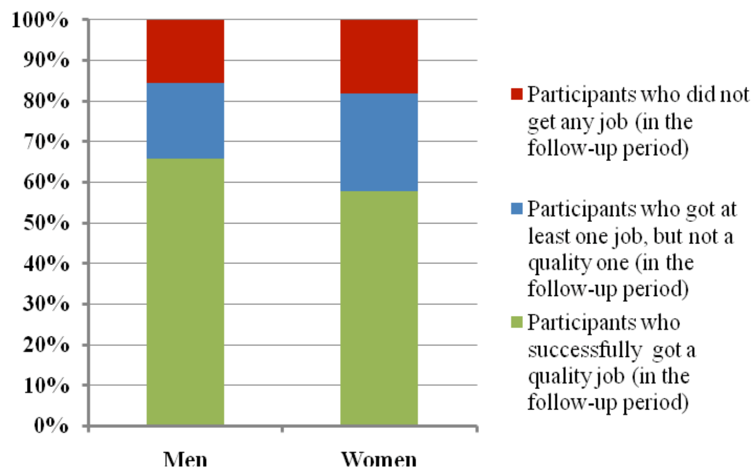
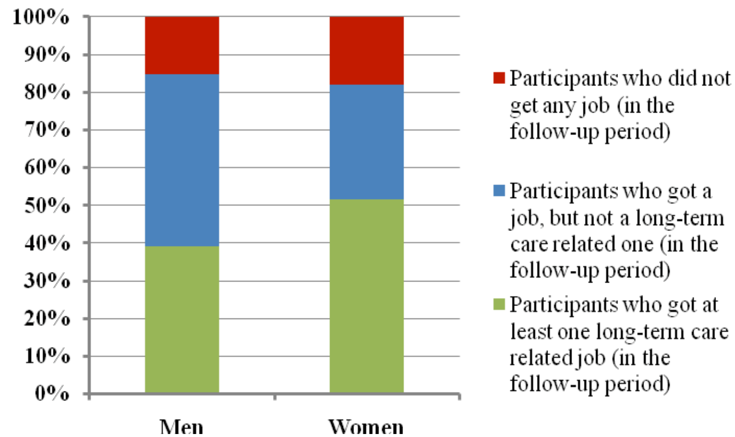


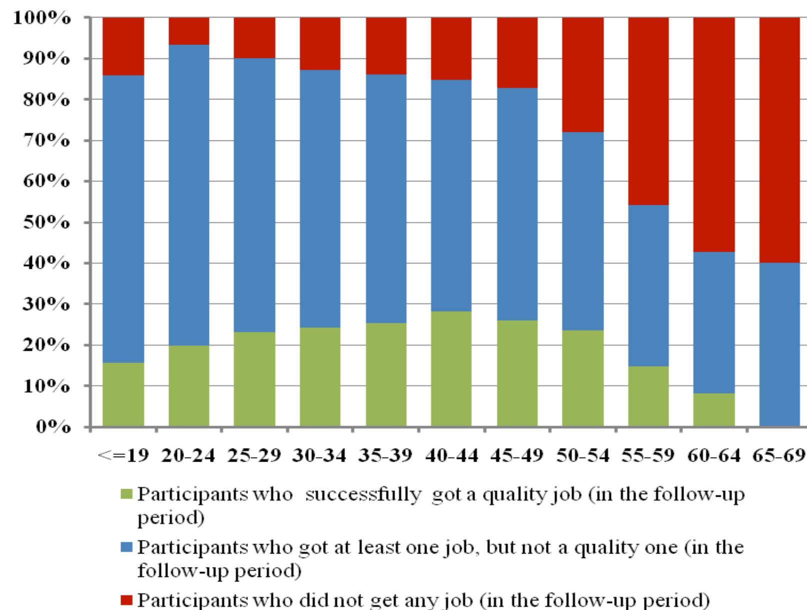
Chart 2
Success of participants in getting at least one long-term care related job by sex



Age

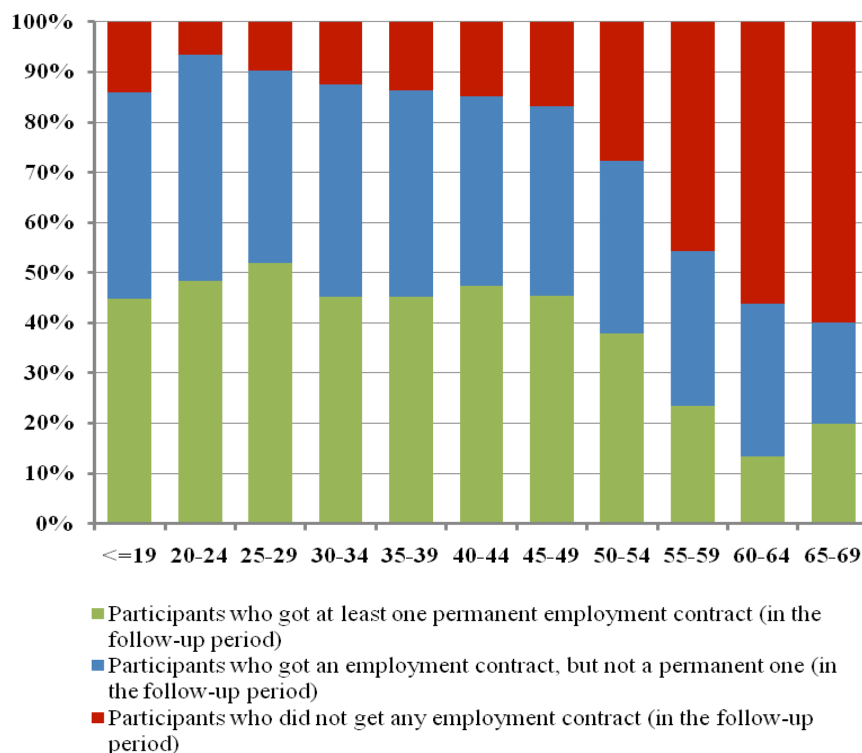
Participants over 49 years of age had less success in getting a job and got a quality job less frequently than younger participants, as defined by the indicator. Participants aged between 25 and 49 years got the best results.

Chart 3
Successful labour insertion of participants by age group



Participants over 54 years of age had significantly lower results in terms of getting a permanent employment contract than younger participants. Participants aged between 25 and 29 years got the best results (51.9%).

Chart 4
Success of participants in getting at least one permanent employment contract by age group



Nationality

Spanish nationality was not associated with a greater frequency of successful insertion (23.1%), than non-Spanish nationality (26.0%), on the contrary, foreign participants performed slightly better.

Bolivians (34.8%), Peruvians (32.3%), Ecuadorians (32.2%) and Colombians (27,1%), were the foreign nationalities with most success in getting a quality job. It should be noted, however, that Peruvians were not employed at a higher rate (24.0%) than other participants during the follow-up.

A European-Union nationality other than Spanish did not increase the likelihood of success (20.3%) and Moroccan participants seemed to be at a disadvantage (13.5%).

Chart 5
Successful labour insertion of participants by nationality

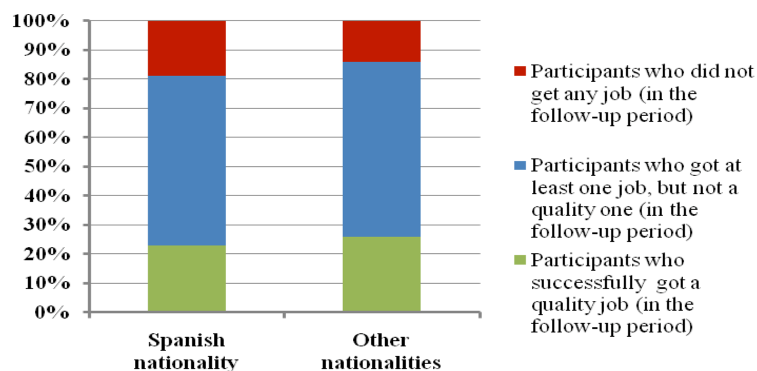
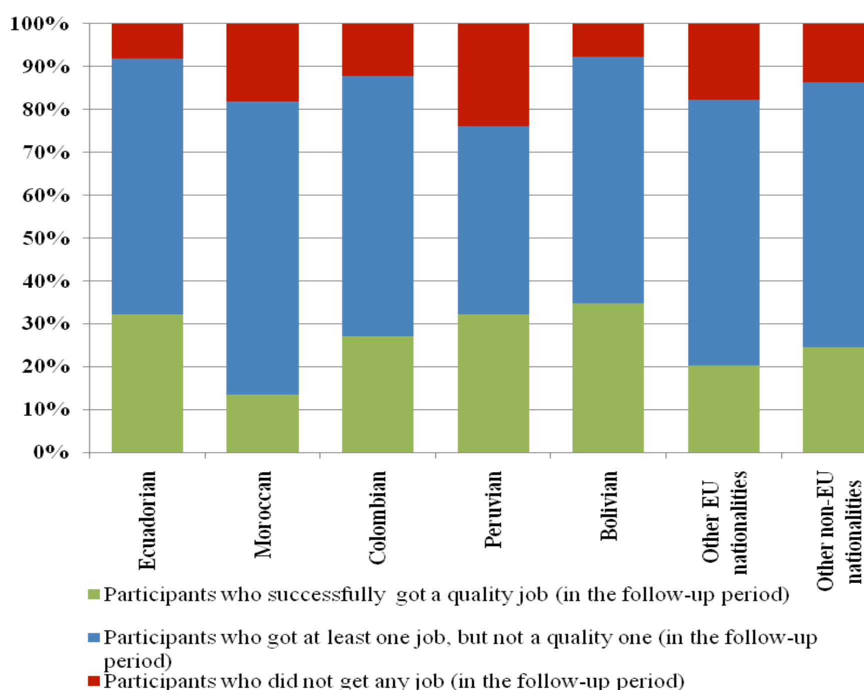


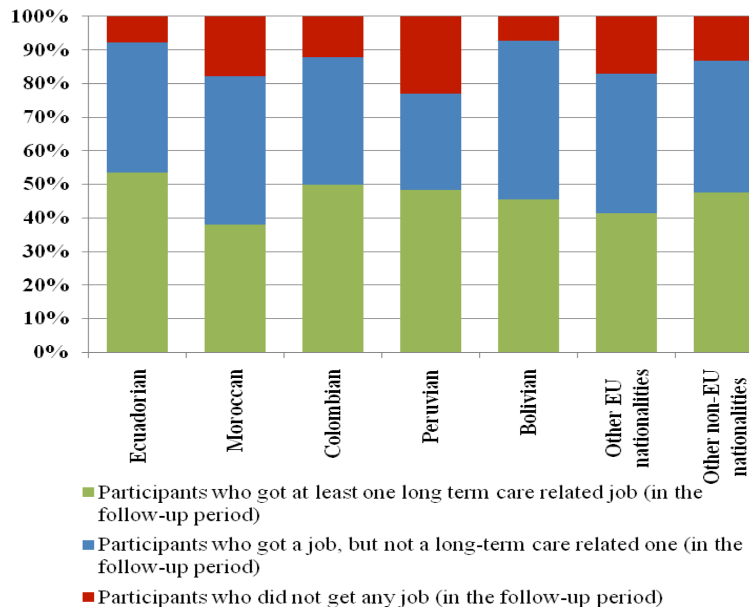
Chart 6
Successful labour insertion of non-Spanish participants by nationality



Moroccan participants also seemed to be at a disadvantage in terms of getting a long-term care related job (38.1%), followed by non-Spanish EU nationals (41.5%). Ecuadorians were hired at the highest rate for long-term care related placements (53.4%).

Chart 7

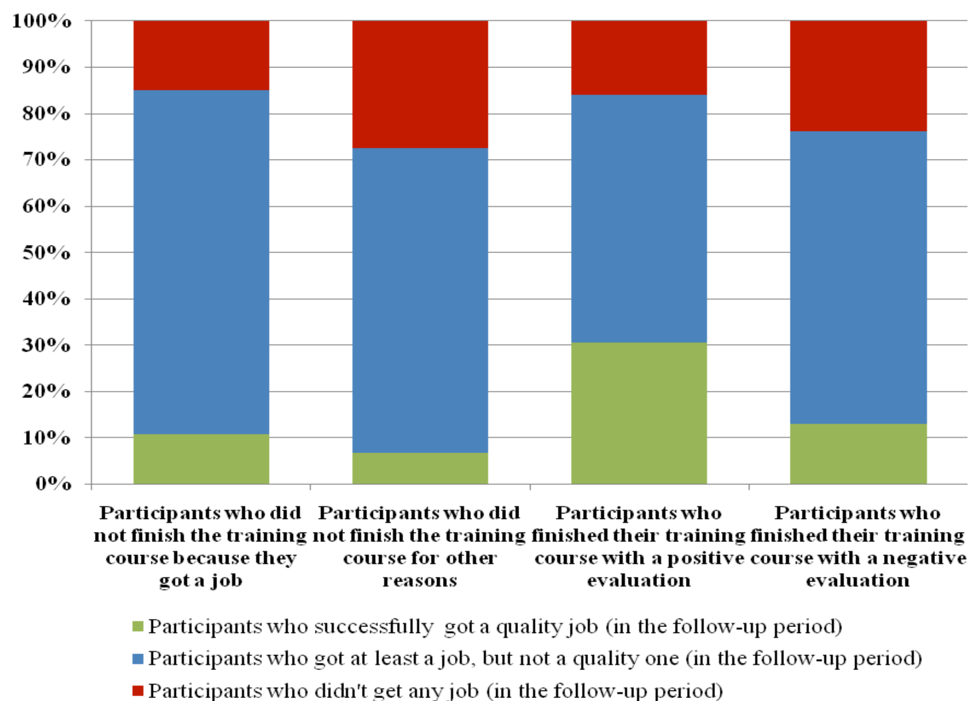
Success of non-Spanish participants in getting at least one permanent employment contract by nationality



Finishing course category

Finishing the training course with a positive evaluation has a significantly better output in terms of the probability of finding a job (84.1%), particularly a quality one (30.6%), defined as per the indicator. Participants who failed to finish the training course for reasons other than employment and those who finished the action with a negative evaluation had the worst results: 27.5% of the former and 23.9% of the latter did not get any job in the follow-up period.

Chart 8
Successful labour insertion of participants by finishing course category



Main results

Factors contributing to successful labour insertion

- Gender: **female**
- Age: **between 20 and 54 years old**
- Nationality (if not Spanish): **Bolivian**
- Training action subjects: **'Nursing assistant in mental health and drug addiction' or 'Nursing assistant in geriatrics'**
- Training course length: **medium or long**
- Training action evaluation: **positive**

Factors contributing to unsuccessful labour insertion

- Gender: **male**
- Age: **less than 20 or over 54 years old**
- Nationality (if not Spanish): **Moroccan**
- Training course subject: **‘Alzheimer care assistant’**
- Training course length: **short**
- Reasons for leaving the training course: **causes other than employment**

Conclusions and suggestions for the catalan public employment service

The following conclusions and suggestions, reached through analysis of the data and review of the literature, are intended as an aid to the strategic planning of the services offered by the SOC.

During the follow-up period, the *Servei d’Ocupació de Catalunya* has considered the long-term care sector as a priority area for active employment policies. The number of training places has increased and a total of 29.525 have been offered from 2005 to 2009, covering 32 of the 41 counties of Catalonia and 72 towns and cities. The slow implementation of the *Ley de Dependencia* (Law of Dependence) and the budgetary constraints and doubts regarding its entry into force make public active employment policies more necessary.

Beyond insertion in the labour market in this sector, progress must be made in achieving quality employment and formal qualification and certification of care workers is needed.

A detailed territorial analysis of the supply and demand of training courses should be carried out. We also recommend coordinating actions with local employment policies and sharing best practices.

Bridging the gender divide in this sector is another policy field to be explored, which could be handled by means of institutional campaigns showing men doing care jobs, for instance.

Participants in training courses in this sector are frequently of middle age (30-55 years old). The authors of this article do not recommend promoting long-term care jobs among people of other ages. Younger workers lack the life experience required for these professions and older workers may find it difficult to cope with the physical requirements of the job.

Low levels of education, particularly among immigrant workers, lead us to recommend training centres to inform participants on how to acquire compulsory basic education.

The significant role of big companies (200 or more workers) and multiservice enterprises as employers should be seen as a priority area for the *Àrea de Serveis a les Empreses* (Corporate Services Department) of the SOC.

With regard to the length of the training courses, although a higher proportion of participants abandon the longer courses before finishing, we do not recommend designing short courses, as they are less efficient in terms of labour insertion. The process for selecting participants is also crucial and it would be a good idea to allow sufficient flexibility for participants to enrol again after leaving the action due to labour insertion.

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Precarious perspective? Professional return and and labour market reentry of women into the health economy.

By Sandra Dörpinghaus and Michaela Evans

Importance of the debate about skilled workers for the health industry

Strategies for securing skilled workers in Germany are currently experiencing a high level of attention. The search focuses on responsive and equally sustainable strategies that will help to ensure the economy's needs for skilled personnel. In the one hand it is required to gather valid information about the demand for skilled workers and the degree of qualification in the individual regions, industries and occupations in the future. On the other hand, a successful dealing with an ageing workforce requires a detailed examination of new concepts for the demographic change. At least the aim is to improve preparedness, ability and participation in an aging society. Concrete starting points range in this context of an expansion of existing training programs, opening new career opportunities for older people on how to ensure long life and an accompanying qualification to improve integration and new target groups into employment. In a press release the Federal Ministry of Economics and Technology (BMWi) states:

"*The demographic change has hit the German labor market a long time ago. Lack of skilled workers has become a structural problem. The lack of staff shapes diverse sectors. [...] The commandment of activity is apparent. To maintain our competitiveness and innovative capacity and thus to prosperity and growth, we need a sufficient number of well-trained and motivated professionals in all industries and skill levels.*" (BMWi 2010)

An avowed way to ensure the supply of skilled labor is to increase the participation rate and the equality of women in employment (Commission of Experts to prepare the first report on equality of the Federal Government 2011). Specifically, it centers on the questions of how to win women especially for the labor market, and keep this labor force; or after biographical passages, which may expose a temporary interruption of employment, can once again be addressed as experts. The healthcare industry is an industry which has demonstrated a marked increase in employment during the recent years. It is also due to the demographic change, rising demand for healthcare products and services and the medical-technical progress as a promising field for future employment.

For all that women's employment in the healthcare industry continues to have a high priority. Nevertheless, the health and care work also offers interesting employment opportunities for men in general. In regard to the past and future employment trends the health sector is often labeled as "job engine". Without a doubt there are existing job prospects, however, this may not obscure the fact that the industry is facing considerable challenges to obtain skilled labor, quality assurance and development. The press release of the Federal Ministry of Health (BMG) of 7 December 2010 on the occasion of the opening event of German "Care-Dialogue" states:

"*We already have a certain lack of skilled labor. Because of the demographic development of the situation will further intensify. Because of that we need a better framework for the nursing professions*." (Press Release of the BMG, 7.12.2010)

Also the opinion of the "Advisory Council for assessing the development of the healthcare system" in 2007 comments on the background, the objectives and the need for action to grant the assurance and development of professionals in the health care industry as follows:

"*All professionals can benefit from a reorganization of responsibilities within the health care system, when it leads to a better match between the needs of a constantly changing supply system and the objectives, tasks and skills of its actors. The current, rapid changes in healthcare realized in a complexity far beyond the horizon of experience, stir up fears among employees, for example in connection with the threat of job loss or abandonment of the practice. They lead to dissatisfaction because of overwork, restriction of professional autonomy and the lack of (e.g. monetary) approval*" (Experts for the Assessment of developments in the Health 2007: 15)

The results of the project "WIEGE - prospects for returners in the healthcare industry" indicate that existing structural breaks and risks of gainful occupation - particularly for women - will continue in the health industry. Beyond that - so the thesis - new problematical areas and conditions may arise in regard to the "job engine health economy". These are caused by complex modernization requirements which at present are processed only insufficiently by deficits in the deployment of labor suitable for qualifications as well as by an insufficient anchorage of the re-entry management in the operational staff and organization development. The prospects for re-entrants depend on the capacity for innovation of the health care facilities to a high extent. Particularly low-

level entry qualifications and helper qualifications for women returners lead in professional dead ends and professional overtaxing.

Are there possibilities to lure women from the reserve?

Re-Employment and professional return as chances for the labor market

The current scientific discussion around "*gainful employment for woman and labor market*" is extremely diverse - it ranges from the (under-) representative number of women in managing positions (Holst/Wiemer 2010), the meaning of the low pay sector for women (Kalina/Weinkopf 2009), to the effects of an increasing gainful employment for women on basis on a social gender justice in enterprises (WSI 2010) up to the "Gender-Pay-Gap" - the description of wage differentials that are still existing between men and women (Hirsch/König/Möller 2009). Caused by the fragmentation of female employment relations the securing of an independent existence for women is not commonly accepted, despite a gainful employment. Sex-specific pay differences, the risks of part-time job and mini-jobs for women, discontinuous records of earnings and difficulties of the consistency of family and profession are still existing (Expert commission for the preparation of the first equality report of the Federal Government 2011).

In a first access, the reasons which speak both from scientific and from a design perspective for a deepening discussion with the re-employment of women into gainful employment in the health economy can be outlined as follows: from an economic perspective it is all about the use of the qualified potential of women and her qualifications in more social and general economic ways. A longer absence from a professional can cause a considerable loss of the human resources, not only individually but also from a business management point of view (Klenner 2009). There is the demographic factor as well: For the next years a clear shortage of the acquisition person potential is expected in Germany. A variety of industries try to search for solutions for the demand for qualified workers in the face of a growing qualified employee competition (Schnur/Zika 2007). Problem description and diagnosis seem to be intersectoral at first sight. Questions, like how to stop the Drop-Out of qualified women

(e.g. engineering) or how to find new ways to design the medical profession more attractive for women are central themes. The preface of the study "professional re-employment after the foundation of a family" of the Federal Ministry of family, senior citizens, women and youth (BMFSFJ) reads:

"*The life drafts and curricula vitae of the women of today are colored and more various than before. And we have the best educated generation of woman which we ever had in Germany [...] with the foundation of a family a considerable part of the women feels today still forced to give up its profession temporarily or completely [...]. Only in the advanced age of the children they look for the re-entry in profession, many of them on encounter difficulties, which not only burden the women themselves but their families as well. The economy is also concerned. If the well trained and educated mothers are not able to return to the job, the employers of generation "40 plus" lose a lot of potential. [...] The re-employment is a long process which can become a difficult steeplechase, especially for mothers of several children [...]. The enterprises profit from female returners if the framework conditions are correct and the women get the chance to regain tasks which correspond to their education and their standard of performance.*" (BMFSFJ 2008: 5)

The topics "re-entry" and "professional return" for women form a central main emphasis of the politics in North Rhine-Westphalia. In view of the shrinking labor potential at increasing demand for qualified workers, enterprises cannot forgo qualified women in the long run (Allmendinger/Kessler/Ebner 2006). Connected to a successful professional re-entry are a number of social chances - they range from the realization and integration of professional and family aims in difficult phases of life like separation, divorce, unemployment or loss of the partner up to safeguarding the future living conditions. "Female Returners" and "Female Re-Entries" represent a just as heterogeneous as demanding target group of the labor market view of the qualification standard, the specific family situation or their expectations to the resumption of a gainful employment. In the face of this the aim of new employment prospects in the health economy needs more knowledge about concrete strategies for occupation prospects and the gaining of new target groups. Thus the following questions gain meaning:

- In which fields of work and activity are new and/or extended occupation options possible?
- For which target groups can these employment prospects be developed?
- Which qualifications are required and do offer prospects in the acquisition system in the short term or in the long run?
- Which framework conditions (e.g. incomes, career opportunities, training offers, work-load) indicate new fields of activity?
- How can the implementation of lasting occupation options be transported in the health economy both by an integrated politics design and by the engagement of the enterprises and facilities themselves?

The “job engine" health economy under the magnifying glass - Do new problems arise?

In the year 2008 about 4.6 million people worked in the health economy. This volume corresponds to a working time of about 3.5 million whole time employment (change to the previous year +57.000) (BMWi 2011). With a share of about 12 % of the employed persons in Germany this industry represents an important area of the national economy (Federal Agency for Work 2010). In the line's of business employed persons an increases of +76.000 could be registered, if one compares it to the previous year. Table 1 shows the distribution of the full vigours in the health economy after professions. With about 224 bn euros in the year 2008 the health economy gained about 10 per cent of the complete German economic performance (ibid.). Current studies and publications refer to the key position of the health economy for economy, occupation and creation of value (Evans/Hilbert 2009). Moreover, the classic health service has proved to be extremely stable occupation and economic sector in times of crisis till now.

Compared to knowledge intensive and personal services in average, jobs in the health economy demand higher qualification requirements from the employees and contribute to the economic creation of value in the area of research and development excessively. According to information from the Statistical Federal Office a steady increase of the numbers of persons employed in the health service since 2001 can be recorded (cf.

illustration 1). Moreover forecasts assume that the number of persons employed could increase by approx. 1 mil. up to the year 2020 (ibid.). Particularly care work will be able to record further increases within the next years, thus considerable challenges to the securing of qualified employees will arise: Based on the 2005 employment structure of the care professions (Germany altogether respectively just the old federal states), up to year 2025 the lack of trained nurses can be numbered as 193.000 or 214.000 fully employed care professions ("status quo scenario") and as 135.000 or 157.000 fully employed care professions ("scenario of dropping quotes of treatments ") (Afentakis/Maier 2010).

Table 1
Full vigours in the health economy (whole time equivalent) in 1.000

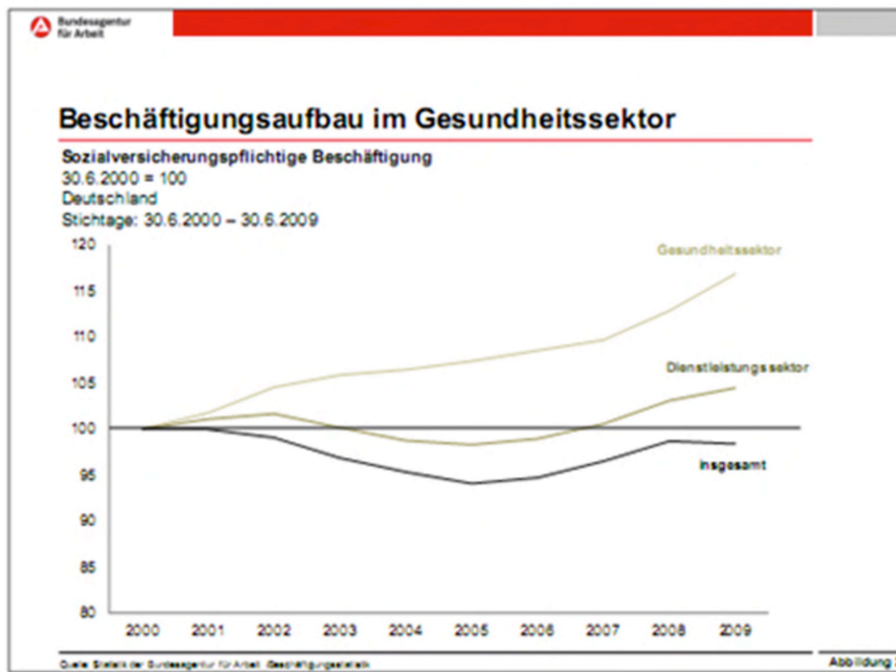
	2007	2008
Professions in the health service altogether	3.450	3.507
Public health service professions	1.950	1.986
Doctors, pharmacists, psychological psychotherapists, dentists	418	425
other public health service professions	1.532	1.561
social professions	286	293
Health craftsman	123	124
other health special professions	70	69
other professions in the health service	1.021	1.036

Source: Statistical Federal Office, health reporting of the federation, 20-04-2010

Within the next years, the social need for manpower will further increase, while the potential of competent personnel is sinking (Schnur/Zika 2007). Hence the healthcare industry must adapt itself to an increasing competition with other industries for qualified employees. At the same time the employment structures, the professional requirements as well as the available professions and qualification profiles are simultaneously subject to considerable changes. Structural radical changes imply a need for customization in regard to competence and qualification, which currently is accompanied by an increase of distinction and specialization in the occupational field "health and care", which leads to the consequence of partly unsolved roles, function assignments and professional prospective trends.

Illustration 1

Trend in employment in the health sector in Germany (2000-2009)



Source: Federal agency for work (2010)
Note: This figure shows demographics of employed workers with a social insurance in Germany between the years 2000-2009. It differentiates between the Health Sector (Gesundheitssektor), Social Services (Dienstleistungssektor) and Altogether (Insgesamt))

Current analyses confirm that the employed person quota of women has increased intersectorally in (West-) Germany within the last years altogether, but not in regard to acquisition participation measured in terms of full-time equivalents. The increase of the acquisition participation of women is based on an increasing number of small employee-employer relationships as well as by a redistribution of the acquisition volume (Expert commission for the preparation of the first equality report of the Federal Government 2011). For the health economy, in connection with this, the following trends can be identified:

- Both part-time and the full-time employment in the health and care professions increased. Altogether in June 2009, 862.000 employees were working part-time nationwide in the health and nursing sector, and further 239.000 were persons in marginal employment. Particularly in the area of the home care the marginal

employment plays an important role at the moment (Federal Agency for Work 2010).

- Significant parts of the occupation growth of the health economy within the last years are based on the increasing importance of part-time jobs and marginal employment. Between 2000 and 2009 one can retrace an increase of the part-time job (+60 %) as well as the development of marginal employment relations (+34 %) (ibid.).
- The generally high importance of part-time employment for women shows itself in the health and nursing sector as well. In June 2009 the share of the women in part-time employment in all part-time employed ones in the service sector was about 86 %. In the health and nursing sector the share of 92 % was even higher and thus reflects the over proportional amount of women working in the health and care professions altogether (ibid.).
- The age distribution of the employees subject to social insurance in the area of "health and care" shows a heterogeneous distribution. Only 10 % of the employees in the health sector are at present "55 or older", 15 % are "younger than 25 years". Furthermore a clear occupation crease can be seen at the "25 to 39-year", this one can be explained with children and education times among others (ibid.). Particularly female re-entries and job returners represent one interesting target group and resource of the staff work, which until now is hardly noticed by the facilities.
- Between 2008 and 2009 there was another fall about 6 % in the unemployment figures in the health and nursing sector. While for the occupational group of the "nurses and midwives", there is altogether a labor market situation which can be described as a full employment, another situation shows itself for the professions of the "elderly care nurses/geriatric care helpers". There was an increase of unemployment between the 1st six months of 2009 and the 2nd six months of 2010 (Federal Agency for Work 2010). On basis of the existing data no statements can be met about the facts, which qualification steps in the occupational field "geriatric care" are affected by the outlined effects.

The results of the WIEGE-Project indicate, however, displacement effects in the area of the helper qualifications and low-level entry qualifications. Many of the jobs for women in the area of social and personal services which have been established within the last years were conceived for helpers, assistants and side jobs. These tend to have low-level entrance conditions, short-term qualification models as well as bad opportunities for earning money. Additionally, within the last 15 years, service industries with high proportions of women were uncoupled from the general development of income in growing measure (Expert commission for the preparation of the first equality report of the Federal Government 2011: 7). Although outlined occupation structural changes can on one hand make it possible for women to re-enter in the health economy after the family phase (again). There exists, however, the danger on the other side that precarization, decrease in professionalism of female waged work altogether are transported in the health economy like the health work.

Results of the project “WIEGE - prospects for returners in the health economy

Aim of the explorative project “WIEGE - prospects for returners in the healthcare industry” was to establish prospects and fields of activity for re-entrants in the health economy as well as to identify starting points for a systematic re-entry management into health care facilities. Some important results of the qualitative expert interviews held in the cities of Bochum and Herne are found in the following. The interviews were held with staff responsible parties and managements out of facilities of the itinerant and stationary old people's welfare as well as the hospital sector:

Re-beginners are not courted systematically as a target group

The topic "re-entry” is no longer a marginal phenomenon; it rather concerns a large part of the women in Germany. About 61 % of the women between 18-65 years have already at least interrupted once their gainful employment and with 44 % almost the half of the women who at present is in acquisition break would like to get into the profession again (BMFSFJ 2008). Keeping the trends in employment in the healthcare industry in mind, it is to assume that the health sector as a growth market represents an

interesting occupation field for female re-entrants. This is especially valid for the core of the health care system, which stands out due to a high share of female waged work - about 84 % of the nurses in Germany are women (Isfort/Weidner 2009). However, the results of the WIEGE project have also shown: From an institutional perspective the interesting group of the female returners is until now not recognized for the labor market and re-entrants therefore are not courted systematically as a staff resource either. This can be explained by various reasons. On the one hand, the qualified employee deficit picked out as a central theme often was perceived by the questioned facilities as a future topic, although not considered being acute. To which extend the fact that examination focus of the project was the metropolis Ruhr correlates with, cannot be answered at this point. It would be plausible, however, that the labor supply in such a metropolitan area is still judged as to be sufficient. It has still to be checked, if and to which extend the results would be different in rural regions. Furthermore a high tie of the employees with the respective employer could be stated in the examination while the “re-entry” "of the outside" was rather the exception. This means that after an average 12 months up to 3 years the women - after a family phase mostly - return in the health sector again and work with their old employer. Moreover, the re-entry did not appear to be a return in most cases after actual absence but the contact to the employer was rather held on the part of the women both about contacts to colleagues and about marginal employment relations during the exit phase.

A systematic re-entry management in the health care facilities is the exception

A systematic re-entry management in the context of an integrated staff and organization development strategy of enterprises of the health economy is rather rare. With regard to dealing with female profession returners, a variety of different everyday practices can be found in hospitals and facilities of the old people's welfare. These contain practical training in hospitals to check the state of knowledge after the acquisition interruption, different arranged with regard to working time volumes and planning, getting ins on a full-time employment to compensate knowledge delays and different qualifications and companionships during the exit as well as in the entry phase. However, in the context of the interviews starting points on which a successful facilities internal re-entry management could build were identified such as:

- the early planning of the re-entry under organizational and individual professional biographical points of view, already during the exit phase;
- the enabling of profession relevant trainings also during the acquisition break; IT supported qualification platforms for example offer an interesting possibility of studying;
- the deployment of positions suitable to the qualifications of female returners, to avoid both overload and lower demand in the work routine during re-entry phase;
- the cooperation and participation of all employees at the process of the professional return as well as
- the integration of the process of the re-entry into a systematic staff and organization development strategy.

Confluence of new qualification profiles to the health economy is difficult

The availability of sufficient qualified staff has a high importance for the patient-orientated physical and nursing supply. The search for skilled personnel is in the focus of the personnel policy of hospitals and facilities of the old people's welfare. In the context of the examination this refers especially to certified care specialist staff from the areas of health and nursing as well as geriatric care. On the other hand chances for re-entrants without completed vocational education in a health profession are hardly seen in the operational practice. In contrast to that there are efforts on part of the educational institutions to provide also low-level offers for re-beginners without completed vocational training.

Besides the regulated trainings of elderly people's nurses, there are various attempts in Germany to train additional care assistance as well as geriatric care for the support and company of older people. Additional support staff has the task of caring about the everyday mastering and organization of the leisure time particularly of people fallen ill with dementia in old people's welfare facilities. This does not cover tasks of the trained old people's nurses, but rather support and activation measures like painting and making things with one's hands, walks and excursions. The legal basis for the occupation of additional support staff or also everyday companion offers § 87b SGB XI – which arose

in the context of the "Care further developmental law" (PfWG). With the aim of the better care to dementia patients in nursing homes nursing care funds also take on the costs for an additional appointment for 25 residents each with special support need. For the hospital market additional trainings arise e.g. in the area of logistical services (supply assistants), kitchen and service (catering assistants), medical and nursing documentation (documentation assistant) or secretarial jobs which aim at supporting care and relieving of activities which can be done with lower or other qualification. Summing up one can say that by the requirements on the reorganization of central power transactions also new chances can be created for re-entrants in the hospitals. Whether these chances are also actually used, however, depends to a strong extent on the existence of structures which make the search for solutions possible in a more cross-department and cross-functional way.

In view of use of new qualification profiles in the implementations of the health economy it could be stated in the context of the WIEGE-Study that between the educational offers and to the (low-level) entry into the health economy there are still adaption problems or potential for development:

- Now and then, many facilities of the health economy are not prepared for use of low-level qualifications yet. It often is not successful particularly in the area of the old people's welfare to establish new qualification profiles in the organization chart of the business durably also until after a promoting phase on the part of the agencies for work.
- This could be explained by the fact that, till now, a narrowly coupled staff and organization development strategy is rather the exception in the facilities of the health economy. Although returners can contribute to the relief of the available staff with a low-level activity profile, however, there is a lack of transparency as well as the exchange via ranges of application and durably acceptable financing concepts.
- In the questioned facilities the re-entry of the age group 50 plus as well as phases of acquisition interruption are considered critical, not least due to the work hardening and the charging working conditions. Particularly at the activities which can be performed by low-level qualifications there are partly competitions

to possible fields of activity for older employees. To say it in other words: Interesting fields of activity for female re-entrants are not occupied of the outside but are provided to older nurses of the facilities.

- On the part of the facilities and the employees there are furthermore still great uncertainties in regard to sustainability as well as the connection ability of the training measures and concepts. This considers uncertainties about changing health political or legal frameworks but also the question about possibilities of further education, so that corresponding measures do not become individual professional biographical impasses.
- Dealing and work with people fallen ill with dementia is an extremely demanding task. The question has to be asked whether low-level entry qualifications with relatively short qualification duration could lead to excessive demands on the part of the employees. In connection with this, the operational health management and accompanying studies concerning job satisfaction gain more meaning.

In the context of the expert discussions, rooms for improvement were still seen not only in view of the new qualification profiles and their confluence to the implementations in the health economy but also at the training offers for re-entrants in the health profession. In connection with this, training measures are (e.g. IT trainings) are a typical topic, which show little reference to the work routine in the health enterprises. Studying concrete cases was repeatedly described as desirable for the preparation on the operational reality.

Summary

Current studies to the employment prospects for women returners are primarily aligned with technological or engineer-scientific oriented job outlines. Keeping the design field of the health economy in view, a number of trade-specific framework conditions which offer both chances and specific challenges for the professional rescue arise. Generally speaking, one can say that the health sector as a growth market represents a promising occupation field for female profession returners and re-entrants. But there also are risks:

The working conditions before the exit phase influencing not only the duration of the acquisition interruption but also being able to contribute to the definite professional exit in the practiced profession. Thus professions which are connected to long working times and a physically exhausting work routine are especially unattractive. The other way round professions which can be practiced by low physical efforts in the context of flexible and self-determined working times apply to the re-turner attractively. Moreover, it is known from studies to the re-entry in the geriatric care profession that the high change dynamics of this profession and the fast knowledge devaluation connected with that brings new challenges after the return, which can result in a "practice shock" for the profession returner (Institute for an Operational Health Promotion 2005).

To promote a low-demanding and successful re-entry, a professional and sex sensitive staff and re-entry management plays an important role, this, however, is rather the exception in the facilities of the health sector. During the last years there were considerable structural changes in field of occupation in the health economy, which are accompanied by new, also low-level helpers and assistance qualifications. These can on the one hand open up actually new occupation horizons in the health economy. On the other hand, the study provided also first symptoms for new displacement effects and tendencies to precarization in the health work since the facilities and enterprises are insufficiently prepared for integration and further development of such qualifications. What in principle can be designed as a contribution to the professionalism of customers, employees and enterprises threatens to become the identification façade for personnel-related cost reduction strategies in the worst case.

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ORGANISATION AND QUALITY OF THE HEALTH AND CARE SERVICE SECTOR

Long-term care of the elderly aged 75 and over: A home care service

By Nuria Rodríguez Ávila and Montserrat Puig Llobet

Introduction[*]

This paper describes the long-term care offered to elderly people within the context of a special health programme in Catalonia (Spain). Nursing assessments are important in the study of quality of life among older dependents. This programme, known as ATDOM, provides home-based care for highly dependent patients aged 75 years or over. The paper reports a case study that combines both qualitative and quantitative data. In-depth protocolized interviews were conducted with semi-professional nurses involved in the ATDOM programme in the health region of "Vilafranca del Penedès" (Catalonia, Spain). The areas studied were health and needing help with activities of daily living (ADL) among dependent elders, and caregiver burden among relatives. The home care indicators assessed were based on NANDA criteria. Our analysis of the ATDOM programme revealed that patients and their caregivers reported their health status to be moderate. One key finding was that family carers tend not to provide the self-care required by elders. From the nurses' perspective, greater emphasis should be placed on developing systems for the detection of needs. Skin lesions are the most common nursing diagnosis found in people aged 75 years or more.

Definition of quality of life

The relatively new concept of quality of life is related to other terms such as happiness, well-being and satisfaction of needs. Specifically, in 1994 the World Health

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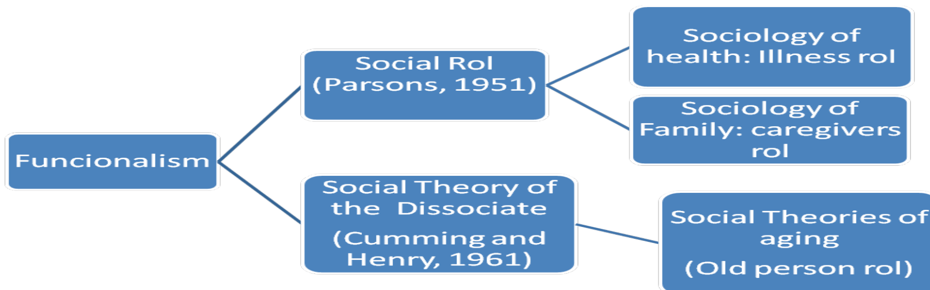
The results presented are taken from the doctoral thesis entitled Cuidados y Calidad de vida en Vilafranca del Penedès: Los mayores de 75 y más años atendidos por el servicio de atención domiciliaria y sus cuidadores familiares [Care and quality of life in Vilafranca del Penedès: Elderly people aged 75 and over and being cared for by a home care service and their relatives], defended on 23 March 2009 by Montserrat Puig.

Organization (WHO) defines quality of life as follows: "*an individual's perception* of *their position in life in the context of the culture and value systems in which they live and in relation to their goals*, *expectations*, *standards and concerns*". Most models of quality of life seek to identify the multidimensional factors which determine it, doing so by means of both subjective indicators (rated by the person) and objective indicators (rated by professionals such as doctors and nurses). The reference models in this regard are "the World Health Organization Quality of Life" (WHOQOL-100) and, in Spain, the "Quality of Life Model" devised by Fernandez-Ballesteros (1992). In the elderly, quality of life is determined by the interrelationship between the individual and the environment, specifically by factors such as the degree of independence, health status, family relationships, financial status and social relationships. In this context, any attempt to assess quality of life in the elderly must take into account the social role of elders with a chronic illness.

Sociological theories on social ageing place considerable emphasis on social functions; Talcott Parsons' functionalist paradigm stresses the process of socialization, social role and the function of social institutions. Alternatively, the dissociate social theory of Cumming and Henry (1961) seeks to explain why elderly people need others.

According to the United Nations (2002), Spain is the country largest percentage of old people, because increased life expectancy is clearly a factor that must be taken into account when analysing quality of life. Changes in family structure, together with other social changes and insufficient resources mean that the informal care system (family care) can no longer meet the care needs of dependent elders. As such, there is a need for formal long-term care services that can respond comprehensively to their needs and ensure they maintain a good quality of life.

Figure 1
Sociological theories of ageing



Source: Present authors.

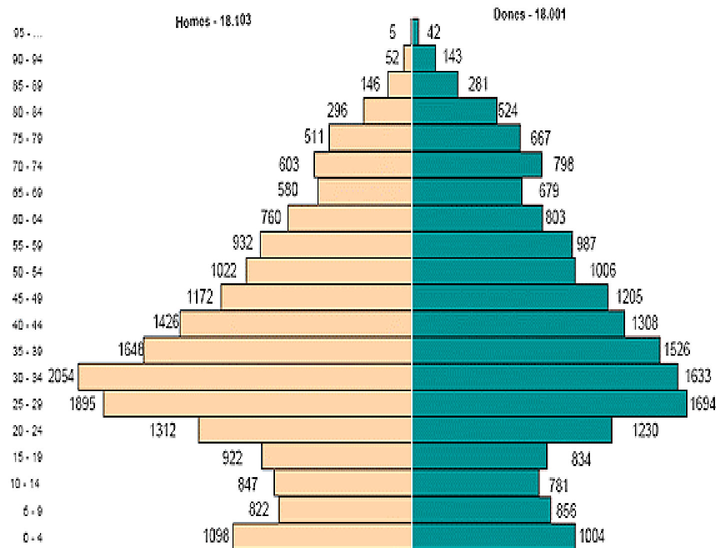
In Spain, formal resources for dependent or disabled elders are distributed across the following categories: home care services, nursing and residential homes, the voluntary sector and social services. Since 2007, these services have been governed by a new law covering dependence and disability, and which makes mandatory provision for telecare services, home care service (formal and informal), nursing homes (day or night) and geriatric institutions.

Methods

The general aim was to identify the subjective and objective elements which need to be considered in order to determine quality of life, in this case in a sample of dependent elders aged 75 or over. The study population was based on patients and relatives enrolled in the abovementioned ATDOM programme.

Both qualitative and quantitative data were collected. The qualitative data were obtained through face-to-face interviews with a representative 10% of the total population listed in the ATDOM database. The quantitative data were derived from other related surveys conducted in Catalonia and Vilafranca del Penedés. The relevant variables are shown in Figure 2.

Figure 2
The population of "Vilafranca del Penedès" (2005) by gender and age.



Source: www.ajvilafranca.es

Table 1
Variables studied in dependent elders aged 75 or over.

Subjects	Variables
Dependent elders aged 75 or over	Lifestyle • Health status (objective and perceived) • Level of dependence • Eating and drinking • Physical activity • Social relationships Subjective wellbeing: • Perceived quality of life • Satisfaction of needs

Source: Present authors.

In 2007, we conducted a total of 59 face-to-face interviews: 26 with disabled or dependent elders, 22 with family caregivers and 11 with nurses from the ATDOM programme. The interview protocol included different types of questions (closed, semi-closed and open), and the following validated tests were administered: the Zarit Caregiver Burden Interview, the Katz Index of Independence in Activities of Daily

Living, the Lawton Index of Instrumental Activities of Daily Living, the Mini Nutritional Assessment and the Social Resources Instrument (developed by PAHO).

Results

The elderly people in the sample reported a moderate health status. Most of them suffered from multiple health conditions (comorbidity) and they were taking various medicines at the same time. As regards their daily activities, help was needed with personal hygiene and shopping. In terms of lifestyle, their diet was poor in fruit and vegetables, but contained adequate proteins. They tended not to drink enough water, and the majority drank wine with their daily meal. They reported going out for walks. In general, the elders reported having a good quality of life, stressing the importance of health, independence, good family relationships, social life, resources and adaptation.

Discussion

The majority of elders attending the ATDOM programme are women (61%). They report feeling satisfied and happy with their caregivers (formal and informal care), and said they received visits from friends and relatives. However, they are not familiar with the health resources available in the town. The instruments administered showed that elderly people require help with basic activities of daily living (BADL) such as hygiene (Katz index) and instrumental activities of daily living (IADL) such as shopping (Lawton Index).

The assessment of lifestyle among the dependent elders showed that their diet was poor in fruit and vegetables (below that recommended by the WHO) but contained an adequate level of protein; however, their hydration was also poor. They reported going out for a walk a few times a day/ week. Compared with the general population they eat healthier food but in smaller proportions. In this context a study carried out by IMSERSO (a Spanish government body responsible for programmes and benefits targeted at elderly and dependent persons) reported that 84.2% of elderly people eat fresh fruit daily and 14% eat meat daily, and that they eat more vegetables and less cold meat. However, they tended to drink less than one daily litre of water. This is consistent with the findings of another study in Spain which found that 97.1% of the Spanish

population over 65 years did not drink enough water. As regards the consumption of alcohol, 46.2% of the present sample said they drank wine daily with their meals. Data from Spain's National Health Survey (2001) indicate that 35.8% of elderly people drink wine almost every day.

The factors which determine quality of life are: adaptation to one's personal situation, the availability of resources, being in relatively good health, feeling loved, being independent, and being well cared for by relatives. Adaptability and social role are important in terms of maintaining good levels of satisfaction. Overall, dependent elders perceive themselves as having a good quality of life, with some limitations. However, it should be noted that their social role changes with the social context. At all events, assessing quality of life is a way of detecting needs and disabilities while intervention is still possible. As such there is a need to promote activities for healthy aging and to reduce burden among family caregivers. In this context the work of the nursing professionals in the ATDOM programme is helping to improve quality of life among dependent elders and their relatives.

Around half the elderly people interviewed said that their physical activity was walking inside and outside their home. In comparison with other countries, Spanish elders dedicate more time to going out for walks, which is no doubt related to the country's climate. As regards leisure activities, the results show that a high percentage of elderly people do not leave their place of residence, although they do receive visits from friends and relatives. The 2006 Report (IMSERSO, 2006) stated that elderly people spent most of their time at home.

Key points

- Dependent elders perceive themselves as having a good quality of life, with some limitations.
- The sociological perspective explains social roles in terms of the functionalist paradigm or dissociate social theory (Cumming & Henry, 1961). However, it should be noted that social roles change according to new and prospective social contexts.
- The assessment of quality of life enables needs and disabilities to be detected while intervention is still possible.

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Care Is Coming Home. Towards a New Architecture of Health Service in Europe

By Rolf G. Heinze, Josef Hilbert andWolfgang Paulus

Introduction

We will start with some basics:

- The demographic change leads to an accumulation of diseases in the total population as well as to a growing need to meet the needs of elderly and chronically ill people at home.
- For the elderly living at home is the first choice: The vast majority wants to stay in their own homes as long as possible.
- Among other social and economic strategies, the use of Information and Communication Technologies (ICT) can help giving the elderly more chances to stay at home, even when restrictions due to age or illness occur.
- The household is already (and was in the past) an important health location and its importance will grow, but the socio-economic changes tend to undermine the help and health resources of families and households.
- The deployment of ICT for care in Europe is low and slow. Therefore, a new interdisciplinary dialogue is needed to speed up the design and implementation of adequate and sustainable socio-technical solutions. Additionally ICT has to be seen as only one component in a set of tools. The improvement of the care at home needs new means of support to enable elderly, families, friends, neighborhood and (medical and nursing) professionals to contribute to a better prevention, treatment and care.

A Brief Look at History

Long before Central Europe had a medical system consisting of surgeries and hospitals as we are used to have nowadays, the household in its various manifestations (manor house, castle, farm, town house) was the most important location, where coping with diseases and maintaining health took place (Murken 1988, Unschuld 2006). Back in 1896 in the German Empire 96% of all children were born at home, today only 2% of the children in the German Federal Republic see the light of day outside of hospitals

(Major 2009). A similar tendency may be observed with death: In former times people died at home, nowadays they die primarily in hospitals and hospices.

"*An interesting aspect as regards the function of hospitals teaches us the history of the Berlin Charité, which can celebrate its 300th birthday this year: "The Charité was a mere hospital for the poor until well into the 19th century. Wealthy citizens of Berlin kept away and got their medical treatment at home. The typical clientele of the Charité consisted of soldiers, destitutes, unmarried pregnant women and prostitutes. They were hospitalized by the Poor Board and usually medicated for free. Possibly, however, they had to work for their cure. Not until the end of the 18th century self-pay patients have been registered more often.*"[19]

The Household - Already a strong player in health care

Even though a large amount of the disease- and health related activities has been transferred to hospitals and surgeries in the last hundred years, many of these activities may still be found in the households these days.

"*First of all, it serves as a reservoir for the little illnesses of everyday life – ranging from minor injuries over common colds to serious influenzas. Moreover it is co-operation partner and helper of professionalized medical care. Many therapies – from drug administration for bedridden patients over motion exercises with the chronically ill to changing bandages and braces – could hardly be carried out without the help of relatives, other household members or neighbors.*

In excess of these quasi "normal" health activities of households, two additional health-related, from the view of health care politics and economically very important fields of activity of households have been established, which both benefit from a close cooperation with professional health providers: The domestic care of primarily elder people as well as the field of homecare where medical treatment of particularly chronic diseases is carried out permanently at home." (Heinze et al. 2009)

In the year 2007 in Germany 2.25 Mill. people were in need of care and recipients of benefits from the nursing care insurance, this is why their number is known. 32 % lived

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[19] http://www.bmm.charite.de/aktuelles/dauerausstellung/BMM_Hintergrundinfos_Charitegeschichte.pdf

in nursing homes. The majority (68 %) was cared for at home, mainly by wives and daughters. 66 % were cared for by their kin only, the rest by ambulant nursing services (Statistisches Bundesamt et al. 2008).

In the year 2005 about 1 Mill. people suffered in Germany from dementia. About 200.000 people will develop dementia every year. Most of them are cared for at home (Weyerer 2005).

The socio-ecomomic change tends to undermine the health and help resources of families and households

The structure of households has changed considerably in the last hundred years, especially as regards the number of household members. In addition, there has been a reduction in the period of time that partnerships last on average. Marriages end more often in divorce by the Family Court than by death. Moreover, other forms of cohabitation of men and women have established themselves apart from marriage.

The Data Report 2004, published by the Federal Statistical Office (Statistisches Bundesamt 2004), gives an overview of the forms of households and life forms in Germany. In 2003 there were more than 38.9 million households in Germany. As regards the peculiarities and characteristics of this household landscape they become especially clear, when changes are viewed in the profile of this landscape. Then, the following trends especially attract attention:

- The extended family - with five or more people - belongs to the distant past. At the beginning of the previous century, it was with a share of 44% of the total number of households still largely the dominant family type. Now it has virtually become a marginal phenomenon with hardly more than 4%.
- In general, the trend is strongly towards smaller households. In 1950, 55.3% of all people still lived in a household with three or more heads, in 2003 this proportion had already almost halved, with 29.3%. The average household size in 2003 was only 2.13 persons, but at the turn of the century it had 4.49 persons (ibid. 41). Nearly 13.2 million people lived in two-person households.
- The growing importance of single households is especially noticeable. At the beginning of the previous century living alone was a marginal appearance, in

1950 20% of all households were single person households, by 2003 the number again increased to 37%. "*Overall, some 17% of the population lived and kept house alone in May 2003, in 1991 the figure was 14%." (ibid. 45). 13.8 million people were living alone counted by the number of heads. Living alone is particularly pronounced in big cities, while this trend has not become established on such a large scale in rural areas.* "(ibid. 45)

- The world of single households, living alone, is strongly influenced by older people. "*Overall, just two fifths of the approximately 13.8 million living alone in May 2003 (38%) were in old age (65 years), while over a fifth (22%) actually belonged to the age of 75 years and more.*" (ibid. 45) However, this does not at all mean that an interest in living alone increases in old age, quite the reverse: the proportion of older people living alone has been declining since 1991, with 38 % for the senior citizens in May 2003 it was five percentage points lower than the proportion in 1991.

The households in Germany have become not only smaller and older; it is much evident that over the years they have become significantly more unstable. An important indicator in this context is the divorce rate. In 2003, 383 000 marriages were contracted in Germany, but also 214 000 were divorced. In 1960 the ratio was 1.0 divorce per 10,000 inhabitants, this ratio increased over the years more and more to 2.0 in 1990 and to 2.6 in 2003. "*Considering the length of divorced marriages and the continuation of the current divorce rate, one could expect that about 42% of marriages are divorced in the course of time.*" (Statistisches Bundesamt 2004: 46)

Although the erosion of the traditional family is obvious, this does not mean that there are no bonds between the generations anymore. The intergenerational relations cover both the receipt of assistance for the elderly by younger family members as well as aid and cash transfers from the older generations towards the younger family generations. "*Today, the multilocal cross-generational family is predominant. The vast majority of adult family members do not live within the same four walls and under the same roof. But nevertheless they are physically not far apart. The intergenerational relationships are characterized by a close emotional bond, by frequent contacts and by diverse and comprehensive support services.*" (Bundesministerium für Familie, Senioren, Frauen und Jugend 2007: 153)

The Data Report 2008 (Statistisches Bundesamt et al. 2008: 49) refers upon the development of alternative forms of life: "*Despite significant transformation processes of the family in Germany, the married couples with children are still the most widely used forms of life. In addition to traditional family forms alternative ways of life have established in East and West Germany. Solid partnerships outside of marriage are found in both common and separate households*."

In addition, continued close relations between the generations can be observed: Adult children, who leave the parental home, are not necessarily difficult to reach or to be contacted. Even adult children live primarily in close proximity to the parents. Additionally, support services and communication within the family are strong. The vast majority of young women and men wish to have children for their own. For the German population the family has not only a high priority, people are very content with the family life as well." (ibid.)

Besides the social changes of the households the economic changes should not be forgotten. The income and the asset of the elderly increased in the last years. But the distance between poor and rich elderly increased too. For the future one can expect that due to discontinuous employment and occupational careers the income of a lot of elderly will decrease (Enste 2009).

The importance of the household as a health location will increase

With a decreasing trend in productivity – mainly due to an increasing number of single households – the demands on the household as a health location will rise. The following basic conditions play a central role:

- The motto „outpatient before inpatient" in care and therapy leads to the fact that people stay longer in their homes.
- Shortening the length of hospital stays in the emergency and rehabilitation hospital, brings people faster, but not necessarily healthier back to their homes
- The aging of society will also lead to more people in need of help and care, due to physical illness and / or disability but also because of demental disease.
- Although the medical, technical and scientific progress allows to remedy or at least mitigate age- and disease-related physical and cognitive deficits, it can also

cause the need for further support: By implantation of an artificial aortic valve, in most cases the quality of life may be improved considerably. Also, the patient must take anticoagulants for the rest of his life, which entails a a permanent monitoring of blood coagulation and an adjustment of drug doses.

ICT for Ageing and Health at home: An overview of history, devices and services

Social Alarm Systems

ICT for housing designed for older people is not an invention of the 21st century. Early beginnings of ICT for housing in Germany can be traced back to the early 1970's. Phone chains were organized by elderly people themselves or were initiated by professionals. A phone chain uses the standard telephone equipment. A group of persons forms the social component of the phone chain. Whenever one member of the chain does not react to incoming calls the caller initiates a predefined action (e.g. informing the doctor or the kin). This ancient form of ICT for housing is in use to this day and is even a promoted by professionals (Görgen et al. 2002, p. 35).

The next step in ICT for housing were social alarm systems. This development came along with the reorganization of ambulant nursing services. Until the 1970's ambulant nursing in Germany was carried out mainly by district nurses. They were organized and financed by the Protestant and Catholic church. As fewer and fewer young women were willing to be a district nurse and the number of active nurses was steadily reduced by retirement, ambulant nursing in Germany had to be reorganized[20].

The result of the reorganization was the "Sozialstation" (social welfare centre). In 1970 the first German welfare centre was founded in the city of Worms (Weber 2005). In the old days of ambulant nursing one district nurse alone took care of a rather large number of patients. In the new social welfare centre, the district nurse became a member of a team of professionals. Such stations are (partly) funded by the state and health insurances.

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[20] http://www.diakoniestation.de/default/geschichte/geschichte.htm

In the following years the new model of ambulant nursing spread out all over Germany. In 1974 the St. Willehad-Hospital in the city of Wilhelmshaven opened a social welfare centre. It was the first hospital in Germany, which opened such an organizational unit. Along with the new organization of ambulant nursing a new approach was developed to improve the ambulant patients' situation by the use of ICT.

The hospital's administrative director Wilhelm Hormann experimented with ICT in ambulant nursing and today can be looked upon as the "father" of the social alarm system in Germany (Hormann 1980). During the second half of the 1970's experimental versions of the system were developed. One of the first prototypes was a wireless system (Paul 1976). Its development stopped, because the "Deutsche Bundespost" (the former federal agency for mail and telecommunication) did not provide the required frequencies. Furthermore the reliability of the wireless equipment was not sufficient at that time.

The following prototypes used the telephone net. In 1981 the time of experiments was finished and the HTS831 was presented (Marx 2006, p. 60). The system had been developed by the firm AEG. AEG also developed the technical equipment for the social call service centre. Later the AEG lab, which had developed HTS831, became a part of "BOSCH SICHERHEITSSYTEME" (Seibt 2005). HTS831 was a box, which was connected to the telephone line. Frequently the customer's telephone was placed on top of HTS831. The telephone and the box could be used without any modification of the telephone line. HTS831 had a red and green button. In case of emergency the user pushed the red button and was contacted by the emergency centre. If the user was unable to reach HTS831, he or she could initiate an emergency call via the "Funkfinger", a wireless transmitter, which the user wears like a necklace. The green button had to be pushed at least once a day. If the user did not send this signal, he or she was contacted via HTS831. If she or he did not react, the centre initiated a predefined action.

When Wilhelm Hormann started the development of social alarm systems in the 1970's, similar projects were initiated in other European countries (e.g. France, Great Britain, Sweden, Switzerland) as well (Hormann 1980). Still, it took until 1981 when the German Red Cross installed its first Social Alarm System in Berlin.

From the beginnings in the 1970' s with a small number of subscribers the German social alarm system expanded to a nation-wide one with more than 350,000 subscribers in the beginning of the 21st century . In September 2006 the German Red Cross, the largest German provider of social alarm systems announced its 100,000th subscriber (Marx 2006, p. 56). Other important German providers are Arbeiter-Samariter-Bund, Arbeiterwohlfahrt, Johanniter- Unfall-Hilfe, Malteser Hilfsdienst and Volkssolidarität. While the technology of the home emergency call systems developed itself moderately over the years, the offered sevices have changed from "emergency call" to "service call" (Marx 2006, p. 35). The system is not only used to call for help in emergency, but also for the organization of help for housekeeping, shopping, ordering meals on wheels etc.

Since 2006 the German Red Cross offers a mobile emergency call service via mobile telephones. For the location of persons the Global Positioning System (GPS) is used. If the mobile telephone cannot receive the GPS-signal, the person can be located by using the signals of the Global System for Mobile Communication (GSM). In metropolitan areas the location via GSM is very exact. In rural areas the location can be somewhat imprecise (Walter 2006).

TeleServices: Entertainment, activation and interaction with others

In the early 1990's again a new type of system emerged in the area of ICT for housing: In contrast to the older systems not only audio- information but also video-information was transmitted. In 1991 the "Haus-Tele-Dienst" (Home-Tele-Service) was established. "*This has been world-wide the first fully inter active broadband video Communications project implemented in a real setting and operating over an extended period of time."(*Stroetmann und Erkert 1999).

In the middle of the 1990's the Institute for Work and Technology (IAT) invented the "virtual home for the elderly", a new concept for living at home in age. The technical basis of this virtual residence was a video conference system. In the "virtual residence", in reality the well familiar home, the range of services offered should not differ from that offered in real (good) residences for the elderly (Hilbert et al. 1999). IAT's theoretical approach was tested in a pilot project called TESS inkontakt (Teleservices für Senioren - Teleservices for Seniors). TESS was carried out by Evangelisches

Johanneswerk, one of the largest providers of health care of the Diakonie, the German social welfare organisation of the Protestant church[21].

The technical infrastructure was provided by Deutsche Telekom, the successor of Deutsche Bundespost. The technical core of the "virtual residence for the elderly" was a communication and coordination centre, which was connected to the elderly's apartments. The data were transferred via ISDN. In the participants' apartments video telephones respectively TV sets with set-top-boxes were installed. One important additional feature was the video conferencing with up to eight participants. The centre offered the following services:

- responses to emergency calls
- responses to calls for "small talk"
- organization of different services: medical, nursing, entertainment, nutrition, household services etc.

The project's results were rather ambivalent: The participating elderly appreciated TESS, especially the video conferences. Hence, while at the beginning of the project they had to pay no fees, only a few of them resigned when they were asked to pay for the TESS-services. The elderly had no problems with the handling of the visual telephones and modified televisions. However massive problems occurred on the providers' side. The providers of technical, social and nursing services did not succeed in establishing a convincing and sustainable business concept. Such a concept was required to offer the innovative service on a continuous basis. The reasons for these problems were manifold. On the one hand in the beginning of the pilot project it was not clear, when the required technical equipment would be available at acceptable prices. On the other hand both firms involved – the social service provider and the telecommunication provider – had quite some difficulties to agree on whether TESS would make sense for them or not. Both firms were deeply involved in ongoing processes of business reengineering at that time and did not really care for details. At the end of the day, however, TESS inkontakt could be labeled a successful barrel burst.

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[21] http://www.johanneswerk.de/index.php? id=371

As a concept it was a ground braking innovation, which was probably the reason why it was accepted in pilot projects, but did not find its way to the mass market.

Telehealth Monitoring

Social alarm systems enable users to call helpers to their apartments in cases of emergency. Telehealth Monitoring Systems enable users to carry out diagnostic and monitoring actions by themselves in their apartments, which formerly had been carried out by medical professionals in hospitals or doctors' practices. An example for telehealth monitoring in the area of cardiac diseases is AUTARK (Körtke et al. 2006). The acronym AUTARK stands for "ambulant and telemedically based follow-up rehabilitation after cardiac interventions". The AUTARK-project was devised and conducted at the Institute for Applied Telemedicine (IFAT)[22], founded in 2003 and attached to the "Heart and Diabetes Centre North-Rhine-Westphalia", which in turn belongs to medical faculty of the Ruhr-University Bochum. Participiants in AUTARK during their treatment in hospital were trained in the application of a mobile electrocardiograph (ECG), which is shaped more or less like a cell phone and which they took home when they left the hospital. In cases of cardiac problems the patients record an ECG and the result is immediately transmitted via an integrated telecommunication device to the respective hospital unit.

The advantage is that easily and without asking too much of the patient "*Patient data, i.e. so-called vital parameters such as ECG, INR values, blood sugar levels, weight, blood pressure, heart sounds, as well as up-to-the-minute cardiovascular and metabolic data, can be sent directly by patients from their homes to our hospital for evaluation. This system is especially effective in detecting acute coronary syndrome, an imminent apoplectic fit, facilitating prompt and appropriate diagnosis and therapy. Telemedical controls (or telemedical consultations) are also especially well suited to all other cardiac and diabetic diseases*." resumes IFAT' s director Heinrich Körtke[23].

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[22] http://www.hdz-nrw.de/en/centre/institutes/telemedicine.php

[23] http://www.hdz-nrw.de/en/center/institutes/telemedicine.php

Meanwhile similar services to those delivered by IFAT are offered by a growing number of further providers. One example for such a firm is the “Personal Health Care Telemedicine Services GmbH”[24].

An overview of the current situation of telehealth at home in Germany can be derived from this project: E-Health@Home identifies, evaluates, designs, and implements telemedicine services for the elderly. The project contributes to the solution to problems resulting from an aging society. The objective is the development of alternatives for those who have been living in residential nursing homes due to health impairment[25].

In spite of several encouraging developments, telehealth monitoring as an application of ICT for housing is far away from being a standard procedure in medical treatment.

Ambient Assisted Living, or: Barrier-free, healthy and smart homes relieve living with disabilities!

Video-based home emergency call systems are being prepared for rollout since 15 years - but rollout is still being waited for. Nevertheless the next innovation of ICT for housing has arrived: Ambient Assisted Living (AAL) and Ambient Intelligence (AmI).

“*In a short way Ambient Assisted Living may be defined as the use of AmI in everyday life. Assisted means assistance by technical devices as well as by technical or human services*”. (Giesecke et al. 2005, p. 44). The most important technical devices of AAL are small computers, most of them invisible for users. These computers are frequently wireless networked and have numbers of sensors to collect information about their environment. Additionally they have actors to manipulate their environment. The concept of AAL and AmI is based on considerations of Mark Weiser on “Ubiquitous computing” (Weiser 1991). The systems of ICT for housing described in the previous chapters needed no or only little additional dedicated hardware. ICT for Housing with the label Ambient Assisted Living, however, implies the use of much additional hardware and networking.

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[24] http://www.phts.de/

[25] http://www.iat.eu/ehealth/

The promotors of AAL for housing intend to construct a flat or a house that cares for its inhabitants, monitors and shelters them. Main components of AAL- centred ICT for housing are sensors, actors, (body area, local area, wide area) networking, and (invisible) computers. Monitored by sensors are kitchenware, windows and doors (open/close), temperature, heating etc. The actors can manipulate the monitored devices. The kitchen stove is switched off automatically, if the cook forgot to do it. The heating is switched off as well, if a window is opened in winter. Additionally vital parameters are monitored of the inhabitants of the "intelligent" house. Either the monitoring of the vital parameters is done the way described in the chapter above, or it is done by a wearable.

A wearable is a garment that contains sensors, which continuously monitor vital parameters of its bearer[26]. The wearable's sensor is part of a Body Area Network (BAN)[27]. The BAN transmits the data collected to the Local Area Network (LAN) of the "Intelligent" House. The LAN transmits the data via a connection to Wide Area Networks to a remote medical centre.

One important player in the field of AAL is the Massachusetts Institute of Technology's (MIT) Department of Architecture. It's "house_n research" is focused on how the design of the home and its related technologies, products, and services should evolve to better meet the opportunities and challenges of the future. Massachusetts Institute of Technology researchers are investigating methods for merging new technologies with person-centred design. They are generating new ideas, technologies, and methodologies that support the creation of innovative products and services that satisfy the emerging and future needs of people as they live in their homes"[28].

In Germany the counterpart to MIT is the Fraunhofer-Gesellschaft (FhG), "the largest organization for applied research in Europe"[29]. The FhG has set up the "inHaus-Innovation-Centre"[30]12 , which consists of two components:

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[26] http://www.wearable.ethz.ch

[27] http://www.ban.fraunhofer.de/index_e.html

[28] http://architecture.mit.edu/house_n/intro.html

[29] http://www.fraunhofer.de/fhg/EN/company/index.jsp

[30] http://www.inhaus-zentrum.de/site_en/

- inHaus1: residential pr operties, opened in 2001
- inHaus2: commercial properties

The goals of MIT' s house_n and the Fraunhofer's Inhaus are very similar. Meanwhile the European Union has discovered its interest in Ambient Assisted Living, too. This interest ended up in the preparation of a new European technology and innovation funding programme: "The programme is intended to address the needs of the ageing population, to reduce innovation barriers of forthcoming promising markets, but also to lower future social security costs. AAL aims - by the use of intelligent products and the provision of remote services including care services - at extending the time older people can live in their home environment by increasing their autonomy and assisting them in carrying out activities of daily living"[31].

"*Europe Is Facing a Demographic Challenge. Ambient Assisted Living Offers Solutions" is the title of a country report, which was compiled in preparation of the funding programme described above*" (Steg et al. 2006). This is a very optimistic view, when you take into consideration that AAL has still remained in the phase of research and development. Both German and international experiences in the field of video-based service systems for the home teach the lesson that the way from research and development to a working application and business model is, more often than not, much longer and stonier than anticipated.

The strengthening of the household as a health location by ICT is necessary, but also slow in Europe

Many research and development projects have demonstrated that ICT for housing offers opportunities to support living (comfortably) at home in age. Yet in spite of these results especially Germany has difficulties to use the potential of ICT for housing:

- social alarm call systems needed 25 years to find 350.000 subscribers,

[31] http://www.aal-europe.eu/

- video-conferencing-based systems have not left the state of pilot installations since 15 years on,
- telehealth monitoring is struggling for future prospects,
- ambient assisted living, for the time being, is only a topic for insiders in the research and development business.

To date there are no scientific studies which would explain the reasons why ICT for housing in Germany is so difficult to implement. One topic most beloved by politicians is an alleged "German technophobia"; however, in most cases this has proved to be rather nonsensical. More serious arguments worth to be followed up might be found along the following, though still speculative, assumptions:

- In Germany many social workers, gerontologists and caregivers perceive technical support and enabling systems as inhuman; instead they see face to face contact as essential. They believe the quality of help would suffer if it is technically supported or even substituted.
- Under the influence of the above argument social and health politicians are reluctant to provide financing of services discussed in this article or to put them on the list of accepted treatments of statutory insurances respectively. Hence, as long as politics, industry and insurances play the game of log-rolling any more encompassing concepts will be moving beyond reach.
- Many engineers have little understanding and little knowledge of the world of social work and care for the elderly and they have a certain reluctance towards "participative" strategies of development and design. Therefore they have difficulties to design systems which would fit real life conditions of larger numbers of elderly and working conditions and concepts of social workers.
- Many pilot projects can only be started with the aid of public funding. The public financiers expect "successful" developments. Under this constraint pilots are more promising than large scale applications which always involve risks – particularly in the intersections where technology and "traditional" social services meet.

- Though large numbers of pilot projects, working groups, professional circles and societies exist in the field, there is no systematic development of technical norms nor coordination and communication about results and outcomes, so that many projects necessarily end up in the archives.

Concluding remarks

As has been shown in this article the bottleneck for the implementation of ICT to support living at home in age is not technology – rather it is the "philosophy" of development strategies, design and fit with the circumstances of everyday life of the elderly and caregivers. Technology is no end in itself. It makes sense only when it really "supports" people to fully utilize their options. From this point of view the present patchwork of pilot projects, model applications and aims definitely need more streamlining, structure and direction, if investments, both past and future, are expected to return profits.

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Local administration challenges caused by ageing population and the attractiveness of care work in the City of Helsinki welfare services value network

By Ilpo Laitinen and Kim Aarva

Introduction

City of Helsinki personnel structure and value network

The City of Helsinki organisation is comprised of 30 departments and 6 public utilities. The City maintains approximately 4,000 facilities round the city area and approximately 20 outside the city borders. In 2010, the City employed a total of 39,198 people, 32,803 of whom were permanent employees. Of them, social and health care services employed a total of 20,866 people, 16,930 of whom were permanent employees. In social and health care services women constituted 89.9% of the entire workforce. Approximately one third of the workforce had been employed for less than four years and, compared to 2009, the percentage of employees who had served for less than two years decreased among both men and women. The median age of permanent employees is 46.4 years. 2.4% of the City's permanent employees retired, but from 2007 onwards, this percentage has seen a steady increase: the retirement of large age groups is expected to start in 2013 and continue until 2020. It will not be possible to refill all the positions vacated during this period with replacement labour. In Finland, the need for care workers in care services, i.e. services in institutional care, service housing, home care and assisted living, will see dramatic growth with the overall ageing of the population. According to calculations made by Vaarama (2006) using current models, if services continue to be provided in the current manner for the current percentage of the age group, the cost of care services for the elderly will double from the levels of 2002, which was EUR 1,598 million, by the year 2030. Work-related immigration is supported by the City and even has its own, dedicated programmes. The percentage of City employees speaking some other language than Finnish or Swedish is 5.1% of the total workforce. Speakers of these other languages have been specifically recruited to the Health Centre and Education and Social Services Departments.

Recruitment has been strongly developed by investing in education, job marketing and social media. The City engages in a continuous dialogue on work-related immigration where legislation is concerned. Apprenticeship training is used to a limited extent, primarily in the training of practical nurses, where the percentage of those who speak other languages than the official languages of Finland is also the highest (46%). Recruitment training refers to training that leads to a profession and prepares the

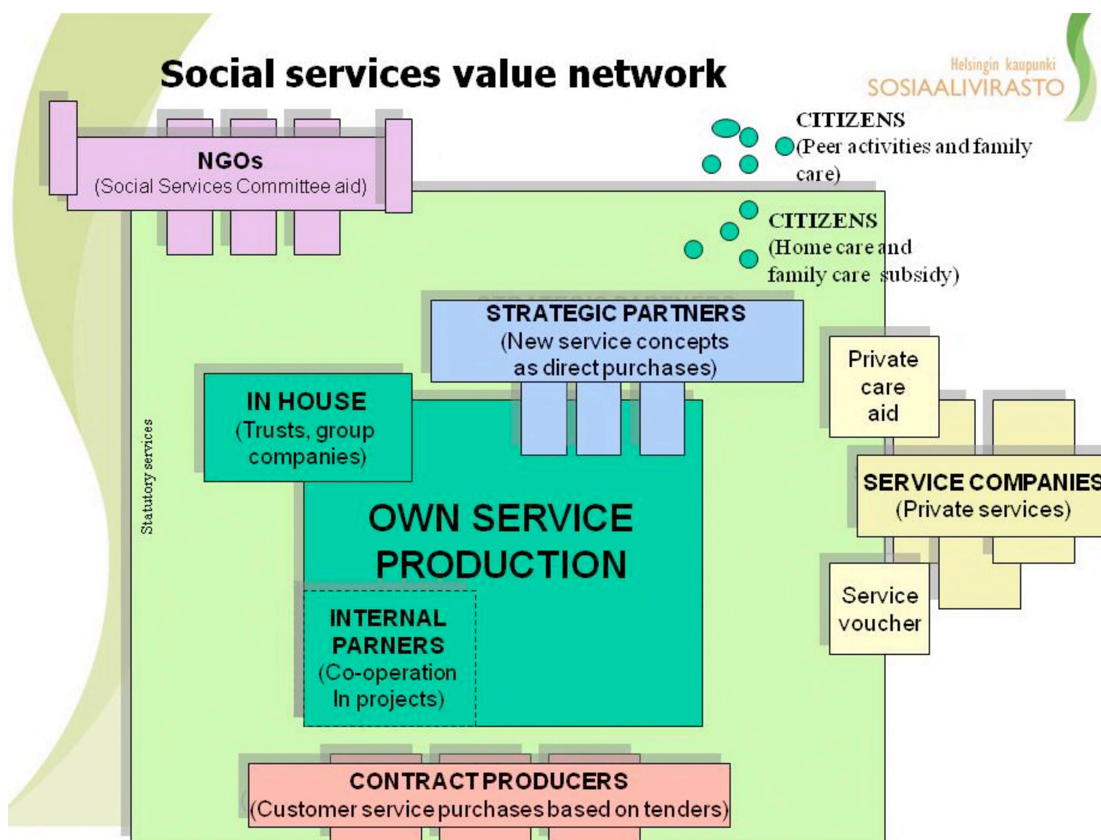
candidate with the skills to perform tasks assigned by the employer. Consequently, all those with an immigrant background provided with qualification training in nursing speak other than the official languages.

In decision-making discussions, it has become apparent that entirely new approaches are needed to produce services and not all of the existing services can be replaced by filling open positions. At the same time, competition for labour has been seen as particularly challenging. Raising the retirement age is a politically difficult issue and the outcome of this debate is hard to anticipate. A great deal of importance has been attached to efforts that develop working efficiency and productivity from a work atmosphere and social capital standpoint, through service innovations and by developing new ways to provide services. The value network refers to a strategically co-ordinated and learning multiprovider co-operative network, which both produces and distributes value. In other words, it is a networked form of a value chain as well as a value community, at whose core is the customer needing shared service, care, caring, assistance, etc. and whose need challenges network actors to act based on values. A learning structure is based on the idea that, with solutions, it is not possible to know everything in advance, but rather they must be formed problem-specifically: existing truths are not the only thing to be shared in a value community – the endeavour to establish a mutual ability to come up with solutions that are appropriate in a given situation is also vital. In a discussion of this nature, the key resource in the learning interaction structure described here is not top-level administration, but a broader, even unofficial, fabric between actors. In this case, the role of local administrators as moderators of the so-called micro-discourse becomes essential.

The City of Helsinki Social Services Board approved the Social Services Department service strategy at the beginning of 2009. The service strategy had been under draft since 2005. The Social Services Department service strategy focuses on strategic choices and policies concerning the approaches used in service production. The value network concept is included in the service strategy. The social services value network involves the generation of value as a whole, which comprehends the provision of social services falling within the purview of the City or closely related functions. Analysis of the value network is the foundation of the service strategy. The service provision value network was created to meet the needs of the Social Services Department and it is a

simplified construct of network theories, business network value generation theories and the ethical objectives of social welfare (Voutilainen 2007).

The municipality is required to provide social services by law. The value network concept looks at various social service providers as actors in the same network. The Social Services Department oversees the provision of services by applying the network concept. The value network concept is an alternative to the so-called orderer–producer model. Stumbling blocks in the orderer–producer model are administration of the whole and managing variations. The Social Services Department has integrated value network control into its current profit unit organisation and management systems. This means that the organisation's internal orderer–producer model has not been adopted.



In-house service provision comprehends services provided by the Social Services Department within its own units. The internal partners are the City's other administrative municipalities interfacing with the Department's own operations and sharing the same customers and strategic objectives. They are usually partners with whom it is possible to achieve mutual added value by combining the core areas of expertise and processes. InHouse services are Helsinki's own public utilities and

companies and organisations belonging to the City of Helsinki Group whose services do not require any bidding. Strategic partners are non-Group affiliates and actors which are fully involved in realising Social Services Department strategies and are bound by close steering. Contract providers are service providers from which the Social Services Department procures services primarily by the bidding process, i.e., using an open or limited procurement procedure as stipulated in the Public Procurement Act. Service companies are service providers operating on direct customer markets. They sell services to citizens who pay for the services themselves and the Social Services Department does not participate in customer steering. NGOs and associations comprehend civil society, citizen activism, the lobbying of various population groups and volunteer work groups. NGOs are undeniably agents that serve the public good. Private citizens and local networks comprised of them are the most important source of welfare and security. The Finnish universal social policy model also overlaps with the informal care area.

The Social Services Department value network forms an entity whose management can be considered challenging. In 2010, the Social Services Department provided in-house services in approximately 750 units, in addition to which it outsourced services from a total of over 500 service providers. In 2010, there were approximately 12,000 people employed by the Social Services Department. Social Services Department expenditures for 2010 amounted to EUR 1.2 billion, with approximately 28% going to customer service procurements.

Research method

The research project consisted of two phases in accordance with the above-mentioned research problems. The goal of the first phase (1 January 2010–31 May 2010) was to identify the key problem areas and items needing improvement in the management of the Social Services Department value network. The research methods used were literature reviews and interviews with representatives of organisations within the value network. Interviews were conducted in March–April 2010. All in all, in the first phase interviews were conducted with 17 people, 8 of whom were officers in the Social Services Department and 9 were representatives of organisations providing services to the Department. All interviewees were top level administrators of their respective

organisations. The interviews were conducted on a thematic basis. A single interview took approximately 1–1.5 hours. Interview themes were welfare services *productivity* and *innovations*. The interview questions were sent to the interviewees prior to the interviews. All interviews were recorded and transcribed for analysis. The interviewees were told that, on the basis of the interview data gathered, the study would make comparisons and summaries together with other data. The interviewees were aware of the fact that direct quotes from the interviews could be used in project research reports, but their anonymity would still be preserved.

Numerous challenges facing the value network productivity and innovation were identified in the first phase interviews. The problems and opportunities identified served as the basis for the second phase (1 June 2010–30 May 2011), in which they were shaped into practical solution proposals for value network management. The possibilities for applying the solution proposals were assessed at workshops held for value network actors. 51 people were invited to attend the workshops. 33 of them attended the workshops held in October–November 2010. Of those who attended, 22 were officers from the Social Services Department and 11 were representatives of organisations providing services to the Department. Nine of the project interviewees also attended the workshops. In addition to top administrators, the workshops were also attended by middle management and employee representatives.

Online interviews, in which a total of 241 service provider representatives participated at the end of 2009, are used in this article in addition to the interview and workshop material. This method was used to determine the perceptions of outside actors concerning the Social Services Department value network. The discussion focused on Department contractors, which are service providers under service agreements and appropriation commitments with the Department. At the turn of the year (2009–2010), a total of 374 invitations were sent for participation in the online discussion on social services and their production. The online discussion method is a Finnish data collection method which is used to allow a large number of people to discuss the same theme whilst evaluating the opinions of others. The method can be characterised as a group discussion method which is held online. The invited parties were selected from the Social Services Department 2009 service agreement register. 241 service providers, equalling some 64% of the total number invited, participated in the discussion. Due to the changes in labour mentioned above and the previous weight given to research with

an overemphasised focus on top administrators, it was decided that this network discussion study be focused on local network administrators who play a crucial role also with regard to work atmosphere and attractiveness.

Local administrators and the power of the microdiscourse – complexity theory on variable management

The idea and importance of local administration is seen in complex responsive processes, which fall under the complex adaptive systems (CAS) set of theories, from an organisation's local, microdiscourse standpoint. According to the theory of complex responsive processes, an organisation's true content is interaction and their local formation. People create meaning and content for organisational functions through their own experiences and relating to others as well as using various avoidance and joining games in the organisation.(Stacey – Griffin 2005; Streatfield 2001, 129–140).

Thus, in a complex responsive process, the interaction between individuals, their sense of community and, above all, competitiveness and co-operativeness form alternating dynamics in the process. These factors are constantly altering the flow of interactivity in various power games, where interaction and community are interwoven and no one individual is capable of controlling or determining the group's process outcome or target, no matter how much decision-making power they may have (Laitinen 2009, 26–34). Therefore, according to the complex responsive process, for example, the expression of top administration's will is followed by an interpretation at the organisation's local level in numerous microdiscourses whose development and orientation are influenced by local administrators, who can be hypothetically seen as playing a crucial role. In fact, some studies show that such microdiscourses are decisive in how an organisation orients itself (cf. Streatfield 2001, 1–12; Shaw 2002, 11–20). This article examines the microdiscursive issue of local interaction and assigning meaning in local administration.

Interaction has a special emphasis in the management of care work. According to Knij and Kremer (1997), caregiving is work which may be salaried or non-salaried and which involves the psychological, emotional and physical care of those who cannot cope on their own. Caregiving may also be simultaneously work and seemingly inactive presence, just being with another person without an objective. According to Anttonen

and Zechner (2009), it is easier to say what caregiving is not than to say what it is. Caregiving is less result-oriented: its purpose is to make everyday routines run more smoothly and safely, without any specific goals. It is difficult to say where care begins and where it ends. According to Tedre (2000), the absolute core of care is repetition, routines. Care itself only becomes evident when it is absent. In a study conducted by Aarva (2009), it is not always clear in care management who is actually in charge of providing care in a real situation, because the situation is a very self-governing event at the patient's home. Care is an interactive event. Julkunen (2008) sees conflicting trends in recent Finnish history. Caregiving services have been productised, management has become professionalised and care itself has been compartmentalised. It seems as though the innermost core of caregiving, i.e., caring and being present, are missing from the list of rationalised care work. It seems that the internal logic of care is moving away from, for example, the principles of linear result-oriented management. Although care management is expected to be efficient from a cost standpoint, in actual care situations the emphasis is placed more on a relaxed, unhurried interaction, presence and love.

The administrative tools employed by local administration and strategic management have slightly different emphases. A strategy is generally perceived as a shared vision to which every member of the organisation is committed. Strategic discussions at the top administrative level are primarily expressions of will. The strategic debate of top level administration requires support at the local administrative level for discussions on the meaning and objectives of daily routines. The underlying assumptions of classic strategic management are largely based on the systems theory. A systems organisation is ideally built on rational, straightforward plans. A system is often a simplified model of complex, complicated phenomena of reality. Complex thinking emphasises random interaction networks, nonlinear organisational behaviour, in which the future is built in each and every present moment, over and over again. The functional dynamics of the complex responsive interaction process are paradoxical, as it is dominated by balance and chaos at the same time.

In the complex adaptive systems theory, complexity can be described as a sort of phenomenon study in which each aspect originates from the interaction between various actors and involved parties. In other words, according to CAS theories, the core is a situation where particular objects struggle for a finite amount of resources. One of the attributes of the emergence phenomenon is the idea that something can emerge without

the influence of some key actor, control or co-ordination. In complex systems, some things are believed to occur or appear without the influence of an "invisible hand". In complex adaptive systems, there are a large number of interacting agents or involved parties. When these agents are interlinked, or networked, they can be said to have formed a network, whilst also being part of one. This is how networks have become an essential part of the complexity theory and research. For many researchers, the interactive relationship of involved parties in networks is synonymous with complexity research. (Laitinen 2009, 26–34; Jalonen 2007; Jalonen 2007, 149–153, 159–169, 171–184; Demers 2007, 157–161; McMillan 2006, 13–18, 25–35.) Involved parties can adapt their behaviour in relation to their goals and strategies, according to their own experiences and history. At the same time, the agents may attempt to independently improve the efficiency of their own actions and achieve their goals. A group of competing and decision-making actors will self-organise without outside coercion.

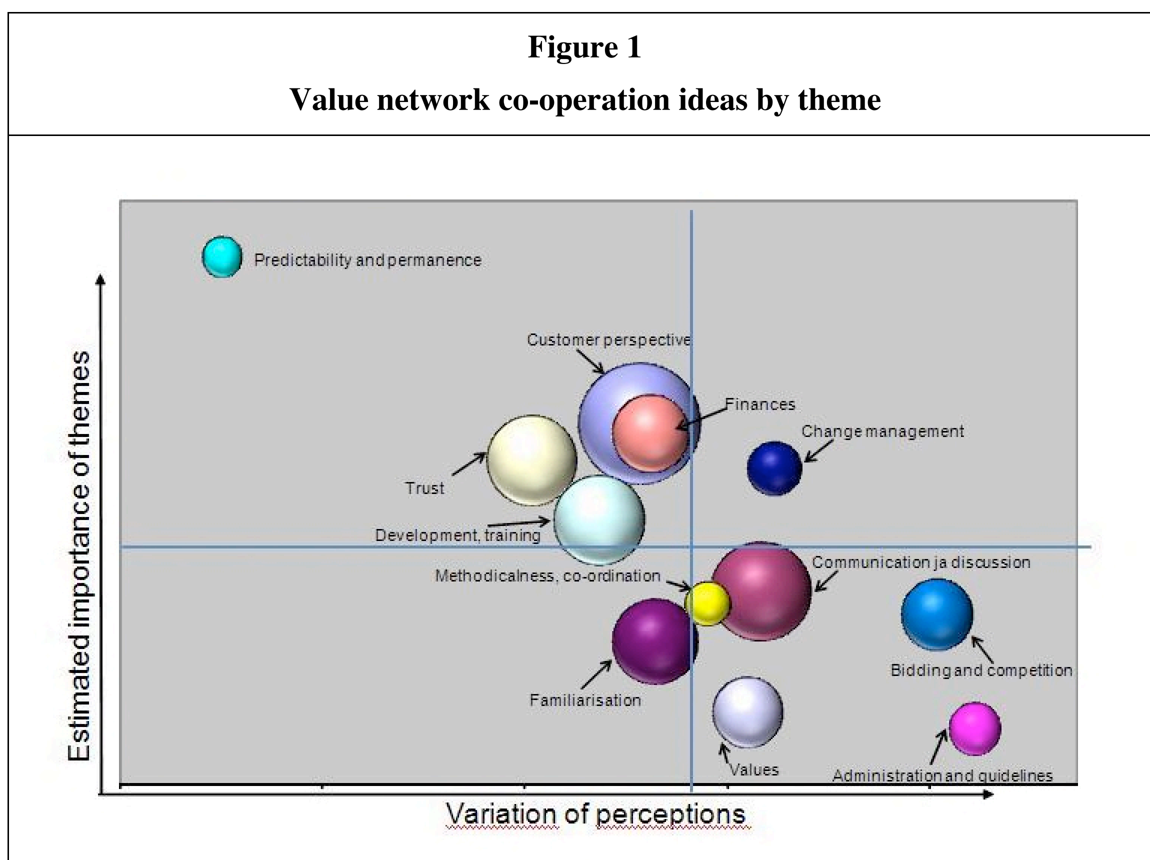
The complex responsive process is an interaction- and human-oriented CAS system critical trend in which the self-organisation of people does not involve the entire system at once, but rather applies specifically to local interaction and involvement in this interaction through presence. These interaction relationships always involve power and power games, not through status, but through setting, processing and assigning meaning to goals (Laitinen 2009). In networks, involved parties and agents (e.g., individuals) form various coalitions, which have a tendency to change constantly. Therefore, there is not a single will in networks, but the dynamics specified above. In networks, those dynamics appear, for example, as microdiscourses that feed its function and change, as coalitions of close parties that cannot be led or directed centrally (Ibid.). In fact, in this article, we claim that it is none other than local administrators that influence the dynamics of precisely that process development and control.

Results obtained from online interviews with social service providers.

At the beginning of the online discussions, the participants were asked what came to their minds when talking about the social services value network. The contents of the received responses varied a great deal. Most respondents (43%) think of value networks in terms of providing social services in general, or goals and functions concerning their own organisation. The values and a value base that steer social services were strongly

associated with the concept of a value network. A large percentage of the respondents (38%) addressed the value base of social services. Over one third of the perceptions stated a network-like approach as a description of value network operating forms. In these cases, the flow of information and central co-ordination of multifunctional co-operative networks, in particular, were mentioned as attributes of a functional network. Some discussion participants felt that the value network was an ambiguous or misleading concept (10% of the responses given). In most cases this involved a conflict between values and business terminology.

Figure 1
Value network co-operation ideas by theme



In online discussions, participants were encouraged to, for example, come up with ideas on how to make value network co-operation work most efficiently. Respondent perceptions on value network co-operation were analysed both as individual ideas and classified by theme. Individual ideas were classified thematically based on their content. Each idea was linked to all categories that included items related to it. Themes were interpreted both in terms of estimated importance and variation of perceptions by using a matrix: themes that the respondents found very important and differed either by little

or greatly as well as themes that they felt were of minimal importance and differed either greatly or by little.

The size of the circles indicates the number of responses addressing the theme (percentage of all responses), with the vertical axis showing the average estimated importance of themes and the horizontal axis showing the deviation of prevailing opinions. The following list shows ideas for social services value network co-operation by theme as percentages of respondents in order of size. The percentage indicates the portion of ideas given related to each theme. A single idea could belong to more than one theme category based on its content.

Table 1

Theme	%
Customer perspective	25
Communication and discussion	17
Trust	14
Development and training	14
Familiarisation	13
Finances	10
Bidding and competition	9
Values	9
Change management	5
Administration and guidelines	5
Methodicalness, co-ordination	4
Predictability and permanence	3

Customer perspective, trust, development and training, finances and predictability and permanence were considered important themes fairly unanimously. Where the customer perspective was concerned, participants in the discussion stressed the individual assessment of service needs and choosing the most appropriate solution based on them. Participants also emphasised allowing the customer to make their own choice. Participants also considered it important that the customer not be forced to navigate through numerous service channels and that the thresholds between different actors and sectors be made to look as low as possible, at least where the customer is concerned.

A large percentage of the respondents felt that trust was important. Some specified more concrete goals, such as long-term agreements and quality goals for service content.

Openness also raised a great deal of discussion. Thought was given to, for example, how broadly content and practices could be openly discussed in such matters as services up for bid. Service development was seen to suffer from fast-paced change. Commitment to development requires that co-ordination responsibility is clearly assigned to a certain party (in many cases, the City) and that opportunities are provided for allocating resources. In terms of development and training, many wished to see more concrete opportunities for joint functions and the sharing of costs.

Developing the operation of the value network as a whole was considered affordable in terms of overall economy. There is a relatively significant difference of opinion, particularly between non-profit and private operators, regarding the transfer of operating costs to the price that the City pays. Many themes were related to the predictability and the permanence of the operating frameworks. Forecasting protocols and flexibility were yearned for in contract relationships. Reducing personnel turnover was also seen as a key goal.

Although change management was important, there was some divergence of opinion. Change management was especially linked to the extent and timing of providing information on changes. This information was considered insufficient. Multiculturality is a major change trend, as are the change pressures on organisational actors. Participants were also asked for their opinions on the Social Services Department service strategy. They considered the strategy and stated policies as successful. Most suggestions for improvement dealt with securing the operating requirements for various types of organisations as well as ensuring customer interests and real opportunities of influencing. It was hoped that the strategy could be taken from the plan stage and put into practice, made concrete. Public utility service providers hoped for an extensive facilitation of operations which are somewhat difficult to describe by quality criteria and service level attributes. Organisations emphasised the use of an expanded definition of quality and partnership-based procedures. Private operators placed an emphasis on the equal treatment of all actors, without the preferential status of, for example, InHouse providers.

Raw data from online discussions was analysed with a data-based approach from a management and control standpoint. The following dimensions can be identified in the

discussion on the management of the value network: systemic, strategic, quality, interaction and ethical.

Systemic dimension of leadership

> A factor that was considered to promote co-operation was the clear organisation of the system, or the value network. The goal is for the value network to have a clearly structured control system that includes partners and where responsibilities and roles are divided according to arguments promoting partnership.

Strategic dimension of leadership

> Co-operation demands common goals, criteria and strategies in order to achieve set goals.

Quality dimension of management

> Co-operation is most successful when there is a great deal of multidisciplinary expertise within the value network. Co-operation works when bidding criteria is loosened and economic efficiency requirements are reduced for the benefit of the service quality received by the customer.

Interaction dimension of management

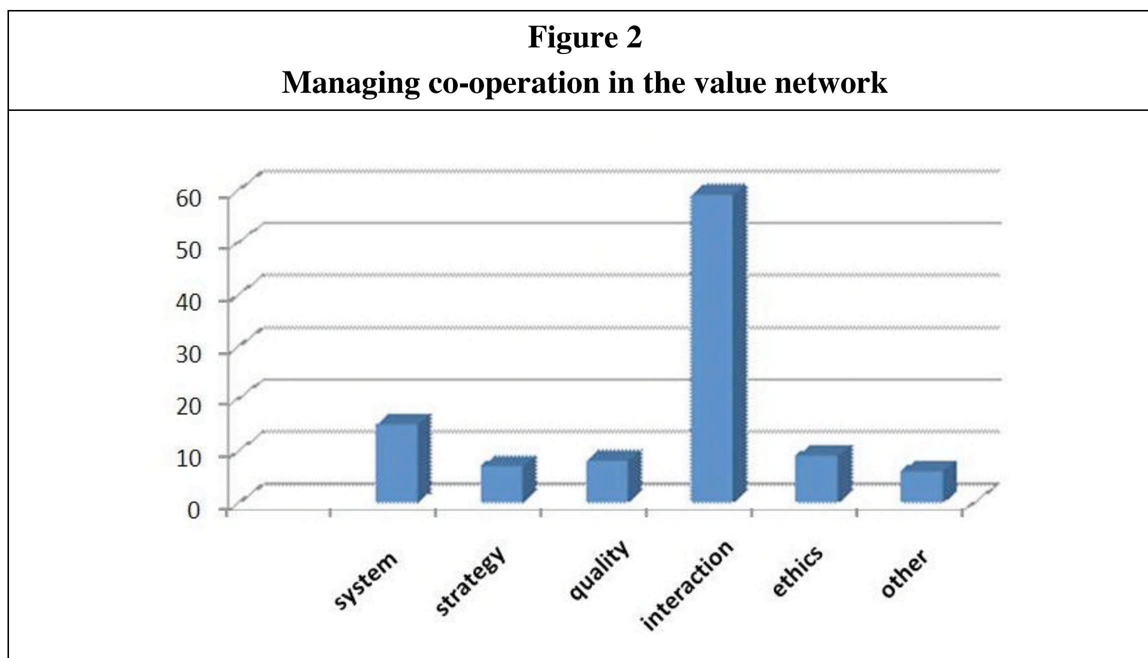
> The value network should have structures, time and the opportunity for interaction. Interaction between value network actors should be open and there should be a common knowledge base.

Ethical dimension of management

> It should be possible to engage in a common value discussion and contemplate ethical choices in the value network.

In issues describing the value network co-operation, interactive factors were considered the most important (59 mentions), whilst strategic dimension factors were considered the least important (7 mentions). The table below lists the mentions given in different categories.

Figure 2
Managing co-operation in the value network



Local administrator views on network functions and the value network

A majority of those interviewed in the "welfare services value network study" and workshop participants were representatives of top level administration in their respective organisations. Therefore, there was a desire to chart the opinions of local administrators concerning network functions, because they represent the level of management working close to the customer interface. Local administrators also play a key role when discussing the productivity and innovation of the service system.

The local administration of social and health services (whether public or private) has been studied relatively little compared to general management research (Aarva 2009). For example, no research has been conducted in Finland on the local administration of elderly care, whereas as many as five studies have been conducted in Sweden (Eliasson-Lappalainen et al. 2005). Very little research has been conducted on local administration in the social sector (e.g. Aarva 2009). There is also little Finnish research on management in the social sector. Pekkarinen (2010) found a total of 28 Finnish studies, only eight of which were doctoral theses. The rest were seven articles published in Finland and some statements, reviews or other equivalent texts.

In a study conducted by Heikka (2008), change management, financial and personnel management as well as co-operation and networking are emphasised in basic social and

health management tasks. According to a report by Kivilaakso (2005), the economic perspective is emphasised in social welfare and health care, with the most visible focus on personnel, both quantitatively and qualitatively. Working within a network has not yet been established as a work form.

The concept of network management is practically unknown. In an article by Wells (2006), which was based on a child welfare social work management literature and research review, it was found that most research has been done within a personnel management frame of reference, where the manager's consulting role is placed at the centre. Contract management is stressed in connection with measurement and accountability, communication and openness with change management; conflicting research results have been obtained on networking. Working within a network is considered an important management tool in research and theory literature. The challenges faced by network management include their complexity. Instead of the static ratio and turnover, management challenges are collaboration issues, such as how to promote genuine structural added value, regenerative capacity and the development of expertise and innovative operations. A significant amount of network management literature and studies define networks according to their information exchange, production and distribution. The focus is often placed on efficiency and productivity. The idea of a "plug and play" type of a network reality is widespread, but not the image of the reality of its relationships, expectations, lost opportunities, power relationships and power plays.

The reassessment of public services, which had kept gaining strength during the 2000s, poses many challenges to the professional expertise of local administrators. One could even say that local administration has never been as demanding a job as it is in the 2010s. This requires that local administrators possess more specific management skills as well as research data and specialised training to support them in their work. The top strategic management is responsible for the operation of the entire organisation, but the heart of a service organisation, its operational core, is lower in the hierarchy. A local administrator is the head of routine operations in an organisation (Nikkilä and Paasivaara 2007). According to Niiranen (2010), the local administration of social services stresses a professional context, and local administration at the customer interface emphasises an individual-centric approach, in which a situation-specific

operating model is given precedence over the organisation's strategic operating model due to the very nature of the work.

Local administration, as a management function and a level of administration, involves management in units which operate close to the employees (Isosaari 2008). In a heath care context this refers in practice to senior ward physicians (also the assistant head physician or physician in charge of ward operations), ward nurses, home care service counsellors, etc. In a social welfare context this refers to senior social workers, team supervisors, ward nurses, daycare directors, head job coaches, senior counsellors, head counsellors, etc. Local administration is management work at the lowest levels of a hierarchy. ‘Local administrator’ is comparable to the terms ‘supervisor’ and ‘foreman’, and ‘local administration’ with the terms ‘supervision’ and ‘work management’ (Isosaari 2006). A local administrator is defined as an employee with at least one hierarchical level below them. According to a Swedish study (Wolmesjö 2005), a local administrator (‘första linjens chef’) is defined as a foreman directly responsible for customer services, the supervision of their subordinate employees and the operating budget. In English, the names ‘front-line manager’ or ‘first-line manager’ are used for the concept.

Similar observations have been made in, for example, a study conducted by Reiko et al. (2010), in which an organisation's top management sees the local administrator's co-operation and network functions as vital, in addition to their basic task and financial expertise. Local administrators themselves, however, consider tasks related to personnel management to be crucial in their work. According to researchers, it seems that top level management places an emphasis on a straightforward management style where local administrator work is concerned, whilst the local administrators themselves put more stress on a leadership style of management, working directly with people.

In the autumn, local administrators who participated in the Social Services Department SoVa coaching programme (25 participants) were sent a survey (Digium survey) on network management. The objective of the survey was to chart the views and perceptions of local administrators concerning network functions and network control and management as well as to determine their opinion on the social services value network. 13 participants responded to the survey. The local administrators were asked to assess what the network means to a local administrator's work, why a local administrator should build networks and what added value networking would bring to

their work. The local administrators were also asked what they thought was essential to and challenging about network management as well as what obstacles they saw in network functions. Finally, they were asked what they thought the Department's value network meant.

The responses were analysed by using the grounded theory (Tuomi and Sarajärvi 2004). Each respondent often offered multiple perspectives to a single question. Items with similar content were grouped in each question.

Key networks in which local administrators participated according to the survey were listed in the order of the number of mentions they received (a total of 34 mentions) as follows:

- Networks related to unit tasks and work development
- Networks related to service production
- Networks related to management, e.g., management groups
- Networks from a customer perspective
- HR management, personnel management networks

According to local administrators, networking promotes development and provides support for their own work; networking increases the opportunities for influence and develops one's own work as partnership brings new perspectives to it. Achieving goals requires networking, and without goals, local administrators could not carry out their strategically mandated tasks. In other words, networking supports and improves the local administrators in their management functions. Furthermore, local administrators emphasise the information gained from networks. The respondent also underscored that working together is more than working alone and that it fosters social skills. Networking is also considered in part a natural function. Networking also improves the service received by customers, and well-being and the quality of work are improved.

Local administrators were asked what kind of a process they thought networking was. The respondents felt that the process was interesting, satisfying, challenging and rewarding, but also slow and drawn-out, requiring constant development in interaction. Networking requires systematic work – it does not happen on its own. The process demands active input and self-initiative, and networks only work if they have active

members. The process begins with familiarisation and setting common goals as well as agreeing on working methods. The network forms on its own around the matter that is being addressed and expands as the process progresses. Work is done toward achieving the set goals and, if necessary, working methods are adjusted. A network (group) might occasionally only serve a single task or matter needing attention, but in some cases, it becomes the permanent operating mode. The older and stronger the network, the more appropriate and informative it is. As a rule, networks are formed because there is a desire to avoid redundancy and to improve the quality of co-operation.

The responses given also conveyed the idea that active, responsible actors are not always available and the Department bureaucracy hinders the implementation of positive experiences. One response criticised the fact that core items may become blurred when facing major challenges. One respondent felt that networking demands the authority to perform network functions.

Responses to the question: "What steers the network?" were divided into two camps. A majority of the responses emphasised set goals. The category includes both the goals set by the network itself and the broader sectoral strategies and policies. Other responses varied somewhat in opinion, but the common denominator for the category content was self-governance. A network is seen as very autonomous, but at the same time, it relies on the passion and active input of its actors. Local administrators felt that the network is led by the following, listed in the order of the number of mentions made (a total of 25 mentions):

- a supervisor or appointed network head
- items that become important over time, commitment or enthusiasm
- a network actor or party benefiting the most from the network and sometimes no one at all
- target or goal

An essential element of network management is maintaining a confidential co-operative work atmosphere and consistency as well as the harmonisation of various interests. Other important aspects are the maintenance of functional structures, the clarity of goals and the open flow of information. The successful management of a network also

requires that its necessity is recognised and that it receives the support it needs. The ability to co-operate and interest in the matter at hand are also very important.

For the local administrator, the biggest challenge facing network operations was inadequate resources, such as lack of time and personnel turnover, as well as fragmented networks which are difficult to define. Inadequate support for network functions, a rigid, clumsy operating environment and the ability to see network functions as a management tool were also considered as obstacles. The lack of a clear commitment to the strategic policies by top level management, a lack of clearly defined operating models and varying operating environments were also considered as challenges. The lack of motivation (courage), the appreciation of partners and personal chemistry as well as the harmonisation of theory and practice also proved challenging.

The concept of the Social Services Department value network was not familiar to all respondents (a total of 12 responses). Five respondents were not familiar with the concept at all, whilst others had a good grasp of the matter.

Conclusions

Seeking to achieve productivity through structures that aim to share flexibility and expertise reduces the amount of centralised, top-down control. An emphasis on analysis and planning has typically been the reality of Finnish public organisations. Complexity and the interaction between several actors affect the fact that not even the best laid strategies or personnel strategies that aim to enhance productivity through commitment and motivation will necessarily lead to the desired and presumed outcomes or changes in working practices in concrete everyday routines. At the same time, the top level management cannot control structures in a centralised manner. In structures with multiple actors and low hierarchies, this inevitably means an increase in complexity. According to the data obtained, trust is a key concept for the development of co-operation and the local administrator is seen as trustworthy and supportive, whilst top management is seen as distant and focused on issues rather than people. Top management is described more critically than the local administrators who work in direct contact with daily work routines.

Receiving support, trust and workload are some of the aspects affecting the attractiveness of local administrator work. The strategically oriented talk of the top

management does not come into close contact with the reality experienced at the customer interface. According to the data obtained, this need is expressed in a new type of dedication to one's own work, i.e. greater flexibility and situational specificity, where meaning and content are built in the customer interface, with peers or even from the bottom up.

It can be said that participants in the value network discussion had a positive attitude toward the value network concept and implementation of a service strategy. Although multiprovider models were supported, the most weight was given to ideas that had to do with the implementation and maintenance of measures that ensure the operational requirements of one's own organisation. There still seems to be a significant conceptual conflict of the social services value network. A large percentage of the service providers see the concept as essentially descriptive of the operational value base or at least being based on it. Key goals in realising a value network are clearly defined, permanent and foreseeable rules as well as continuous interaction. According to the data obtained, interactive factors are emphasised in network management and control, whilst strategic dimension factors are considered less important. Another factor that was considered to promote co-operation was the systemic dimension in which the value network is seen as a structural, inter-organisational control system, where roles and responsibilities are divided according to arguments promoting partnership.

For local administrators, a network means co-operation that aims to ensure the success of a unit's service task. A local administrator is responsible for the formation, planning, realisation, monitoring and assessment of networks for their own unit. In a local administrator's work, the network means working groups which are related to the development of work, service production and participation in various service processes which are essential to the unit's task. A network is thought to comprehend non-organisation service providers, internal partners or colleagues who are met at different functions. Local administrators also characterise working with subordinates and participating in the unit management group as network functions. Network management is therefore shared management, following the same policy – exchange of information. In a network, it is possible to get support for one's own work and provide support to others. Multidisciplinary teams are, in the view of local administrators, also networks.

A network can also mean co-operative approaches. A network is more tightly knit than an email distribution group. A local administrator's network functions may be informal

– sparring, exchange of information and influencin by like-minded people – or a formal establishment of a network together with partners. It could be networking within one's own organisation or outside it.

Network functions are used to make meaningful contacts for the customer. Local administrator network functions are an important part of developing service quality and functionality. It is co-operation for achieving common goals, enhancing expertise and generating added value for one's own work. Local administrators form the lowest functional and operative level of a service organisation hierarchy. If top management was an organisation's mind, or its reason, then local administrators would be its heart. According to the theory of responsive processes, an organisation's true content is interaction and their local formation. The interactive work of local administrators at the customer interface is vital to achieving the entire organisation's goals, and trust in the organisation comes from working close to the customers.

If operating methods and models do not change, labour shortage will become a major problem for Finnish society in the near future, and welfare services and welfare management are no exceptions in this. This situation applies to both public and private providers of welfare services, and customer demands are also simultaneously increasing. Pressures related to ensuring service production flexibility and availability are, in fact, related to these increasing customer demands and shrinking resources. Simply increasing e-services and the desire to delay one's own retirement will not be enough. The society described in this article is in transition toward a networked and interactive negotiation society in the provision of services. According to this study, it can be characterised by newly networked, low hierarchy management models, the constructive development of network cultures, and continuous, multiform learning in the networks.

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XREAP is promoting interdisciplinarity and multidisciplinatity. This book expressed this broad perspective integrating economic and sociological points of view combined with the view of particioners in the field of long-term care.
XREAP serves as point of collaboration with different institutions at national and international level, promoting the companies participation and the Research Centres of Catalonia. It promotes the capacity to propose national and international research strands and to work together in relevant and innovation projects, as well as in the field of higher education and knowledge dissemination.

Fruit of this effort has been the organisation together with the **Management School of the Radboud University** the first seminar on long-term care service bringing together insights of the situation of this sector in Catalonia and the Netherlands. However, this electronic book includes also contribution from Germany and Finland faciliationg the lecturer a wider European perspective on developments in the lang-term care labour markets and the organisation of the care service.

One of the mayor concerns of the European Union is its ageing population and to develop adequate social and economic strategy to face this challenge. One of the key issues is how care for elderly and dependent people in the future assuring the access of all, who need care, to high quality services. There is a wide range of system configuration in the European Union as well as at national as at regional level. But all these particular systems must gave respond to two main challenges caused by the multiple demographic changes:

a) The increasing demand of professionalized care services and

b) The lack of qualified workforces to satisfy this demand assuring a high care quality under public budget restriction.

This e-book brings together articles of authors from four European countries reflecting trends in the search for new combinations between institutional, family and community provision for high quality long-term care services. We expect that the given insights on the diverse landscapes of care services and the variety of solution will stimulate the regional, national and European debate on long-term care services.

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