

FACT SHEET

An overview of the Social Services Sector in Europe

Definitions, data availability and comparability

The term “social services” in Europe is defined broadly, covering services for elderly people, people with disabilities, children, excluded and disadvantaged groups. As this paper focuses on the frontline employees of the sector we can identify the following main types of waged carers (EUROFOUND, 2006):

- “Formal carers” employed by health or social care agencies and funded mainly through public expenditure. The location of care will be in the care recipient’s home, in the community or in a residential institution.
- “Mixed economy” formal carers – waged carers working for voluntary bodies, non-profit organisations, or ‘for-profit’ care organisations.
- “Independent formal carers” – carers who are registered with an employment agency for casual and short-notice placements. These carers are often self-employed or may engage in caring work to supplement their primary income.
- “Personal assistant” carers – recruited directly by the care recipient or his family. This may be a permanent, casual or live-in arrangement.

Due to the variation in the historical development of these services in different EU-member states, an important issue that arises when conducting research in this area is the lack of consistent EU-wide data for the sector. The problems regarding the data availability include the following:

- The terms used to describe the types of professions and qualifications in this field and the variation of the organizational structures in the sector from country to country. For example, in some EU member states, social services only refer to a non-market sector providing care services to different groups. In other countries, there are three distinct sectors: public, for-profit and not-for-profit (Lethbridge, PESSIS - Promoting employers’ social services in social dialogue Final European Report, 2012). In the same context, the data-statistics about the sector collected from different countries do not cover the same time periods.
- There is no consistent European-wide categorization of the sector by the types of services offered. So far there is no data available regarding the share of employees offering services to old people, people with disabilities or to disadvantaged groups.
- There is lack of data regarding the types of professions grouped under Social Services Sector in Europe.
- There is no consistent EU-27 data regarding the share of beneficiaries (children, disabled people or disadvantaged groups) from the services of the social care sector.
- In many cases Social Services Sector data in national statistics is not separated from those of Healthcare, which is an area that might have different characteristics and problems.

The European Commission uses the term Social Services of General Interest (SSGI) to describe the sector covering services provided directly to a person in need of support, care, training, counselling, empowerment, and play a preventative and socially cohesive role. Examples include elderly people's homes, long-term care, adult education and child care services, as well as services for homeless people and migrants (Social Services Europe).

The issues of availability and comparability of the data between different countries of the continent makes it difficult to draw solid conclusions regarding the problems of the sector at the European level.

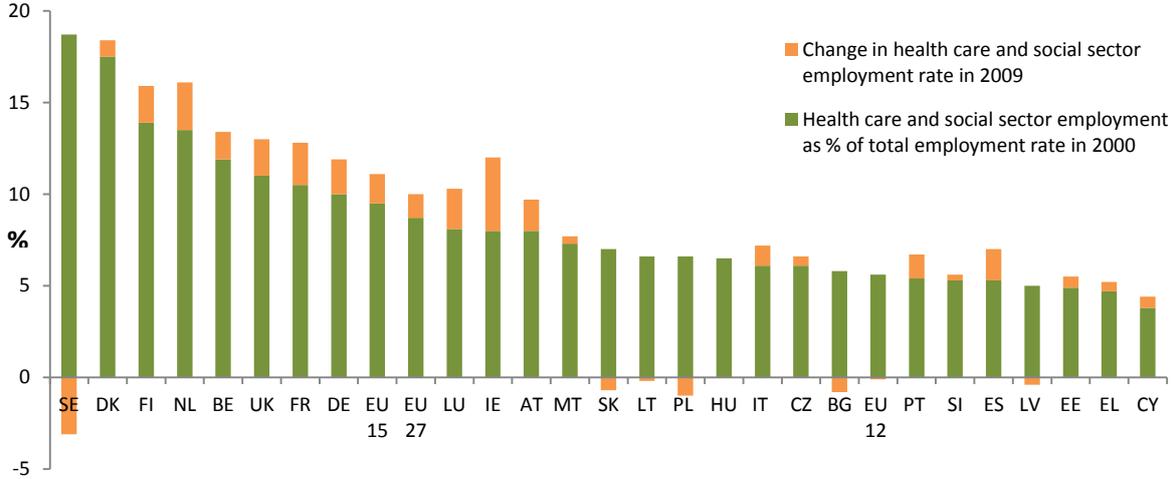
For this reason, the following part attempts to give a picture of the social service providers sector for people with disabilities in Europe presenting facts and figures that are as targeted as possible. In the cases where there is no information available for this specific area the paper provides data for a sector with similar problems (e.g. social care for elderly people) or for a broader category including social care (e.g. human health and social care, or social care in general). Similarly, this fact-sheet provides examples from different countries that are not directly comparable as the data was gathered from different sources. Still, these examples were selected to shed light on the tendencies in the social care sector in Europe.

A snapshot of the Social Services Sector in Europe

An expanding sector with a growing economic contribution

In Europe as a result of demographic and societal trends the demand for social services is growing. In fact, between 2000 and 2009, the human health and social care sector was among the most dynamic in terms of employment expansion in the European economy. In fact, 4,2 million new jobs were created in the health and social sector in the EU (see figure 1). This means that the total employment in the sector accounted for more than a quarter of the jobs created in the total EU economy during the same period (European Commission, 2010). According to the European Commission, in 2009 21,4 million people were employed in the sector. In a period of a growing uncertainty in the European job market the contribution of the sector in the European economy is significant.

Figure 2: Employment rates in human health and social work (as a % of total employment), 2000- 2009 (European Commission, 2010)



As mentioned above, social services and healthcare are grouped together in the statistics available for the EU-27 member states. Research conducted in 2012, titled “Project PESSIS”, gives an estimate of the number of employees in social services sector, (Lethbridge, PESSIS - Promoting employers’ social services in social dialogue Final European Report, 2012). According to this study, in Germany more than 2 million people are employed in social services (see figure 3).

Figure 3: Employment in Social Services sector in 11 EU countries (Lethbridge, 2012)

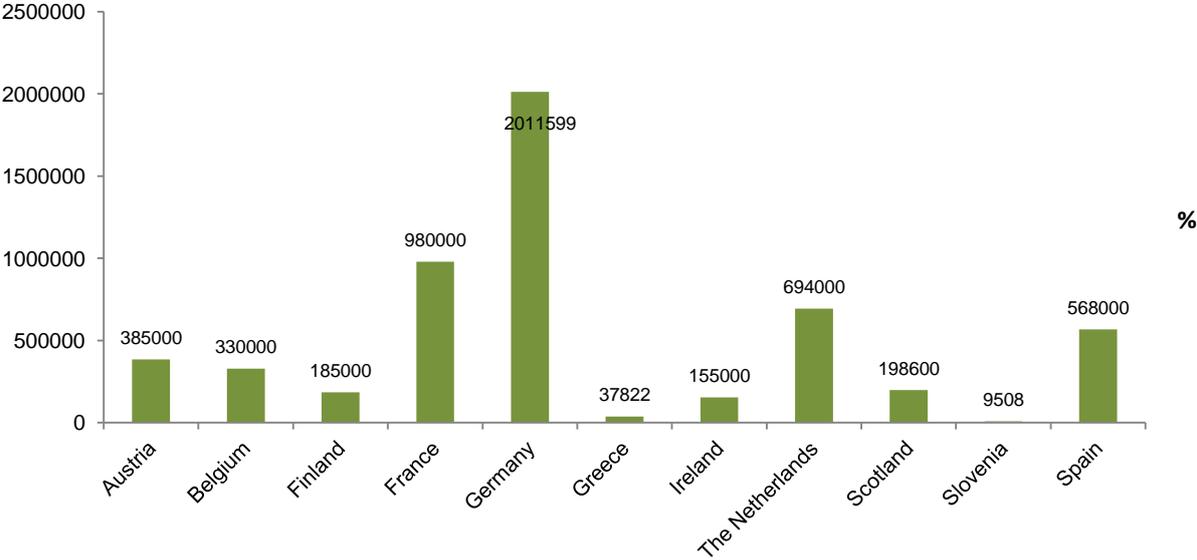


Figure 4: Value of the social services sector/growth rate (Lethbridge, 2012)

Country	Value of the sector/growth
Austria	3.35% p.a.
Belgium	Value of sector 7.8 million euro. Non-market sector growth rated 5% p.a.
France	3.7% jobs growth

Finland	7% jobs growth rate 2000-2007
Germany	1.5 billion euro. 6.7% gross added value. 16.2% jobs growth and 8.1% jobs growth (without social insurance)
Greece	Lack of evidence
Ireland	4.5 billion euro
The Netherlands	2004-2009 Elderly 2.6% jobs growth Disabled 3.2% growth Childcare 11.4% growth
Scotland	n/a
Slovenia	n/a
Spain	12.3 billion euro value added 1.17% of GDP (2010)

The impact of the economic crisis on the service providers for people with disabilities

The austerity measures that were taken in the majority of the EU member states as a response to the global economic recession and the resulting fiscal crisis have impacted the social care sector. The austerity measures are primarily focused on reducing public expenditures. Healthcare and social protection account for a significant part of the public spending. For instance, according to Eurostat social protection spending represents 26% of GDP on average in EU member states (Bernard Brunhes International Group, 2012). In this context, EU member states with high levels of public deficits such as Greece, Hungary, Romania and Portugal have taken such harsh social protection budget cuts that have even put at stake the political stability in these countries (Hostmann, 2011).

The social services sector seems to be heavily impacted by the economic crisis. The levels of expenditure reductions were more drastic in the social services sector in comparison with social security, healthcare and education (Bernard Brunhes International Group, 2012). However, the extent of budgetary cuts varies from country to country. Based on the 2011 ASISP¹ country reports that assess the socio-economic impact of social reforms we can identify two main groups of countries (ASISP):

1. Member states with limited expenditure reductions in social services (Denmark, Germany, Sweden, Finland, Austria, Belgium and France)
2. Member states severely impacted by the budget cuts in social services (Baltic States, Bulgaria, Greece, Hungary, Ireland, Italy, Portugal, Romania, Spain and the UK)

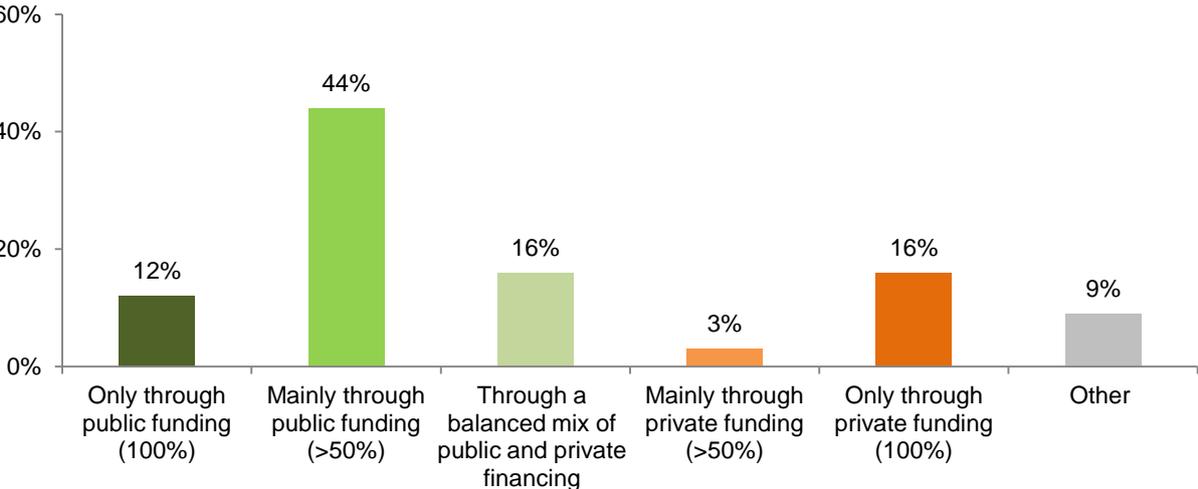
In this context, the social service providers to people with disabilities are also affected. In fact, the progress that was done before the crisis in the area of the rights of people with disabilities as presented in the UN Convention on the Rights of Persons with Disabilities (UNCRPD) is now at risk

¹ ASISP stands for Analytical Support on the Socio-Economic Impact of Social Protection Reforms

(Bernard Brunhes International Group, 2012). The funding of the sector is severely impacted. The budget cuts are not only affecting the public sector but given that even the non-public service providers heavily depend on public funding (see figure 4) (EASPD, 2012). As shared by one of the social service provider organizations in Scotland, the downward pressure on the prices of contracts with local government leads to diminishing value of pay packets as well as to increasing workload of employees when the recruitment is frozen. Also in Belgium and The Netherlands, service providers have shared the worry that the budget cuts by the government may lead to a reduction of the size of the social service sector in the short term (up to 4 years).

As a result, the austerity measures have hit the public provisions available for the private, the non-for-profit and the non-governmental social service providers for people with disabilities. Additionally, closures of social care providers are reported in rural areas in Greece, Romania, Portugal and Ireland. Another development related to the budgetary cuts is the merger between different social services or the reorganization of service providers (e.g. reduced opening hours or days) (Bernard Brunhes International Group, 2012).

Figure 5: Sources of funding of service providers to people with disabilities (EASPD, 2012)



The results of a research conducted by EASPD regarding the impact of the economic crisis on policies, strategies and programs for disabled people at national level are alarming. The importance given to the issue of disability seems to be decreasing. Indeed, almost 6 out of 10 service providers mentioned that the crisis impacted the long-term disability strategies (EASPD, 2012). Moreover, 69% of the respondents reported that the recession had an effect on the annual disability plans and programs and 72% on the operational programmes concerning service providers for people with disabilities (EASPD, 2012).

The examples mentioned in a report created by the Bernard Brunhes International Group to assess the impact of European Governments austerity measures on the rights of people with disabilities are revealing (Bernard Brunhes International Group, 2012):

- In Greece, all non-for-profit providers for people with disabilities that have been interviewed mentioned that after the economic crisis they have experienced significant cuts in their funding coming from the public sector
- In Spain a local authority confirmed a 15% decrease in local funding of non-governmental agencies that are working with people with disabilities (Bernard Brunhes International Group, 2012).
- In Portugal, between 2009 and 2011 public expenditures on professional rehabilitation for people with disabilities were reduced by 62% with a reduction of more than 26% of participants.
- In Ireland, a 15-23% reduction in direct funding to social service providers has been reported between 2009 and 2011.

Another problem that is connected with the austerity measures in the EU is the discontinuation of projects undertaken in the context of the European Structural Fund (ESF). Before the economic crisis several specialized and innovative services (such as day care and home care services) were created with significant financial support from the ESF co-financed by the member states. After the recent economic recession the local and national co-financing capabilities were drastically reduced. As a result, after the completion of the ESF projects many projects were discontinued and many services were closed (Bernard Brunhes International Group, 2012). Moreover, although the ESF can be used in order to improve the services for people with disabilities in a period of public budgetary cuts many service providers have encountered difficulties when attempting to access these funds. According to EASPD's research 43% of their member organizations who participated in the survey find quite or very difficult to contact authorities in charge of the implementation of the Structural Funds (EASPD, 2012). Similarly, 54% of the respondents encounter difficulties in finding sources of co-funding and 58% of those whose application was successful face difficulties in managing their grants (EASPD, 2012).

Moreover, according to EASPD the staffing situation in this sector is quite diverse across different EU member states (EASPD, 2010). More specifically, in some Western countries the jobs and the compensation levels were retained at the pre-recession levels. On the contrary, in Ireland and the Eastern part of Europe the crisis impacted the number of employees who either started to look for a second job, another job offer or employment opportunities abroad.

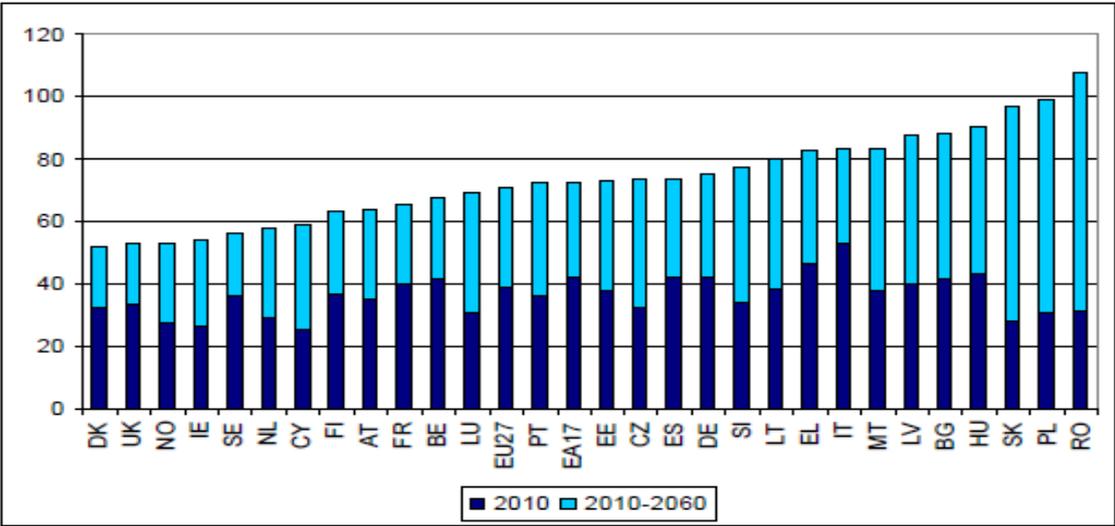
On the other hand, the staff shortage issue is less prominent in the time of recession primarily due to the fact that many unemployed people are willing to take up a position in the social care sector in the absence of job opportunities in other sectors. Several organisations that were interviewed from Scotland and Ireland confirmed the fact that recently they do not observe a lack of candidates for vacancies.

Ageing Population-Future Needs in Social Care

As the quality of life and healthcare is rising in the EU, so does the life expectancy of the general population. On the other hand, the birth-rate in Europe for the last decades has been well below the natural replacement level of 2.1. Even though, in some countries the rate seems to be closer to this

number, the overall average for the EU27 was 1.59 in 2010 and it is projected that it will remain practically stable with a small rise to 1.64 by 2030 and to 1.71 by 2060 (European Commission, 2012). Moreover, as the baby boom generation is ageing the proportion of the people in need of long term care is increasing. More specifically, the proportion of young people (aged 0-19) is projected to remain fairly constant until 2060 in the EU27 and the euro area (around 20%), while those aged 20-64 will become a substantially smaller share, declining from 61% to 51%. Those aged 65 and over will become a much larger share (rising from 17% to 30% of the population), as will those aged 80 and over (rising from 5% to 12%) (European Commission, 2012). Taking into consideration that OECD reported in 2011 that 50% of the people that received long-term care were over 80 years old (Alice Anderson, 2012), it is unquestionable that the demand for the long-term care will increase significantly in the following decades, along with the healthcare expenditures, which will be financially supported by a continuously shrinking share of the population.

Figure 6: Effective economic old-age dependency ratio² (European Commission, 2012).



Structure of the sector

In Europe three major types of social service providers can be identified: public, not-for-profit and for-profit. The share of contribution of each of these sectors in terms of employment and value varies depending on the country’s history and welfare state. Generally speaking, the public sector remains a provider of services and at the same time offers funding to private or non- for-profit providers. In some cases it also subsidizes individuals who then pay the service providers (Lethbridge, PESSIS - Promoting employers’ social services in social dialogue Final European Report, 2012). Still, as a result of the economic crisis in several EU member states (for instance Bulgaria, Czech Republic, France, Italy, Lithuania, The Netherlands and Romania) public provisions for social services are affected by the

² The effective economic old-age dependency ratio is an important indicator to assess the impact of ageing on budgetary expenditure, particularly on its pension component. This indicator is calculated as the ratio between the inactive elderly (65+) and total employment (15-64). The effective economic old age dependency ratio is projected to rise significantly from around 39% in 2010 to 71% in 2060 in the EU27. In the euro area, a similar increase is projected from 42% in 2010 to 72% in 2060 (European Commission, 2012).

austerity measures aiming to reduce the public expenditures (European Commission, 2010). In countries heavily impacted by the economic crisis such as Greece, Bulgaria, Ireland, Latvia, Portugal and Romania the budgetary cuts directly affected the social services sector employees (wage reductions, recruitment freezing, staff redundancies, etc.) (European Commission, 2010). Another trend that is obvious in recent decades in the majority of the European countries as reflected in the PESSIS study is the growth of for-profit providers.

In general, the European social services sector is characterized by fragmentation. The majority of the small-sized enterprises can be found in for-profit and not-for-profit sectors. (Lethbridge, PESSIS - Promoting employers' social services in social dialogue Final European Report, 2012). Figures 5 and 6 provide data on the share of social services jobs and number of employers by sector in some European countries (public, for profit and non-for-profit).

Figure 7: Share of employees in social services providers by sector (public, for profit and non-for-profit) (Lethbridge, PESSIS - Promoting employers' social services in social dialogue Final European Report, 2012)

Country	Public	For-Profit	Not-for-profit	Comments
Finland	62% elderly 89.7% childcare 50% other social services	18.6% elderly 5.8% childcare 15.3% other social services	18.6% elderly 4.6% childcare 34.5% other social services	Expansion of for-profit & not-for-profit
France	30% jobs	8% jobs	62% jobs	For-profit sector expanding. Not-for-profit includes 100% of disabled jobs and 37% childcare jobs)
Scotland	33.9% jobs (focus adoptions, adult placement & adult care)	39.9% jobs (focus on child-minding & adult care homes, school care accommodation & nursing agencies)	26% jobs (focus child care agencies, offender management)	Sector have specialist focus
Slovenia	n/a	n/a	26.7% of jobs	Limited data

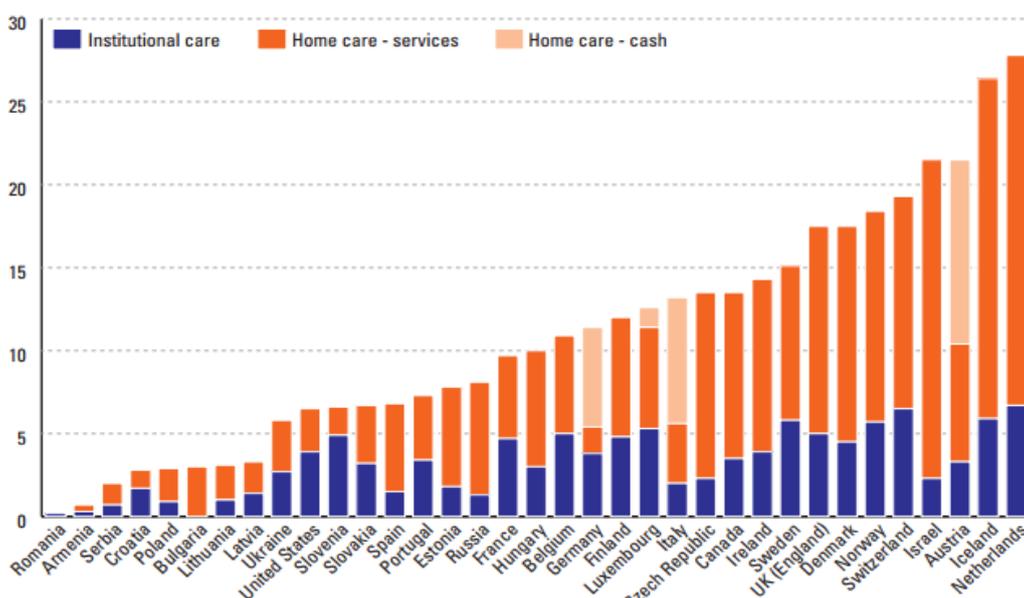
Figure 8: Share of social services providers by sector (public, for profit and non-for-profit) (Lethbridge, PESSIS - Promoting employers' social services in social dialogue Final European Report, 2012)

Country	Public	For-Profit	Not-for-profit	Comments
Belgium			2,222 Elderly services 1,063 Disabled services 2,788 children/young people	Data on number of enterprises
Germany	5% residential elderly 23.7% child/youth centers	40% residential elderly	55% residential elderly 76.3% child/youth centers	Over 100,000 enterprises with 90% not-for-profit

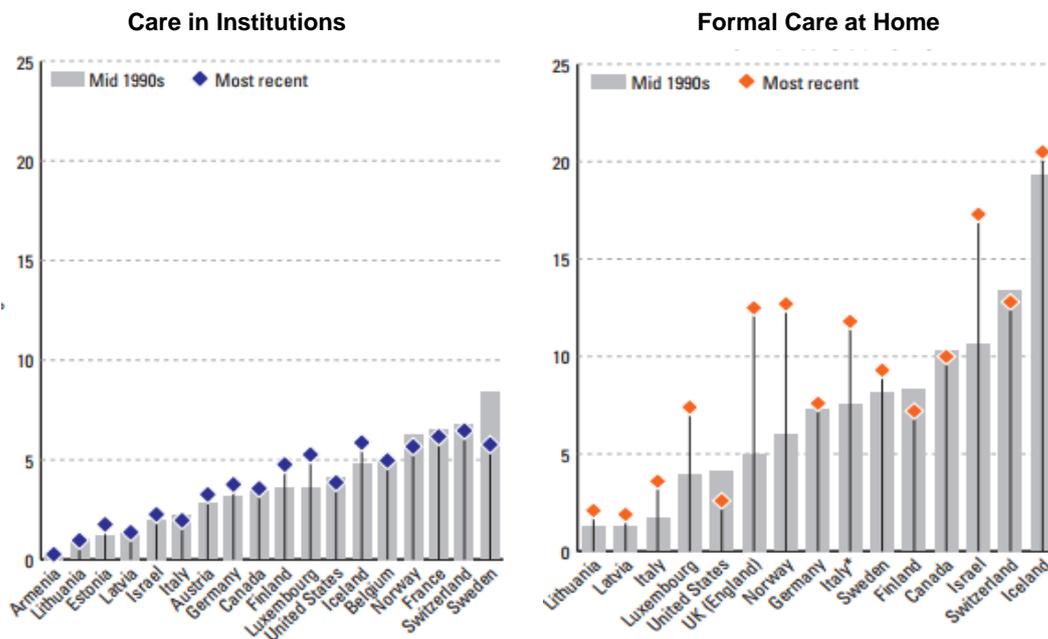
Greece	68 day care homes 1,009 assistance-at-home 1,319 municipal creches	10,000 beds in care homes 1,200 creches	270 elderly care homes	
Ireland	200 local disability centers 5,276 home helps (largest provider)	128 home care providers 3000 play centers Thousands of child minders	800 local disability centers 41 home care providers	
The Netherlands			<u>Disability:</u> 525 enterprises 75% with fewer than 10 employees <u>Elderly:</u> 125 nursing homes, 360 retirement homes, 1,150 care enterprises <u>Childcare:</u> 2,800 75% with fewer 10 employees	Disability & childcare enterprises - small numbers of employees
Spain		5,534 enterprises	19,000 social action with less than 10 employees	

Another trend in the social care sector is the increasing importance of home care especially for disabled and elderly people. According to a research conducted by the European Centre for Social Welfare Policy and Research, during the last decade in most of the European countries an emphasis has been put on ageing at home rather than in institutions (European Centre for Social Welfare Policy and Research, 2012). The trend is obvious in the following graphs (figures 8, 9 and 10). Figure 8 shows the type of care benefits received by people over 65 years old in several European countries. Figures 9 and 10 show the evolution of the forms of care provided to elderly people since the mid 90s.

Figure 9: People aged 65 and older receiving care benefits (cash or in-kind) in different care settings – 2009 or most recent year (European Centre for Social Welfare Policy and Research, 2012)



Figures 10, 11: Evolution of people aged 65+ receiving care in institutions and formal care in their homes (European Centre for Social Welfare Policy and Research, 2012)



The profile of the social services employee

The social services sector is labour intensive. Consequently, the quality of services provided, heavily depends on the employees of the sector. Although the profile of the social services employee varies from country to country, the following part offers an overview of some common characteristics of the social care workers:

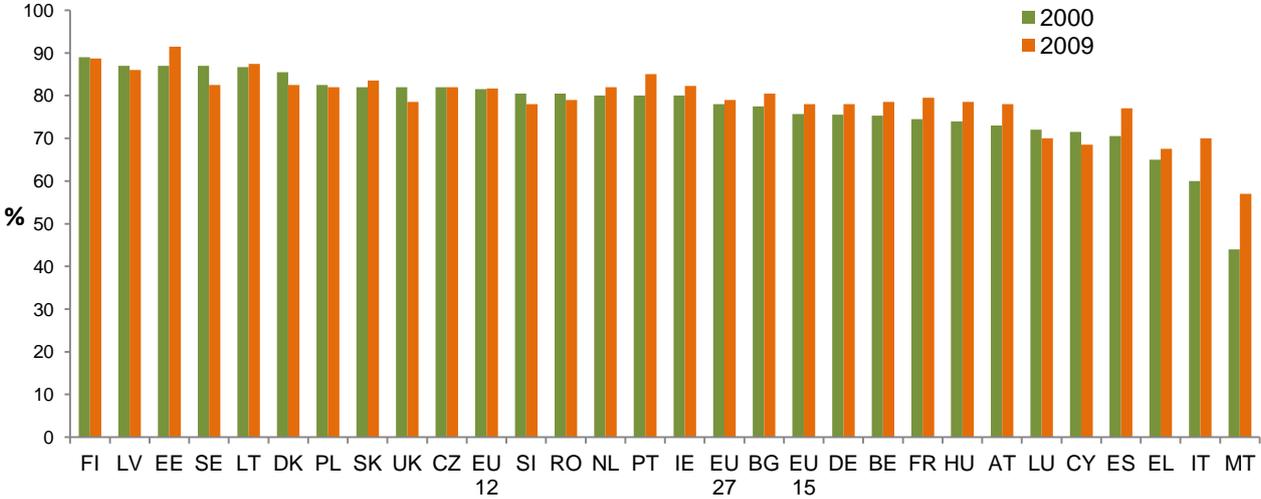
Gender

Due to employment segregation and gender stereotypes the social service providers' professions are predominately female-dominated (European Commission, DG Employment Social Affairs and Equal Opportunities, 2010). For example in Italy 89% of the social care employees are women (Simone Casadei, 2011). In England the same statistic is 82% (Skills for Care, 2012). The trend is similar in Eastern Europe, for example in Poland social care sector employs 89% women and 11% men (Social Work in Poland, 2007) and in Romania (85% women and 15% men) (Social Services in Romania – Partnerships for community care, 2013). Even in the Scandinavian countries that have a long tradition of gender equality the sector employs much more women: in Denmark 33% of the female workforce works in the sector (including healthcare) whereas the same percentage for men is only 10%, the share in Finland is 30% and 7%, for Norway 35% and 10% and for Sweden 27,5% and 5% (ILO, 2008-2013).

Although there are no European-wide data regarding the gender of the workforce in social sector the statistics regarding Health and Social Care Sector are indicative. In fact, 78% of this sector's employees are women and the gap of male and female employment further widened between 2000 - 2009 (see figure 11) (European Commission, 2010). All the interviews conducted by the project team with the organisations employers of social care workers confirmed the fact that from 70% to 90% of their personnel are female.

Furthermore, according to EUROSTAT's data in most Member States pay gap between the two genders in health and social sector is higher than the one in the total economy (European Commission, 2010).

Figure 12: Female employment rate in total employment in human health and social work 2000 and 2009

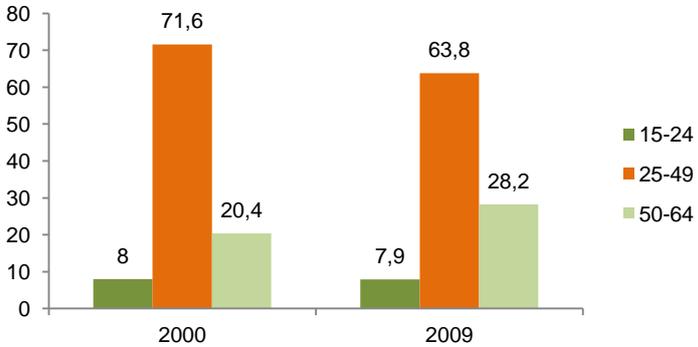


Age

In many European countries the workforce in social services sector is ageing. So far there is no research that provides consistent data for the average age of the workers exclusively in social sector across the EU. The majority of the employees in the health and social care sector in EU-27 belong in the age group of 25-49 y.o. Between 2000 and 2009 the share of people over 50 y.o. in the health and social sector increased by almost 8% (European Commission, 2010).

The problem of the ageing workforce is more severe in the services provided to elderly people. In some countries a big share of these employees are aged 50 or above (Lethbridge, 2011).

Figure 13: Employment shares in human health and social work by age group, 2000 and 2009 in EU 27



Working patterns

The incidence of part-time contracts is in general quite high in the sector compared to the economy as a whole. The occurrence of part-time employment is even higher in home care services (European

Centre for Social Welfare Policy and Research, 2012). Once again, no comprehensive study has been conducted to describe the types of contracts in social sector. Figure 13 provides a combination of qualitative and quantitative data regarding the working patterns of care workers in several countries (Lethbridge, 2011).

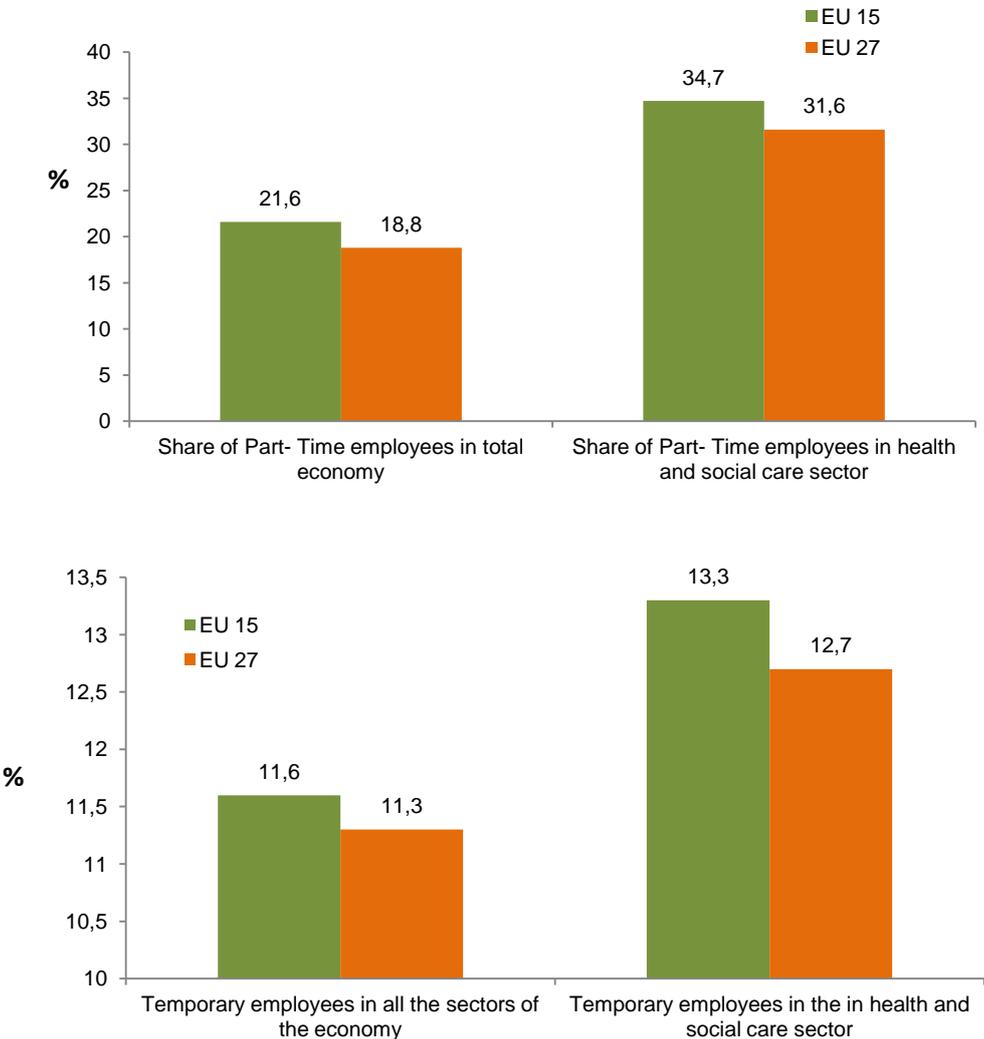
Figure 14: Types of contracts of care workers in several countries in Europe

Country	Part time	Full time	Fixed-term contracts	Agency workers	Self-employed
Czech Republic		Majority	Infrequent users		
Denmark	0.25 to 0.33	Majority	Few	Few	Few
Finland	11.90%	88.10%	19.90%	6.1% hourly	1-2%
France	Majority in home care services	Majority in residential care homes			
Germany	Majority home care				
Ireland		Majority	Majority not in Health Service Executive	Majority in settings where recruitment is difficult (e.g private nursing homes)	
Netherlands (2008)	5,6%	85,2%	5,6%		3,9%
Norway	40% 1-19 hours/week	60%			
Romania	Few	Majority		Few	Few
Slovak Republic		Majority		Few	Few
Sweden	50%	63% municipal healthcare			
Ukraine	On request	Majority			

Interviews conducted by the project team in Belgium confirm that part time contracts make up a large part of the social care sector. Interviews on the situation in England even demonstrated the so-called 'zero hours' contracts, standby contracts where carers can be called upon to perform ad hoc work as little as 15 minutes long.

Comprehensive data does exist regarding the combined health and social sector in the EU-27. As it is shown in Figures 14-15 more part time and temporary contracts exist in this sector compared to the total economy in both EU-15 and EU 27 countries. The share of part-time employees grew between 2000 and 2009 following the trend that was obvious in all the sectors of the economy. Still there are significant differences in the types of contracts across the EU. For instance in Hungary, Slovakia, Bulgaria, Greece and Czech Republic the percentage of part-time employment is well below the EU-27 average (European Commission, 2010).

Figures 15-16: Types of contracts in Health and Social Care Sector (2009)



Compensation

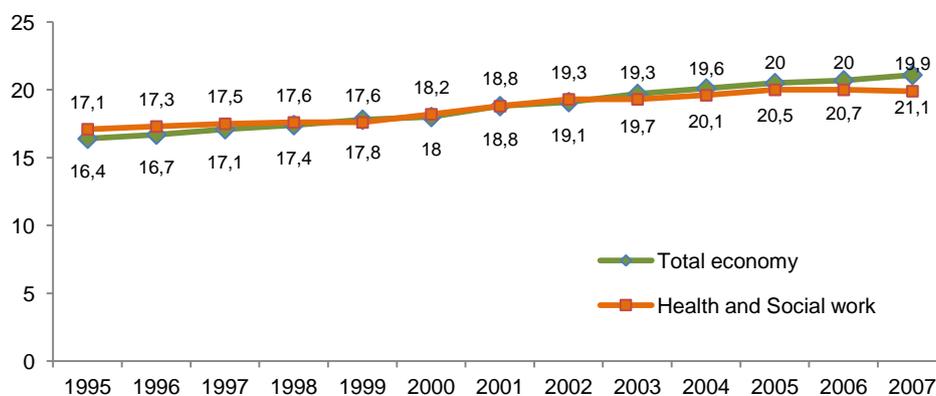
Workers in social care earn less than the national average wages. Graph number 16 shows the gap between the hourly earnings in total economy and the social and healthcare sector. Given that the working conditions in this sector are tough the low salaries make the professions of social care unattractive (European Commission, 2010).

The problem of lack of consistent and reliable data about the social care sector in EU is even more prominent regarding the compensation of employees of the sector. Some research has been done regarding the wages in the Long Term Care. According to OECD’s research wages in LTC are generally low. More specifically, low-skilled LTC workers in most countries earn somewhat more than the average for low-skilled workers (OECD, 2011). For instance, the median hourly pay for care workers in adult care services in the United Kingdom is GBP 6.56, which is 14% higher than the national minimum wages (OECD, 2011). Furthermore, according to the same survey experience may

not translate into remuneration and quite often Long-Term-Workers do not receive extra job benefits or have limited benefits that most other workers have (OECD, 2011).

Interviews conducted by the project team with a number of organisations providing social care services to disabled people confirmed that in most of the cases salaries of front line workers are either on the national minimum level or slightly above it however still below the national “living minimum”. Although we did see that in the recent years, in some of the Western European countries, the wages of social care frontline workers have converged more towards acceptable levels, in part thanks to the efforts of sector organisations.

Figure 17: Evolution of hourly earnings in the health and social services sector compared with the total economy, 1995-2007, EU-27



Qualifications – Training

On average workers in the Health and Social Care sector have a medium or high level of education. More specifically, in the EU-15 almost 40% of the workers in health and social services have tertiary education level. This percentage is 13% higher compared to the total economy. In the EU-27 the share of health and social work employees with a higher education degree is 32% and is equal to the share of the total economy (European Commission, 2010). However the data that group together health and social care sector might be misleading. According to EUROFOUND’s research social services front line staff does not share the same level of education with healthcare professionals. Social care 1st line employees often lack basic training and qualifications prior to entering the sector, and adequate on-the-job training after they start their careers (EUROFOUND, 2006).

So far, there is no universal certification or training for social service providers covering all the 28 EU member states. In 2008 the European Care Certificate (ECC) was introduced as a basic entry certificate in the care sector. The ECC is awarded after passing an exam consisting of 5 main sections (values, life quality of the care recipient, working with risk, understanding of the carer’s role and safety at work). It provides employers with evidence that the ECC holder has the basic knowledge required to work safely in the care sector. The certificate is awarded by the Lead Partner organisation of ECC in the countries that participate in this initiative. Personal details of successful candidates are recorded in

a central database as a protection against fraud. The employer can check this database. So far the following 16 EU member states are providing this qualification: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Germany, Hungary, Ireland, Italy, Latvia, Lithuania, Poland. At the beginning of 2013 almost 2,500 people across these 16 countries had successfully completed the exam (European Care Certificate). However, it is important to note that none of the organisations service providers, which participated in the interviews conducted during the course of the project, mentioned any awareness of a pan European universal qualification certificate for social service providers. This leads to the conclusion that ECC has a number of limitations, which need to be addressed to improve its adoption throughout Europe.

Another pan-European initiative that helps to the direction of the European mutual recognition of qualifications is the EU Directive on the Recognition of Professional Qualifications (2005/36). This Directive establishes common minimum qualification requirements. So far, for the following healthcare professions: nurses, midwives, doctors, dentists and pharmacists, there is a system of automatic recognition whereby certain qualifications (listed in an Annex to the Directive) are deemed to satisfy a minimum level of equivalence. Automatic recognition of qualifications is about granting access to professional registration and is not necessarily indicating the suitability of a candidate to undertake a particular job. In July 2013, after months of extensive discussions, the EU Institutions have reached an agreement in principle on a revised EU Directive on the Mutual Recognition of Professional Qualifications. The revised directive covers issues such as: language requirements, proactive warning system and adequate training to perform in the profession (NHS Confederation - Press Release, 2013).

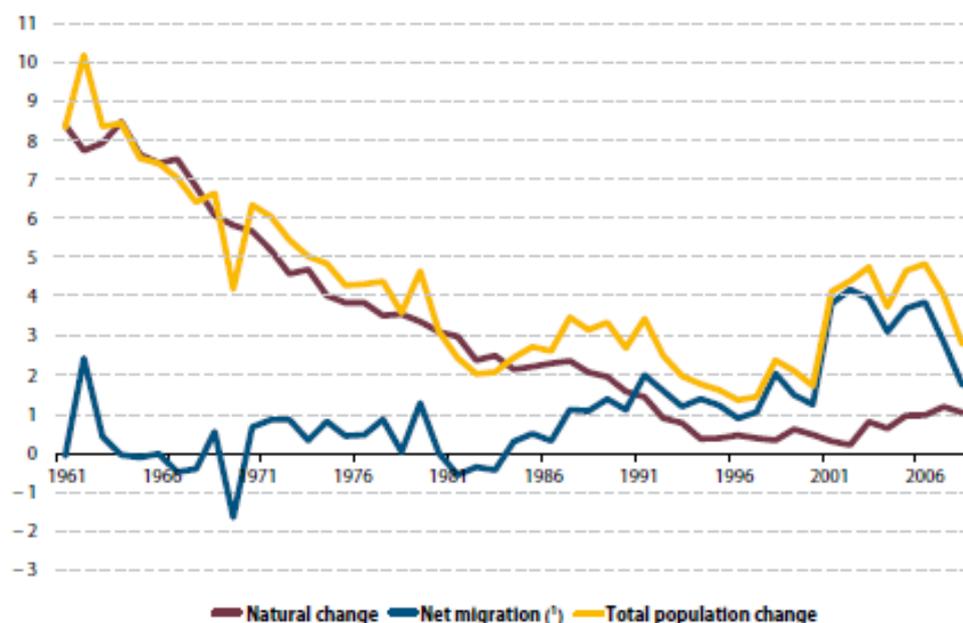
The European landscape of the qualifications in the sector is quite fragmented. In several EU member states new systems of training for care workers have been introduced recently as a step towards the professionalization of the sector. In some countries such as France, Denmark, Finland, the Netherlands and Lithuania specific training requirements exist for the social service providers (see table 1 in the appendix for a brief summary of qualifications per country). The trend towards the expansion of care work at the patient's home deteriorates the problems of the social workers training as it is difficult for this type of employee to undergo structured training. Monitoring their qualifications and whether they meet the requirements of their job is also quite challenging (Lethbridge, 2011).

Migration and the social care in Europe

Migration in EU

Migrants have always been an important part of Europe's population and workforce. Even though there have been many voices against the unregulated inflow of migrants in the developed countries, it is a fact that the low wages and the willingness of immigrants to do the jobs that native-born people do not want to do, have helped many European countries to build up their economies. However, the flow of migrants has greatly varied over time, not only from countries outside Europe, but also between the different European countries (Figure 17).

Figure 18: Population change by component, EU-27, 1990–2009 (Eurostat, 2011)



A study on the integration of the immigrants (Eurostat, 2011). showed that on a EU level the activity rate³ of the various age groups of immigrants and especially in the prime working ages (25-54) is identical to the activity of the total population (Table 2 in Appendix A), whereas the over-qualification rate of foreign born persons in the EU is much higher than the over-qualification rate⁴ of the total population (33% to 21%). This can be seen both for foreign born men (+10 percentage points) and foreign born women (+15 percentage points). The rate of over-qualification was even higher for persons born outside the EU (Table 3 in Appendix A). In terms of educational attainment the study revealed that for the higher and medium level of education, the share of foreign born people is identical to the share of the total population, however at the lower level of education migrants are represented with a higher percentage (Table 4a,b ,c in Appendix A). Finally, analysing the median disposable income⁵, we can see that in the majority of Member States, this is considerably less than that for the total population, with Greece, Italy and Austria having the lowest percentage in EU27 as the median income of the migrants corresponds to 74% or less of the median equivalised disposable income of the total population (Table 5 in Appendix A).

³ Activity rate represents active persons as a percentage of the total population of the same age group.

⁴ Over-qualification rate is calculated as a share of the population with a high educational level, and having low or medium skilled jobs among employed persons having attained a high educational level.

⁵ Equivalised income is defined as the household's total income divided by its 'equivalent size', to take account of the size and composition of the household, and is attributed to each household member: the total household income is divided by its equivalent size using the so called 'modified OECD' equivalence scale (this scale gives a weight of 1.0 to the first adult, 0.5 to any other household member aged 14 and over and 0.3 to each child under 14 years).

Migrants in Social Care

With an increasing demand for social care workers in an ageing European population, a new supply of workers has been established mainly in the countries of Western Europe by immigrants, skilled workers from the countries of Eastern Europe and from countries outside the EU. Even though, this is a significant trend in the labour market, the unregulated nature of the migrants' employment, who frequently do not even have the legal right to work in a EU country, creates a grey zone in the labour market, making it very difficult for researchers to find relevant data coming from one reliable source. Nevertheless, a recent publication has been able to provide and draft a description of the current situation in Europe and the reaction of the governments to the new wave of migrant care workers (Alice Anderson, 2012).

According to this publication over the last years there has been an increasing demand for care workers in EU which is successfully filled by a supply of skilled migrants from the Eastern countries. The main driver of this inflow is the cheap labour cost that these workers can provide. On the other hand, the immigrants chose to migrate to the Western countries, as they provide a better quality of life and a salary which even though might be low comparing to the European standards, it is significantly higher than the salary in the countries of origin. In the midst of this evolution and the soaring cost of the health expenditures, the governments chose to support the situation, allowing the market to be self-regulated by absorbing the cheap labour and the demand for care services to be fulfilled by the external supply with zero cost to the government. Even though in the short term this tactic benefits both sides, it is very important to understand that in the long run, allowing the labour market to operate under these conditions will only lead to the continuous misunderstanding of the positive role that migrants can have for the society. An unregulated regime can only lead to the exploitation of the workers and the invisibility of this group to the society. Moreover, the inability to measure the size and the quality of the migrant working force can put in danger the quality level of the care services provided to the most vulnerable groups of a society like children, elderly people and people with disabilities. Finally, the uncontrolled emigration of skilled workers gradually creates a labour shortage in the sender countries, which will have to turn to the third world countries in order to fill their demand.

In an attempt to confront this problem some Member countries have signed bilateral agreements to ensure the sustainability of migration and to support circular migration. More information on some of the bilateral agreements among European countries or between European countries and third countries are given in table 6 (Appendix A).

Why migrants choose to work in Social Care?

In order to understand what drives the immigrants to social care jobs, one needs to understand what drives migrants away from their country of origin in the first place. As discussed earlier the reasons of migration vary, but either it is for political reasons, for studies or for unemployment reasons, an immigrant always takes such a decision in a quest for something better, something different to what he can find in his own country. However, we have seen over time that some Member countries tend to

absorb more migrants than others and moreover some sectors tend to employ them easier and more frequently than others.

The reasons for these trends are economical, as well as political and even though the size of the phenomenon cannot be accurately measured and therefore evaluated, many studies have attempted to explain it. In a recent study on the common practice and policies of migrant labour in social care (Franca J. van Hooren, 2011) it is reported that there are two main drivers behind the increase of the migrants in social care. The first is an increase in the demand for workers willing to fill positions in sectors with often less than desirable working conditions. This is not always connected to lower salaries, but rather to the unwillingness of the native workers to accept jobs that are considered to be inferior to the average job. Of course, the definition of the average working conditions varies from country to country and from time to time even for the same country, as it is closely connected to the economic environment. In other words, in a booming economy native workers are seeking for more prestigious jobs, creating a gap at the low end positions and an increased demand for migrant workers who are willing to fill this gap. This has been the case over the last years in social care. Insufficient wages and bad working conditions with no perspectives have pushed the native workforce away from this sector, creating a significant gap which the employers try to fill with the cheap migrant labour.

Secondly, another driver is the structure of the social care system in some countries and the public investments of governments in public services. Studying the different systems of three Member countries (UK, Netherlands and Italy), scholars concluded that the structure of the social care system (private or public), the cash allowances provided by the governments and other factors such as language, immigration legacies or labour market discrimination, played an important role in the attractiveness of a country to the migrants (Franca J. van Hooren, 2012). More specifically, it was found that in countries such as England where social care is provided mainly by private agencies (Figure 18) the need for migrants is the result of poor working conditions in the sector. On the other hand, in the Southern countries such as Italy with a more family care regime, the government provides cash allowances for private care of the elderly people at home and therefore the need for migrant workers is based on the demand for cheap labour. Finally, in countries with high public provisions and governmental investments in public services such as the Netherlands, there is no real need for migrant workers in social care.

The third factor that has also influenced the flow of migrants in some specific Member countries is the recurrent regularisations. An easy and legal access to a country's social security system is a tremendous incentive for migrant worker to immigrate to that country. Nevertheless, it is disputable whether the need for cheap migrant labour forces some countries to adopt such policies, or it is the abundant supply of regularised migrants that allows some sectors, such as social care, the luxury to provide low wages and bad working conditions to their employees without immediate consequences.

Figure 19: Summary of characteristics of elderly care and migrant care work in Italy, England and the Netherlands for 2007 (Franca J. van Hooren, 2012)

	Percentage of elderly people (aged >65 years old) receiving public funds			Public expenditure on elderly care as % of GDP	Percentage of migrant workers in		
	Residential care	Home care	Attendance allowance		Total workforce	Private care	Agency-based care
Italy	0.8	1.8	9.8	0.1	10.3	78	2
England	3.3	5.8	19.3	0.5	14.2	(low)	20.7
Netherlands	6.8	20.1	-	0.8	17.7	(very low)	11.3-13.5

Strengths and weaknesses of employing migrant workers in Social Care

The employment of migrants in Social care brings a lot of benefits, but it also comes with some challenges that need to be addressed and overcome. Even though collecting data on the current status of the migrant labour market is a difficult and challenging procedure, nonetheless few reports coming from the UK have managed to outline successfully the main advantages and problems that Social Care sector copes with when it comes to the employment of immigrant workers.

Starting from the benefits it is commonly accepted that by far the most significant advantage is that the recruitment of migrant workers addresses workforce shortages. Having to deal with bad working conditions and low wages, native-born workers find it difficult and unpleasant to follow a career in the social care, creating a gap that the employers find very difficult to fill. However, recruiting migrant workers has significantly helped in filling this gap with skilled, hardworking and diverse employees. In a recent survey many employers and HR managers in the Social Care sector admitted the importance of migrant workers in the viability of their services. Apart from this, they outlined the major additional benefits of the foreign workers in their sector which include their willingness to accept shifts, work in unpopular settings, their reliability, honesty, politeness, high qualifications and respectful and caring attitude towards the elderly people (Hussein, 2011). Moreover, they identified additional language skills as a very positive side-effect of recruiting migrants, especially valuable when working with specific groups.

On the other hand, the employment of migrants in the social care comes with some major challenges. It is commonly agreed the major problem with the recruitment of foreign-born employees is the language barrier. Even though in some countries language course are provided by the state, developing professional language fluency is a time consuming procedure and it is not always supported by governmental policies (Skills for Care, 2009). Other challenges are related to the bureaucratic procedures required for the regularisation of migrant workers during their recruitment as well as after their placement in work. The main difficulties, as stated by the employers and HR managers (Skills for Care, 2009), are the following:

1. Recruitment of migrants :
 - Police checks & evidence

- Obtaining Visas
- Getting references

2. After placement in work:

- Qualifications' recognition is uncertain and lengthy
- Modifying induction and training
- The overall problematic nature of the work
- Requirements by employer & staff for personal and cultural sensitivity to migrants
- Different concepts of 'care'
- Language and communication issues

Moreover, some problems have been also identified in the perception of the migrant workers in the working environment by the native-born employees. The root cause of the problem starts from the fact that the introduction of skilled, hard-working, low-wage foreign workers in the workforce, is inevitably affecting the perspectives and the wages of the native-born workers. Employees, who might have many years of working experience and developed skills, are now, in a way, threatened by the waves of cheap labour in the local markets and therefore they develop a reluctance to embrace and integrate the migrants in their sector. This behaviour, which in some occasions has been reported as aggressive and hostile, affects irreversibly the psychology of the migrant workers and creates an unpleasant working environment for these people (Skills for Care, 2009).

A synopsis of all the above advantages and disadvantages is given in table 7 (Appendix A).

Recruitment methods - Restrictions – Challenges

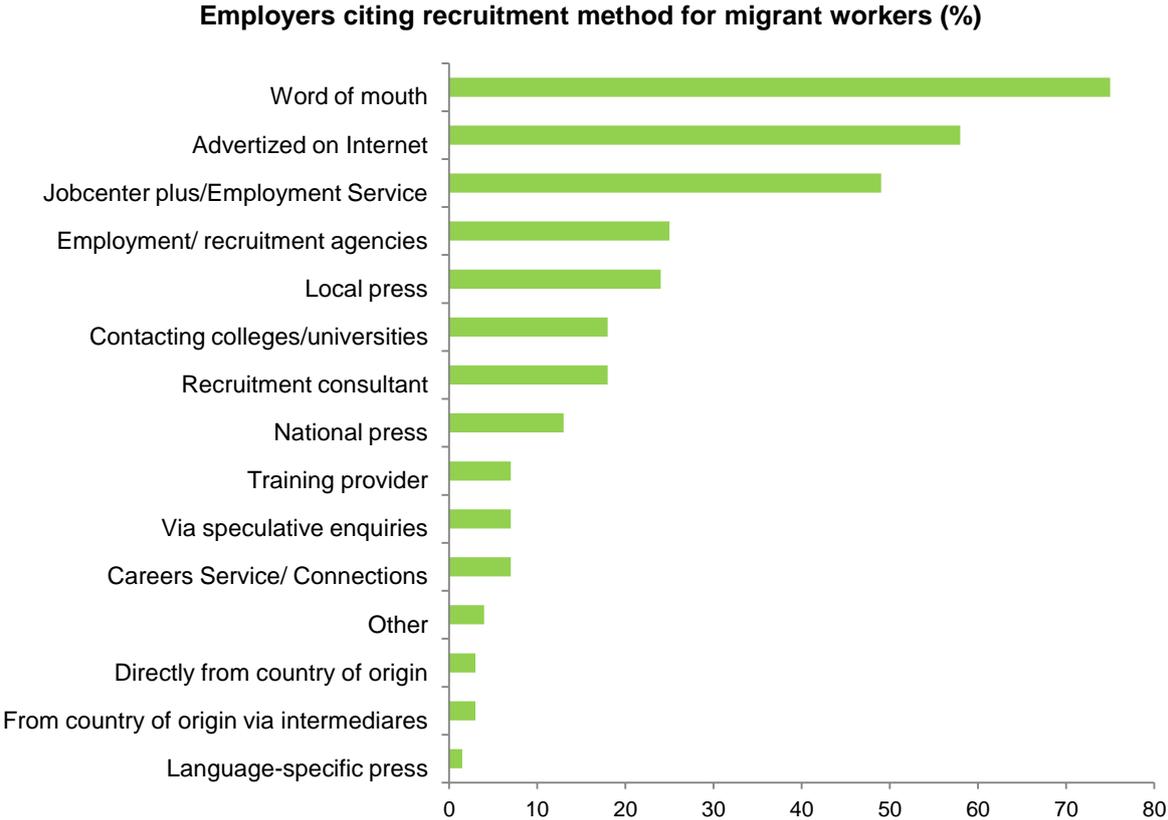
The main driver for recruiting migrant social care workers is by far to address the staff shortages in the ageing European countries. However, some secondary drivers have been reported such as (Hussein, 2011):

- Skills
- Valuing their job
- Qualifications
- Hard working
- Caring approach
- Difficulty to find native-born workers

However, there has been little effort by most of the countries to organise recruitment procedures for migrant care workers and even less to measure the effectiveness of these procedures. Nevertheless, some studies have managed to collect sufficient data on the methods used mainly by the private sector in order to recruit workers from developing countries and thus identify the main issues related with the recruitment and relocation of these people. In a study done in 2009 in England (Skills for Care, 2009) it was reported that the main recruitment methods include agencies, training and

development centres, local newspapers, job fairs, leaflets, web-sites, local radio, events in local universities and word of mouth (Figure 19). However, it was observed that the approaches employers deploy vary geographically and even though in some areas employers prefer to recruit foreign workers from the local labour pool, some others collaborate with job agencies, or use internet platforms (such as EURES), for filtering potential candidates before going over to the country to interview them personally.

Figure 20: Employers’ recruitment methods in England (Social care 2009 F)



Despite the fact that the Social Care sector suffers from increasing staff shortages and in spite the abundant supply of skilled migrant workers, many factors seem to affect the recruitment of foreign workers. The first and the most common is the language barrier. It is commonly admitted by the employers that the linguistic skills of the foreign workers is the bottleneck in the fast integration of these people in the working environment and in the society. Nonetheless, taking in consideration the increasing ethnical diversity of the ageing population (previous generations of migrants), migrant care workers bring cultural skills which comparing to the language skills are very hard to learn. Therefore, steps need to be taken towards the establishment of supporting funds for the training of migrants in the local language before and/or during the recruiting procedure.

The recruitment of migrant workers, however, is a complex political issue. Despite the efforts for a united and open-border migration policy in the EU, the recent economic crisis has drawn the attention to the increasing national unemployment rates and has given rise to voices suggesting that the native-born workers deserve the available jobs and should be served first (Afonso Al., 2012). As a result

many countries implement more and more restrictions in the recruitment of migrant workers, increasing in this way further the demand and supply gap in the care services. Moreover, a side-effect of this policy is the increase of unethical recruitment tactics, as many agencies fail or avoid to properly inform the recruits about various employment issues such the working hours, cost of living, poor working conditions and the very low wages (Skills for Care, 2009).

Problems in Recruitment and Retention of the workforce in Social Care

The social care sector is labour intensive and over the last years recruitment and retaining difficulties have become more common. Given the fact that the majority of the workforce consists of baby boomers, the need for the recruitment of young people has become imperative and it is expected to become more crucial in the following years. Even after the financial recession, which revitalized the interest of young workers for the low wage jobs (Shereen Hussein, 2011), some countries still seem to report high vacancy rates and workforce turnover in social care. For example, according to the annual report from the “Skills for Care” organization in England, for 2011 the overall vacancy rate for staff in social care was 3%, with an overall turnover rate of 19%, very similar to the percentages of 2009 (3% and 18% respectively) (Skills for care, Annual report, 2012).

Despite the growing problem, there are very few attempts on a European level to identify the reasons behind this issue. Moreover, the small size of social care services organizations and the scarcity of information concerning the sources of recruitment (Shereen Hussein, 2010) , makes it very difficult to collect reliable and quantifiable information about the recruitment methods in the sector. Nevertheless, based on the data collected from various reports we can identify and summarize the most common issues faced in recruitment for the sector (figure 20).

Figure 21: The most common problems in the recruitment of new workers in social care services. Sources : (Department of Health, 2011) (EPSU, 2010) (Skills for Care, Workforce Strategy, 2009)

Problem	Details
Recruitment methods	The most common method used is the word of mouth. Even though it is effective, it is a slow and much localized procedure. Lack of organized and targeted recruitment campaigns make it impossible for the employers to interact with the labour market and attract workers from different areas and/or countries. Moreover, lack of collaboration with Universities and Job centres, deprive the new graduates of the opportunity to easily access the sector.
Employers attitude	One reason why new graduates remained unemployed despite the high level of vacancies was because employers reportedly required experienced workers for the vacant posts, unwilling or unable to provide training to new hires.
Sector attractiveness	It can be described by two main parameters: the reputation

	and the remuneration. The first is strongly connected with the difficult working conditions in this sector and the extent to which the objectives of the equality and diversity policies are achieved in the organizations. Concerning the remuneration of the employees, the low wages of the sector and the long working hours make social care services sector very unattractive to the new graduates.
Lack of non-monetary incentives	Despite the low wages of the sector, non-monetary rewards such as access to training and development opportunities, transport schemes and childcare vouchers offered by some organizations have been reported to improve the attractiveness of the sector. Unfortunately, few organizations implement this recruitment strategy.
Immigration Policy	Immigration policy changes mean that the recruitment of workers from outside the European Economic Area will no longer be an available strategy, despite the positive aspect of such workers expressed by the employers and managers of the sector.
Lack of funding	Reducing of funding and health provisions from the governments over the last years has led to poor and ineffective recruitment strategies and further damage the attractiveness of the sector, despite the recession.

On the other hand retaining the workers in the workforce of the organization seems to be equally difficult for the employers. Most of the employees chose to leave the organization in the first years of their employment, resulting in a gap of skills in the sector and an increasing age average of the workforce. Problems with retention appear to be linked most often to difficulties with management and staffing levels, leading to intensity of work and a reduction in the quality of care provided. Employees who stay in the job for longer than a year are more likely to stay in the job or the sector than those who stay for less than a year. The most common issues in the retention are listed in figure 21.

Figure 22: The most common problems in the retention of new workers in social care services.

Sources : (Department of Health, 2011) (EPSU, 2010) (Skills for Care, Workforce Strategy, 2009)

Problem	Details
Right values and Quality of care services	Many employees decide to work for social care services because they believe in the moral values of the profession such as providing descent and quality care to the people in need. However, the low quality of the services and the manager's behaviour in some organizations have a

	significant impact in the perception of the sector.
Team work	The team atmosphere in the organizations and the relations with the patients has been reported as another crucial factor for the workers.
Flexible working hours	The workforce in the sector is mainly consists of women, many with family responsibilities. Lacking flexible working hours is one of the most prominent problems of the sector, commonly resulting to a bad work-life balance.
Staffing levels	Low levels of staffing is a common problem that puts increased pressure on existing staff to work longer hours, or simply it can mean that they are expected to fit in more tasks in their existing allocated hours. This phenomenon can be a major factor in prompting workers to seek alternative employment.
Development and Training opportunities	It is commonly admitted by the employees that training gives them the opportunity to develop their skills and learn practical ways in which they could better assist the people they were working with. However, training schemes are not often used by the employers, who frequently are looking to hire only experienced people. Moreover, according to a number of interviews the research team conducted, some organizations mentioned that the financial crisis negatively impacted the training programs the organizations' offer to their employees.
Insufficient recruitment methods	The first 12 months of the employment is a very crucial period for the retention of a new worker. During this period the person will be tested and he/she will form an opinion about the sector. However, lack of opportunities for the young workers to acquire an insight experience of the sector before applying for a position, often results to disappointment, as the expectations are not met for both the employers and the employees.
Funding	Staff shortages caused by funding constraints can lead to work intensification and moreover, reduced quality of care.
Poor Management	One of the most eminent but frequently neglected reasons for high turnover rates is the insufficient management. Bad quality of supervision, lack of motivation and vague responsibilities result to dissatisfaction and search for alternative employment.

Working Conditions in the Social Care Sector

One of the most important reasons of the unattractiveness of the professions in social care is the unappealing working conditions of the sector that seem to be more or less similar throughout Europe.

First of all, care-giving is mentally and physically demanding. Work-related accidents and injuries such as lower back problems are common as employees lift and carry care recipients. In fact, in the United States, nursing aides, orderlies and attendants have the third highest number of injuries and illnesses, second only to truck drivers and labourers (OECD, 2011). But the health issues that social care providers face are not only restricted to physical injuries. Carers are quite often under psychological pressure due to the extreme working conditions that include verbal or even physical abuse by the care recipients or their families. The findings of the European Nurses Early Exit Study (NEXT) are revealing: 22% of nurses experience violence by patients or family at least once per month (OECD, 2011). In 2012, the British Association of Social Workers conducted a research collecting comments from frontline social workers. Among other interesting quotes the following one is quite informative regarding the working conditions in the sector: *"It makes me so sad that this job seem only to be possible if you sacrifice your own health and well-being. It is dire out here, very toxic."* (The British Association of Social Workers , 2012). A similar quote from another British social worker makes clear the emotional pressure under which social workers are on daily basis: *"Working with very traumatized children and absorbing the stress of other professionals, carers and family members takes a huge toll on your own emotional health and well-being"* (The British Association of Social Workers , 2012).

Secondly, working hours in this profession can be long, unsocial and uneven impacting the carers' work-life balance. Working during the weekends or late at night to follow the needs of the care recipient is quite common among employees of this sector. In research conducted in 2011 in several European countries regarding the care services the problem of working hours was mentioned by social care employees in several countries. For example, in France the following problems were mentioned: *"erratic hours of work, weekend work and night work that cause stress, fatigue, exhaustion, physical illnesses, anxiety and depression"*. Another issue that was mentioned in the French research is professional isolation (Lethbridge, 2011). The problems seem to be similar in Italy where the care-giver *"will often live in the same house with their customer, and the working time will be much longer than what he or she is paid for but being provided with a home to live is perceived as a form of extra salary and a significant advantage for the caretaker since an average rent would be too high to afford"* (Lethbridge, 2011). Similar problems are faced in the UK *"a 24/7 work pattern with no additional unsocial hours payments."* (Lethbridge, 2011). In the same context, Eurofound's report found that a significant number of women do not return back to their job after giving birth because of difficulties in balancing work with family life (EUROFOUND, 2006).

As mentioned earlier in this report, the incidence of fixed contracts in the social care sector is higher compared to the economy as a whole. This problem coupled with the low salaries make care-givers feel insecure and potentially causes them to search for jobs elsewhere. The following quote from a social care worker in the UK is revealing: *"Zero hours contracts are common. Workers are sometimes*

told that, where there is no work available, they must either go to other places, have the time deducted or taken as time they owe the employer' (The British Association of Social Workers , 2012).

The low compensation packages in the sector are deteriorated by the recent economic crisis. As mentioned before, in countries heavily impacted by the crisis for instance Greece, there have been direct or indirect pay-cuts in the sector. But even in EU member states less affected by the recession the problem of reduced budget is obvious. *"The recent cut in budget has had a significant impact on the structure of my employer"* and *"I am very concerned that I will be losing 5% of my annual salary with no increments for the next 2 or 3 years"* where two very typical quotes from the research of the British Association of Social Workers (The British Association of Social Workers , 2012).

A similar problem that is more prevalent in home care is the absence of reimbursement for team meetings and travel between clients. In the same context, the working conditions in home care can be tough in disadvantaged neighbourhoods and in difficult home situations (OECD, 2011). Moreover, care-takers that offer their services at private homes often complain for working in isolation.

Another common problem in several European countries is that frontline employees in the social care sector have a very heavy workload involving not only care-giving but also administrative tasks. A recent survey conducted by Liquid Personnel- a social care recruitment consultancy in the UK is revealing: social workers spend only 15% of their working week face-to-face with service users. They invest 35% of their time in administrative tasks, 12% in attending meetings, 11% in travelling and 11% on the telephone (Burke, Social workers putting in longer hours, survey finds, 2012).

The front-line employees in social services make a significant contribution to the quality of life and the well-being of disabled and elderly people. They also bear a tremendous responsibility about the health of their customers. Still, the profession of the care-giver seems not to be appreciated by the society. Their contribution is often invisible as the services are offered at private homes. The media and other opinion makers have created an image of "financial burden" for the sector. In the same channels the employment in social care is presented as poorly paid, boring and repetitive (EUROFOUND, 2006). A quote from an interview our team conducted with a representative of an organization from the social profit sector in Belgium is enlightening: *"the sector (especially the familial help) has the image of a cleaning lady"*. Similar are the comments made in the study of the British Association of Social Workers: *"(I would ask for) more acceptance of the value of the social workers and job security"*, *"recognition and value as to what we do"* (The British Association of Social Workers , 2012). Similar is a case in Germany where *"younger workers feel the meaning of their work is hardly recognised by others"* (OECD, 2011). Additionally, the health and social care occupations are considered to be female dominated. This of course wouldn't be an issue if in Europe female dominated professions were not paid less and perceived to be of a lower "value". A study from the UK shows that simply being in a female-dominated occupation can reduce your compensation by as much as 9 per cent (Pillinger, 2010).

The problem of the sector's poor image is further deteriorated by the limited career advancement planning and the very few training opportunities. The frontline employees usually do not have clearly

defined career paths as is the case in other sectors of the economy or even in healthcare. The following statement made by a social worker in the UK summarizes the situation: “*Poor remuneration, poor career progression*” (The British Association of Social Workers , 2012). The lack of focus on skills enhancement and guidance of the social sector employees is obvious in the findings of another survey conducted in the UK by the firm Liquid Personnel. This research revealed that 88% of newly qualified social workers found it difficult to fit in training, while 63% felt they did not receive enough supervision (Burke, 2012). The lack of career progression opportunities, on-the-job training, personal development and lifelong learning opportunities (Social Services Europe, 2012) have already been identified in many EU member states. Several initiatives throughout Europe have been taken to introduce training courses and to recognize in the form of qualifications the skills of social sector workers. For instance, in France during the last two decades many training centres entered into partnerships with universities in a move to promote the status of the professions, perceived as «de-qualified». In this context the universities have created «professional BAs» («licences professionnelles») and new qualification procedures have appeared (Ward, 2006).

Social Dialogue in the Social Service Providers Sector

Given that the social service providers’ organizations are facing staff recruitment and retention issues and the workforce is experiencing tough working conditions, the employee-employer dialogue is crucial for overcoming the HR problems of the sector. The following part offers an overview of the social dialogue in the social services providers sectors both at the national and at the EU level.

At the national level

Although as explained in detail the sector faces similar problems throughout Europe such as tough working conditions, the form and depth of social dialogue between employees and employers varies from country to country. According to the PESSIS research, in the system of social dialogue in social services sector two main groups of EU member states were identified (Lethbridge, 2012):

1. Countries with established social dialogue structures (Austria, Belgium, Finland, France, Germany, the Netherlands)
2. Countries with some existing employee- employer agreements but no formal social dialogue structures (Greece, Ireland, Scotland, Slovenia, Spain) (Lethbridge, 2012).

The same research concluded that the social services sector at the country level is represented by more than one employees’ and employers’ groups. For instance, in Scotland the employees of the sector are represented by 3 workers/trade unions and in Austria by 4. In Germany there are 8 employers’ associations representing the sector (Lethbridge, 2012). Moreover, according to PESSIS, the coverage of bargaining agreements is higher for public sector employees (Lethbridge, 2012).

At the EU level

At the EU level there is a legal basis for social dialogue. In fact, the “European Social Dialogue” promotes discussions, consultations, negotiations and joint actions involving organisations

representing the two sides of industry (employers and workers). It takes two main forms: a tripartite dialogue involving the public authorities, a bipartite dialogue between the European employers and trade union organisations. This takes place at cross-industry level and within sectorial social dialogue committees (DG Employment, Social Affairs and Inclusion). At sectorial level, the social dialogue is promoted by the sectorial dialogue committees that enable the dialogue between the social partners in the sectors at European level (Commission decision of 20 May 1998 – 98/500/EC) (DG Employment, Social Affairs and Inclusion). In brief, the legal structure for social dialogue at the EU level exists but the initiation of such a dialogue depends on the social partners. So far, the social services sector is not represented by a committee in the European Social Dialogue depriving the sector from sharing good practices and from providing structured input to the key European policies such as the EU 2020 strategy and the working time directive (Lethbridge, 2012).

Moreover, there is no formal input from social services employers on the EU policy making process. This means that the employers cannot contribute to important decisions for the future of the sector such as the EU 2020 Strategy and the working time directive (Lethbridge, 2012).

Field Research Findings

The project team conducted a field research, which consisted of more than 20 interviews – with providers of social services, umbrella organisations and with graduates who are either interested or not interested in joining the social services sector. This field research revealed a number of insights, which together with best practices from other countries and industries served as a basis for the development of a tool kit and Recommendations for European policy makers.

The first important learning of the conducted research is the fact that in the time of recession the issue of staff shortage is less prominent than it was before 2008. Indeed, lack of job opportunities in public and private sectors forced people to seek jobs in the organisations providing social services. Next to that, in several countries, budget cuts by the government will lead to a stagnation or reduction in size of the social services sector in the short term.

Another insight refers to the fact that key motives that encourage people to enter the Social Services sector can be split into two main types:

- Material drivers

In particular, the perspective of job security in the social services sector, and the part time work which attracts women with children. Some of these motives became stronger during the recession: lack of job opportunities in other sectors, decreasing salaries, layoffs, etc.

- Inner drivers

These drivers are characterized as an inner desire to have a fulfilling and meaningful job, make an impact on somebody's life, make a change and help the person in need.

The organizations, which were interviewed in the course of the field research, outlined following challenges that they face in the process of personnel recruitment and retention:

- low wages together with few extra benefits;
- flexibility required on the job;
- decreasing government funding and downward pressure on the price contracts;
- negative image of the Social Services sector related to the low wages, low stability, lack of career advancement opportunities and poor working conditions.

At the same time, several organizations proved to be successful in the deployment of progressive tools and techniques for staff attraction and retention:

- attractive and progressive wage structure;
- introduction of permanent contracts;
- development and introduction of career paths both vertical and horizontal;
- trainings for employees and providing benefits that can compensate for low wage;
- marketing campaign targeted at improvement of the social services sector's attractiveness.