



# Context analysis report: Partner Country Profiles

TDAR 2015



**TDAR Work package 4. Evaluation****Context analysis report: Partner Country Profiles****P0: Sweden****1. How adult social care is organised****1.1 How care is paid for**

In Sweden (population 9.6 million), adult social care is ‘collectively funded by taxpayers’ and ‘available according to need, rather than ability to pay’ – to ensure it does not become stratified by social class. Presently, almost all elderly care is publicly funded.

**1.2 How care is regulated**

Sweden is divided into 290 local authorities, each with tax-setting powers. These local authorities are responsible for providing adult social care, while central government enacts laws, regulates and inspects and contributes some supplementary funding.

**1.3 How individuals access care**

To access care services, a person (possibly with the help of relatives or a local government officer) applies to the local authority. Applications are assessed by local government officials who decide what services the elderly are entitled to. Care services are provided either by directly employed local authority care staff or by private or voluntary-sector care providers, commissioned by the local authority.

**1.4 Size of the adult social care workforce**

The adult social care sector in Sweden employs a workforce of some 200,000 people (4% or 1 in 25 of Sweden’s total workforce of 5 million). This workforce includes a range of professional roles such as nurses, occupational therapists and physiotherapists, but the majority of employees work in support roles as care workers or auxiliary nurses (i.e. healthcare assistants).

**1.5 Skills of professional staff**

Professional roles require staff to hold appropriate qualifications and undertake continuing professional development. These skills are developed and maintained through higher education programmes delivered in universities.

**1.6 Skills of support staff**

For support staff, there is an upper secondary school national health and social care programme delivered through post-compulsory school and college-based education.

**1.7 Regulation of skills**

Social care employers are encouraged, but not legally required, to recruit staff with qualifications gained through the national health and social care programme. Although the government’s quality assurance system requires employers to ensure that support staff have whatever competence their role requires, compliance by employers is not monitored.

**1.8 Demand for care**

Demand for care workers varies across Sweden, but the Stockholm area has experienced severe staffing shortages. Similar pressures are expected now over the next two decades, as the proportion of Swedish people aged 80 and over increases significantly, due partly to the large number of people born in the 1940s and partly to the rise in life expectancy. Between 2020 and 2030, there will be 45% more people aged 80 older. Over the period 2010 to 2050, it is anticipated that the elderly care workforce will need to expand by up to 75%.

### **1.9 Demand for skills**

In addition to increased recruitment pressure for employers, care staff themselves will require different and higher skills than currently. In Sweden today the care professions are dominated by women born in the 1940s and 1950s. Today and tomorrow's women have different career expectations regarding salary, job impact and self-development. In addition, they are much more likely to move between employers and even occupations during the course of their working life. The sector will need to become a much more competitive employer, offering more attractive workplaces with more engaging tasks, progression opportunities, better wages and full-time work. It will also need to recruit more men.

### **1.10 Supply of skills**

At the same time, the numbers of young people entering the workforce are declining. According to some estimates, the number of high school students will fall by over 100 000, a fall of almost a quarter, within the next ten years. This, combined with rising career aspirations, is likely to mean substantially fewer enrolments by young people on the national health and social care programme. There will be a corresponding need to attract adult recruits, including significant numbers of migrant workers, into the sector. In these circumstances, adult vocational education and Swedish language training will be even more essential to ensure quality and dignity in elderly care.

### **1.11 Workforce development**

Employers who want to upskill support staff may send them to local authority-funded adult education for national health and social care programme courses. Likewise, individual workers may take these courses for career development. Courses on the national health and social care programme are delivered by occupationally competent teachers employed by the learning provider. Courses are classroom-based and teachers typically have no contact with learners' workplaces. Workplace training for support staff is normally limited to statutory and mandatory training: fire training, health and safety, moving and positioning and such like. This training is delivered either by a member of staff or an external learning provider. Care employers tend not to employ in-house training managers.

## **2. Adult education**

### **2.1 Non-formal adult education**

There is a well-established culture of self-organised adult learning in Sweden, dating back to the 19th century, based on voluntary study associations and study circles (many established by organisations such as churches, the temperance movement, political parties and so on). This voluntary-sector provision has a particular focus on social inclusion and learning for adults with limited formal education. Such voluntary sector, community-based adult education is designated as 'non-formal adult education'. Well over a million people participate annually in non-formal adult education.

### **2.2 Formal adult education**

In the late 1960s, a local authority-based, publicly-funded system of adult education was introduced. This publicly-funded system is referred to as 'formal adult education'. About 200,000 participate in it annually.

### **2.3 Role of adult education in VET**

This 'formal', local authority-funded provision aims to enable adults to study for national qualifications at the post-compulsory upper secondary school level, including vocational qualifications in areas such as health and social care. (National, upper secondary qualifications represent the main route into non-graduate level work for young people in Sweden.) It has also provided a vehicle for the state to deliver labour market training to combat unemployment, assist in retraining and adaptation of the Swedish workforce to economic changes, to support full employment.

### **2.4 How individuals access adult education**

Local authority provision is free for those entitled to it, but, due to major cuts implemented since 2008 following a reduction of 25% in central government subsidy, there is now some shortage of places. By law, those with the lowest educational level have priority. As with elderly care, while local authorities are legally required to ensure the

provision of this type of adult education, they have the option of providing it directly themselves or commissioning it from outside providers (who may be voluntary sector organisations or private companies).

### **3. Language learning for migrants**

#### **3.1 Swedish for Immigrants (Sfi)**

Swedish for immigrants (Sfi) is a national Swedish language learning programme offered free to any migrant (excluding Norwegians and Danes), registered with the local authority, aged 16 and over who lack basic knowledge of Swedish. SFI takes learners from complete beginner to CEFR level B1 (Independent Speaker: Threshold or pre-intermediate). Learners are entitled to SFI classes for as long as they meet SFI criteria (for some learners this equates to a number of months, for others several years). SFI was instituted in 1965 (after a significant influx of migrant workers) to equip migrants with enough basic Swedish to cope in Swedish society. Existing study associations were funded to deliver the programme until 1986, when responsibility for provision was transferred to local authorities (moving it, in effect, from the 'non-formal' system to the 'formal'). SFI now constitutes a discrete strand of local authority provision, subject to national quality standards, and, again, may be directly provided by the local authority or commissioned from external providers. Studying in SFI is voluntary for the individual and migrants are under no legal obligation to participate. However, local authorities may require newly arrived migrants to participate in order to receive financial assistance. It is relatively common for learners to leave the programme early if they find employment. This is one reason why migrant care workers may not have completed the SFI programme.

#### **3.2 Swedish as a Second Language (SVA)**

SVA is instruction in Swedish as a second language. SVA courses range from intermediate to advanced levels. These courses are provided by adult education providers and are open to learners with Swedish at B1 and above.

*by Kerstin Sjösvärd (2013)*

#### **Sources**

Sjösvärd, K. (2013), *Introduction to an English-language version of ArbetSam materials*. Stockholm: Lidingö stad/Stiftelsen Stockholms läns Äldrecentrum.

## P1: Germany

Germany (population 82m) is a federal parliamentary republic made up of 16 states (*Bundesländer*). The federal government is responsible for foreign and European policy, defence, justice, employment, social affairs, tax and health. The states are responsible for internal security, schooling, tertiary education, administration and local government, including social care. One in four people in Germany is over 60 years old.

### 1. How adult social care is organised

#### 1.1 How care is paid for

In Germany long-term care insurance is compulsory for all citizens, as part of social insurance. This insurance system is administered by public and private health insurance organizations. Payments to citizens receiving care services are based three levels of need.

The contributions that citizens pay towards statutory long-term care insurance are scaled according to income. The Federal Employment Agency covers the contributions for persons who receive unemployment benefit or cost-of-living allowance (i.e. state subsidy for those on low incomes).

Citizens may also purchase additional care insurance privately (in order to afford more expensive services). In some circumstances, the state will supplement these private payments (*staatlich geförderte private Zusatzversicherung*, 'state-subsidized private insurance'). For example, if you pay at least 10€ a month, the state gives an additional 5€ per month.

#### 1.2 How care is regulated

In Germany the *Pflegekassen* ('care funds', an autonomous adjunct to the public health-insurance companies, *Krankenkassen*) are responsible for providing the money for adult social care. *Pflegekassen* pay out money to individuals in need of care, who use that money to pay for the services of care providers.

Care is provided by social welfare agencies and private elder-care facilities. The providers negotiate funding directly with the Regional Association (*Landesverband*) of the *Pflegekassen*. Quality is assured by the *Medizinischen Dienst der Krankenversicherung* (MDK), commissioned by the Regional Association (*Landesverband*) of the *Pflegekassen*.

The Federal government enacts laws and regulates.

#### 1.3 How individuals access care

By law, a person is eligible for long-term care if, due to physical, mental or psychological illness or disability, that person requires frequent or substantial help with normal day-to-day activities on a long-term basis (i.e. for an estimated six months or longer). First the person in need of care (or an authorised representative) has to make a request to their health insurance company (*Krankenkassen*). Next the medical service of the public health-insurance companies (*Medizinischen Dienst der Krankenversicherung* (MDK)) assesses which of the three levels of care is needed. It then makes the appropriate payment and the person in need of care selects a care provider to meet their care needs.

#### 1.4 Size of the adult social care workforce

The elder-care sector in Germany employs a workforce of some 950 000 people (2.3% of Germany's total workforce of 41m). This care workforce includes a range of professional roles such as elder-care professionals, nurses, occupational therapists and physiotherapists as well as employees that work in support roles as care workers or auxiliary nurses (i.e. eldercare assistants).

The structure of the German elder-care workforce has one feature in particular that is unlike Sweden: between professional and managerial staff qualified to European Qualification Framework (EQF)<sup>1</sup> level 5 and above, and support roles that require no specific level of qualification, there is an intermediate 'technician-level' role requiring a three-year dual-education qualification at EQF level 4. (A law passed in 1993 requires care providers to ensure that

at least 50% of their staff are qualified to at least this level.) These staff are support staff in the sense that they are not degree-level qualified professionals, but it is important to differentiate them from support staff who may have undergone training and gained lesser qualifications, but do not hold this three-year dual-education qualification at EQF level 4. This analysis will differentiate the two groups as ‘qualified support staff’ and ‘non-qualified support staff’.

Currently, *qualified support staff* (i.e. support staff who hold the three-year dual-education qualification at EQF level 4) make up 50% of the German elder-care workforce.

*Non-qualified support staff* (i.e. support staff who do **not** hold a three-year dual-education qualification at EQF level 4) make the rest of the German elder-care workforce.

Notes

1. See appendix for EQF level descriptors

### 1.5 Skills of professional staff

Professional roles require staff to hold appropriate qualifications and undertake continuing professional development. These skills are developed and maintained through higher education programmes delivered in universities.

### 1.6 Skills of support staff

Individually, support staff are not required to hold any qualification. However, care providers are legally obliged to ensure that at least 50% of their staff hold a three-year dual-education<sup>1</sup> qualification in elderly care (corresponding to EQF level 4).

Usually care homes have one or two persons acting as care managers (*Pflegedienstleitung*) who through continuing education and practical experience acquire expertise equivalent to EQF level 5.

In addition to the three-year dual-education EQF level 4 qualification, there are other qualifications at EQF levels 1-3 available for support staff (see section 7 below).

Notes

1. The dual education system is practised in several countries, notably Germany, Austria and Switzerland, but also Denmark, the Netherlands and France, and for some years now in China and other countries in Asia. It combines apprenticeships in a company with related vocational education at an institution of vocational education and training.

### 1.7 Regulation of skills

At least 50% of staff delivering direct care must (by law) hold the three-year dual-education elderly care qualification or a higher qualification.

Support staff assist professional staff with elderly care functions such as therapy and hygiene.

Support staff roles include:

- *Altenpflegehelfer* [Elderly Care Assistant]
- *Kranken- und Altenpflegehelfer* (1 year programme) [Nursing and Elderly Care Assistant]
- *Pflegefachhelfer* [Social Care Assistant]
- *Fachkraft für Pflegeassistenten* [Specialist Social Care Assistant]
- *Gesundheits- und Pflegeassistent* [Health and Social Care Assistant]

A range of qualifications support these roles. The qualifications usually take one year and include 800 hours of classroom theory and 1400 hours of practical learning.

Regulation of skills for support staff is regional, i.e. at the level of *Bundesländer* (there is no national requirement for support staff to be qualified to any level).

### 1.8 Demand for care

The number of older people in need of care in Germany is forecast to be 2.7m in 2015 and 3.4m in 2030. This will lead to demand for about 325 000 additional full-time care personnel.

This includes about 140 000 qualified support staff (i.e. staff holding at least the three-year dual-education qualification) and about 185 000 non-qualified support staff.

### 1.9 Demand for skills

The level of skill needed in elder care is constantly rising, as care develops.

The intention at policy-level is to address the need for higher level skills by requiring at least 50% of care staff hold the three-year dual-education qualification.

Germany, however, is facing a shortage of care workers, in particular qualified support workers (i.e. three-year dual-education qualified care staff). The severity of this shortage varies from region to region but is increasing everywhere. (Note that many other sectors are facing similar labour shortages.)

To address this German employers are currently seeking to attract and recruit

(1) young unqualified Germans into the three-year dual-education programme

(2) staff from other (mainly EU) countries who hold care-related qualifications that can be re-accredited in Germany to satisfy German regulations. (Note that this type of managed labour importation is a strategy that German employers have adopted in previous periods of labour shortage, e.g. the 1950s and 60s.)

Staff recruited from abroad are generally required to evidence German language competence at CEFR level B1 prior to their appointment (i.e. before entering Germany). Once in Germany they then go through a process of (re)accreditation. This process often (and in the elderly-care sector almost always) involves practical work undertaken through internships. Thus a foreign worker with an academic qualification in care work from their own country would still be required to gain practical experience in Germany e.g. as an internship or as a care assistant (equating to the German dual-education approach).

While migrant care workers with care qualifications from their home countries are going through this (re)accreditation process they are only paid as non-qualified support staff or trainees until they achieve German accreditation.

### 1.10 Supply of skills

Within the sector there is concern about where the additional 140 000 qualified staff (see section 8 above) will come from. Elder care work is relatively low-paid and low-status, making it more and more difficult for eldercare employers to recruit and hold personnel.

The requirement that 50% of staff hold the three-year dual-education qualification makes it hard to recruit migrant workers into elder care. Still, as the need for qualified care-workers is constantly rising and as there is an increasing shortage of labour in Germany eldercare providers are currently trying to recruit qualified staff from other countries. Once recruited, these foreign staff go through a process of (re)accreditation in Germany, which requires both practical experience with a German care provider and attainment of CEFR level B1 German language competence. Language competence is assessed at state-level and practice differs in the different *Bundesländer* but assessors try to ensure that foreign staff have B1 competence in the context care work.

Currently migrants and/or people with a migration background make 19,5% (2010) of the German elder-care workforce.

**Note:** In Germany migration is categorised both in terms of foreign-born residents and German-born residents with a 'migration-background' (*Migrationshintergrund*).

*Persons with a migration background can be foreign or German citizens, and include the following groups of people: foreigners born abroad, foreigners born in Germany, (Spät-)Aussiedler, naturalised citizens who have themselves*

*immigrated, as well as their children who have no personal, direct experience of immigration. Persons with a migration background have either immigrated themselves or are the second or third-generation descendants of immigrants.*

[Source: German Federal Agency for Civic Education, Country Migration Profiles, <http://www.bpb.de/gesellschaft/migration/laenderprofile/58349/germany>]

### **1.11 Workforce development**

The skills of the support workforce are primarily developed through the three-year dual-education programme. Access to the three-year dual-education programme is based on completion of ten years of schooling in Germany.

The trainee is employed as a care worker by a care provider and released for one or two days a week to attend a specialist elder-care vocational school for the theoretical element of the qualification.

Care providers that wish to participate in the three-year dual-education system are required to employ a qualified practice instructor, whose role is to supervise the trainee at work.

Costs to the employer therefore include the employment costs of the trainee, the cost of releasing the trainee for college classroom training and the cost of employing the qualified practice supervisor.

The number of traineeships that a care provider can offer is determined by the *Pflegekassen* ('care funds', an autonomous adjunct to the public health-insurance companies, *Krankenkassen*), based on monies allocated by the *Pflegekassen* for care.

## **2. Adult education**

### **2.1 Non-formal adult education**

There is a well-established culture of non-formal adult education in Germany. One example is the *Volkshochschulen* (VHS, that is 'folk' or 'people's high schools') who organize a variety of different educational programmes. The first *Volkshochschulen* were founded in the late 19<sup>th</sup> century. Today there are about 1000 *Volkshochschule* all over Germany. They exist in a variety of legal formats and are mostly run by local authorities and voluntary organisations.

*Volkshochschulen* are financed by the six 'pillars': regional and local grants, learner fees, donations and external funding from e.g. the federal government the European Social Fund, the state government (i.e. the *Bundesländer*). Since folk high schools only have to cover part of their costs through learner fees – and do not need to make a profit – VHS courses are comparatively low-cost and so accessible to most of the population.

Many other institutions besides *Volkshochschulen* offer non-formal learning and overall take-up of these learning opportunities is high.

### **2.2 Formal adult education**

Continuing education in Germany is only lightly regulated by the state. Only providers of distance learning require State approval. In research, the sector is described less as a 'system' and more as a 'field'.

Due to Germany's federal structure, responsibility for education is shared. The federal government is responsible for vocational education '*Berufsbildungsgesetz*' (Vocational Training Act). The '*Sozialgesetzbuch*' (Social Security Code) law regulates the subsidies for special training for the unemployed. Another law, the '*Aufstiegsfortbildungsförderungsgesetz*' (Upgrading Training Assistance Act), sets out the conditions for financial aid for people who want to improve their vocational competencies and become a '*meister*'.

The '*Bundesländer*' (states) have obligations and responsibilities for general education (they are also responsible for school education within their borders). The '*Weiterbildungsgesetze der Länder*' (state government law on continuing education) regulates the subsidies for VET offered by adult education centres. Of the 16 *Bundesländer*, 13 have continuing education laws that guarantee basic public provision of continuing education.



In addition to this, *'Bildungsurlaubsgesetze'* (educational leave laws) define employee rights to leave for educational purposes.

### 2.3 Role of adult education in VET

Adult education in Germany is classically divided into

- General adult education with special areas such as political adult education; cultural learning, family learning etc.
- Vocational adult education, where the largest part is employer-initiated; also very important is adult education for those in unemployment.

The federal government is responsible for vocational education *'Berufsbildungsgesetz'* (Vocational Training Act).

### 2.4 How individuals access adult education

In Germany, it is estimated that there are approximately 25,000 continuing education institutions (2008). These are: institutions that provide regular and publicly organised education as a primary or secondary task. This includes commercial units, i.e. institutions with branches are counted several times.

- 37% of the institutions offer general and vocational continuing education
- 56% only vocational continuing education
- 6% only general continuing education (with political and cultural education)
- 41.3% are private providers
- 23.5% are adult education centres

Approximately 1.2% of GDP in Germany is spent on adult education, approximately 28 billion euros (2007, conservative estimate, only direct costs).

The most important financers of adult education in Germany are the participants themselves, followed by employers (again only direct costs). Public sponsors (federal government, states, communities, EU) take third place with taxes and revenue from unemployment insurance used for educational measures for job-seekers.

## 3. Language learning for migrants

Migrants coming to Germany can participate in 'Integration-Courses' which usually consist of 660 hrs (including a 600 hr language course and a 60 hr orientation course). There are five groups of persons for which different rights and obligations are defined:

- **German nationals** have no statutory entitlement to an integration course. However, if places on a course are available, the Federal Office for Migration and Refugees (BAMF) may allow German nationals to participate if they do not yet speak adequate German, or have particular integration needs. A token fee of €1.20 for every lesson of the integration course is payable (Contribution to costs). Those in receipt of unemployment benefit II or social assistance (*Sozialhilfe*) can apply for fee exemption. These conditions apply equally to non-German **EU citizens**.
- **Ethnic German repatriates admitted into Germany on or after 1 January 2005**, their spouses and children are legally entitled to a free integration course (funded by BAMF).
- **Foreign nationals with residence titles issued before 2005** can access an integration course where places are available. Foreign nationals in receipt of unemployment benefit II may be required to attend. A token fee of €1.20 for every lesson of the integration course is payable.
- **Foreign nationals with residence titles issued from 2005 onwards** may have a legal entitlement to attend an integration course and/or may be legally required to attend (e.g. if they cannot make themselves understood in German). The local immigration office decides if attendance is required when it issues a residence title. Likewise foreign nationals in receipt of unemployment benefit II may be required to attend. A token fee of €1.20 for every lesson of the integration course is payable.

The course itself leads to Level B1. Participants who do not reach B1 can repeat 300 hours of the course. There are full-time and part-time courses and additional special courses (e.g. including literacy, courses for women, for young

adults, for parents, etc). Courses are offered by various providers. Participants who are funded need to show a certificate of eligibility (*Berechtigungsschein*) from the immigration authority (*Ausländerbehörde*). Note: free courses for migrants are offered only up to CEFR level B1.

Courses in German as a second language range from intermediate to advanced levels. These courses are provided by adult education providers and are open to all learners, on a fee-paying basis.

*By Florian Frommeld (September, 2014)*

### Sources

<http://www.pkv-wiki.com/cms/pkv/info/grundlagen/zusatz/pflege-bahr/voraussetzungen-fuer-die-staatlich-gefoerderte-pflege-zusatzversicherung>

Federal Statistics Office <https://www.destatis.de>

[http://www.recht-in.de/gesetz/heimpersonalverordnung\\_verordnung\\_ueber\\_personelle\\_anforderungen\\_fuer\\_heime\\_heimpersv\\_heimpersonalverordnung.html](http://www.recht-in.de/gesetz/heimpersonalverordnung_verordnung_ueber_personelle_anforderungen_fuer_heime_heimpersv_heimpersonalverordnung.html)

Facts about Germany <http://www.tatsachen-ueber-deutschland.de/en/political-system.html> [accessed 23 August 2014]

[www.die-bonn.de/doks/dietrich0802.pdf](http://www.die-bonn.de/doks/dietrich0802.pdf)

<http://www.bamf.de/DE/Willkommen/DeutschLernen/Integrationskurse/TeilnahmeKosten/teilnahmekosten-node.html>

German Federal Agency for Civic Education <http://www.bpb.de/gesellschaft/migration/laenderprofile/58361/immigrant-population>

## P2: England

*Note: Adult social care is organised differently in each of the UK's four nations (England – population 53.9 million, Scotland – pop 5.3m, Wales – pop 3.1m and Northern Ireland – pop 1.8m). The information given here relates to England.*

### 1. How adult social care is organised

#### 1.1 How care is paid for

Funding for elderly care is means-tested: i.e. the individual is required to pay for as much of their care as they can afford. Individuals who lack the ability to pay for care are entitled to care funded by their local authority (through a combination of local taxation and central government grant.) In practice, most people are required to pay some or all of the cost of their care.

#### 1.2 How care is regulated

Central government regulates adult social care through laws, public policy and quality monitoring. Responsibility for provision of adult social care is devolved to local government (the 152 English *Councils with Adult Social Services Responsibilities*). These councils must directly deliver or commission social care services to meet the needs of local people. Services are paid for through a mix of central government funding, local taxation and fees charged directly to service users.

#### 1.3 How individuals access care

Individuals access care either directly from a care provider or through their local authority.

Local authorities are required by law to assess anyone living in their area who may need care and then decide whether to provide a service. Local authorities assess needs according to standard criteria, but have discretion as to how they apply the criteria. Where a person meets the local authority's criteria, the local authority will arrange care for the person.

The local authority also assesses the person's ability to pay (based on standard national criteria). Where a person is entitled to publicly-funded care, the person can request a personal budget (i.e. direct payment of the funds the local authority allocates to their care) in order for the person to arrange care for themselves.<sup>1</sup>

Where the person is not entitled to publicly-funded care, the person is required to pay for any care that the local authority arranges for them.

Individuals may also arrange care privately without reference to their local authority.

About 90% of care is delivered by private companies or voluntary organisations, with only around 10% of care directly delivered by local authorities.

#### Notes

1. In March 2012 about 193,000 people were receiving direct payments from local authorities and an estimated 100,000 of these used those payments to directly employ their own staff (Skills for Care 2013b). This suggests that people receiving direct payments make up just over 10% of all those receiving formal, paid care (1.8m people). In 2002 less than 10,000 (about 3%) received direct payments. Numbers then grew quickly with a sharp increase in 2008-2010, but recently the total has stabilised at around 200,000.

#### 1.4 Size of the adult social care workforce

Key trends over the past twenty years include (1) local authorities changing their role of direct providers of care to commissioners of care; (2) significant growth in the size of the workforce; (3) significant growth in the number of migrant workers (particularly in certain geographical areas). Regarding the provision of care: where once local authorities had provided up to 90% of care directly, they now provide only about 10% with most care provided by commercial companies. This has led to very large number of employers in the sector and despite considerable consolidation in recent years (i.e. private equity companies buying up large numbers of small care providers to create care groups) there are still an estimated 17 000 different employers in the sector.

In 2012 (the most recent year for which data is available), there were an estimated 1.63 million adult social care jobs (including 1.23m full-time) in England and an estimated 1.5 million workers doing those jobs. The total number of jobs was estimated to have increased by 4% since 2011 and by 15% since 2009.

There are an estimated 5.5m informal, unpaid family carers, many aged over 65 and many providing more than 20hrs per week of care. It is also estimated that 3.5m people do voluntary work for health and/or social care organisations.

Of the 1.63m paid jobs, about 150 000 (9%) were in local authorities, 300 000 (18%) were in voluntary organisations, 900 000 (55%) in private companies, 55 000 (4%) in the NHS. The remaining 234 000 (14%) were jobs where the workers were directly employed by the person they were supporting.

The great majority of the 1.63m jobs involved actually delivering care: 1 236 000 (76%). Managerial roles accounted for 121 000 (7%) of all jobs. Professional roles (e.g. qualified nurses and therapists) made up a further 93,000 (6%). Other roles (e.g. cleaning, catering and maintenance) accounted for the remaining 180 000 jobs (11%).

The number of adult social care providers was estimated at 17,000 (up by 2.5% on 2011) with an estimated 39,000 establishments (i.e. workplaces) providing or organising adult social care (up 1.5% on 2011). Of the 17 000 providers, 46% offered residential services and 54% non-residential services.

**Migrant workers:** In 2001, foreign-born care workers accounted for 7% of the total adult social care workforce. In 2011, official workforce records suggested that about 20% of adult social care workers (i.e. about 250 000) were non-British. Of the non-British workers, 26% (65 000) were from European Economic Area (EEA) countries and 74% (185 000) were from non-EEA. Most migrant workers were recruited in the UK.

These migrant workers were concentrated in certain areas: in London it was estimated that between 50% and 60% of all care workers were non-British; 26% in the South East; but only 9% in the North West and 5% in the North East.

### 1.5 Skills of professional staff

Professional roles require staff to hold appropriate qualifications (generally starting at European Qualification Framework (EQF)<sup>1</sup> level 6 and above) and undertake continuing professional development. Staff must register annually with their professional body and evidence up-to-date qualifications.

**Managerial roles** All managers are expected to meet national induction standards that cover (1) Governance and accountability; (2) Systems and processes to promote communication; (3) Partnership working and relationships; (4) Using person-centred practice to achieve positive outcomes; (5) Team leadership and management; (6) Managing resources; (7) Equality, diversity and inclusion; (8) Safeguarding and protection.

Care services that are required to register with the Care Quality Commission (CQC), the government's quality monitor, (which includes all services providing personal care) must identify a 'registered manager'. CQC states that registered managers must have the necessary qualifications, skills and experience to carry out their role. In practice, this means gaining a diploma in Leadership and Management in Health and Social Care at EQF level 5.

#### Notes

1. See appendix for EQF level descriptors

## 1.6 Skills of support staff

There is a comprehensive framework of national qualifications available for support staff. These qualifications are based on national occupational standards developed by the sector (i.e. by adult social care employers in consultation with relevant government agencies).

Qualifications start with pre-employment programmes (EQF levels 2-4) for 14-19 year-olds.

Qualifications aimed at working staff are divided into two categories: qualifications of occupational competence; and continuing professional development (CPD) qualifications.

Occupational competence qualifications include employer-led induction based on national induction standards (EQF level 3), apprenticeships (EQF levels 3-5) and diplomas at EQF levels 3 and 4. Continuing professional development (CPD) qualifications tend to focus on specific areas of care, e.g. dementia, and are pitched at EQF levels 3 and 4.

Both occupational competence and CPD qualifications typically mix on-the-job coaching and assessment with classroom and/or e-learning, supported by portfolio-building.

Learning providers include local authority training departments; private training providers; commercial e-learning providers; local colleges of further education (often offering qualifications to employers on a commercial basis) and the in-house training departments of care providers themselves (many care providers employ their own trainers).

At the same time, there is considerable pressure to contain workforce costs: it is estimated that spending on workforce accounts for 80–85% of social care budgets. Support staff are typically paid little more than the national minimum wage. As a result, employers find it difficult (a) to afford wages that attract higher-skilled individuals; and (b) to release staff for training.

Despite employer commitment to training and the efforts of commissioners to incentivise employers to train staff, recent workforce surveys suggest that only half the current adult social care workforce is qualified to EQF level 3. There is, additionally, longstanding concern in the sector regarding the basic skills (i.e. literacy, language and numeracy) of support staff.

## 1.7 Regulation of skills

Since the 1990s there has been a significant effort to professionalise the adult social care workforce. In 2000, legislation was introduced that required 50% of staff on duty at any one time to be qualified to at least EQF level 3. That requirement no longer stands. Instead, national minimum training standards set out the competences expected of support staff in ten generic areas<sup>1</sup> and the government quality monitor, the Care Quality Commission (CQC), stipulates only that staff have whatever skills and qualifications are necessary for their work.

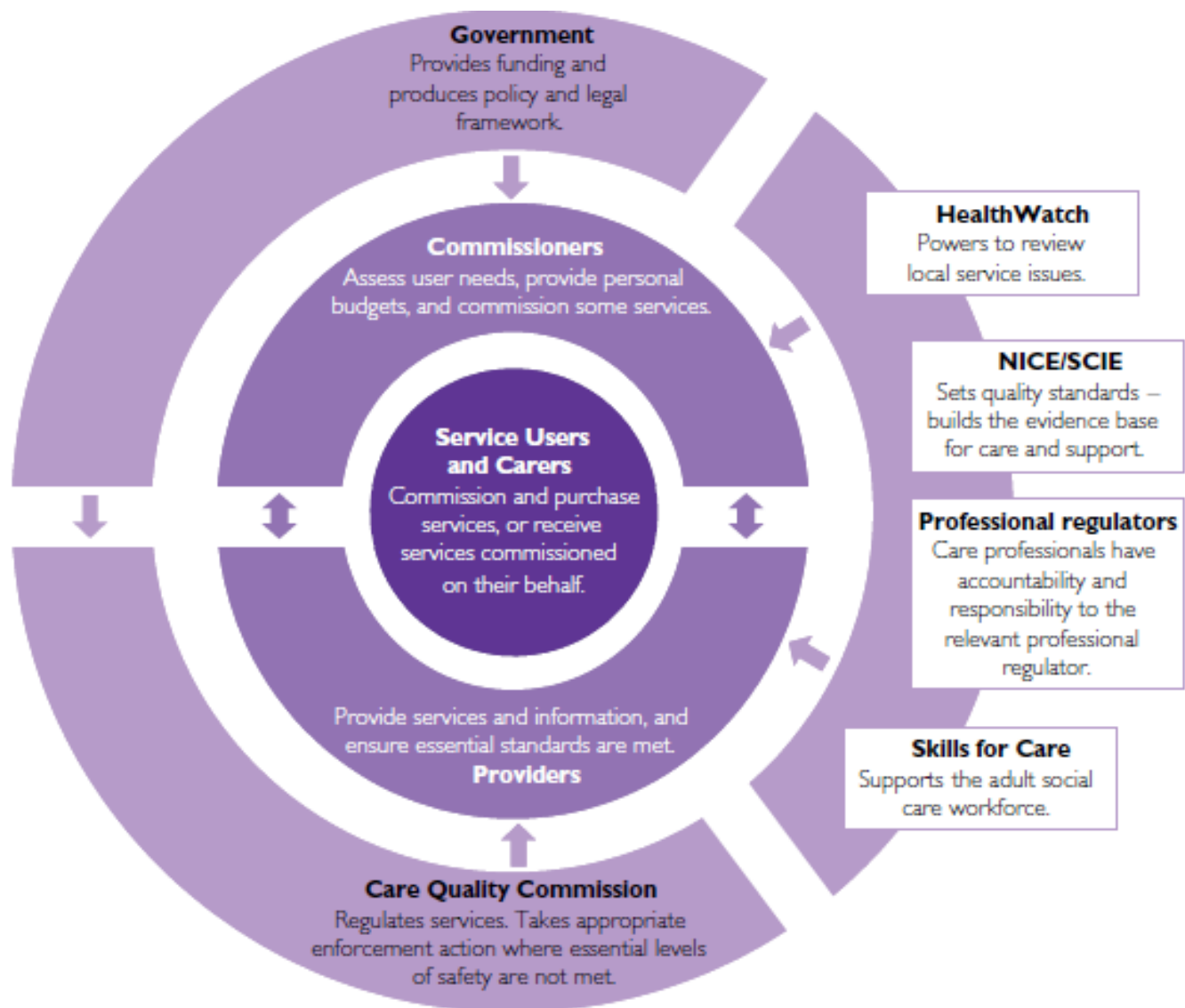
In practice, CQC's minimum expectation is that (a) the registered manager checks that all support staff meet national induction standards<sup>1</sup> within the first 12 weeks of their employment; and (b) staff undergo training to comply with generic health and safety law.

Beyond meeting induction standards and complying with legal requirements, many employers encourage staff to undertake an EQF level 3 diploma followed by occasional CPD learning. To prepare support staff to take on supervisory responsibilities, employers may offer them support to undertake an EQF level 4 diploma.

### Notes

1. National induction standards (EQF level 3) for support staff cover (1) Role of the health and social care worker; (2) Personal development; (3) Communicate effectively; (4) Equality and Inclusion; (5) Principles for implementing duty of care; (6) Principles of safeguarding in health and social care; (7) Person-centred support; (8) Health and safety in an adult social care setting. (See <http://www.skillsforcare.org.uk/Standards/Common-Induction-Standards/Common-Induction-Standards.aspx>)

**Overview of adult social care system in England**



Source: HM Government (2012) *Caring for our future: reforming care and support*. p32  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf) [accessed 12 Aug 2014]

**1.8 Demand for care**

It is estimated that approaching 1.8m people currently receive formal, paid care. This number is expected to rise sharply over the next 25 years as the population ages, with a particularly marked increase in the number of people aged over 85 (expected to more than double).

Over that period (i.e. the next 25 years), the numbers of older people using non-residential formal services are projected to rise from 1.5m to 3.1m; and the numbers of older people in care homes (and long-stay hospital care) will rise from 345,000 to 825,000. Growth in demand is also anticipated in other services e.g. for adults with physical and sensory impairments and for adults with learning disabilities.

To meet this increase in demand, official projections suggest that the adult social care workforce will need to increase from the current 1.63m to up to 2.6m by 2025.

In addition to the need to increase the absolute size of the workforce, the adult social care sector is also under pressure to deliver care in new ways. The two main drivers of this are (1) restructuring related to policy-makers'

desire to contain costs (even though most individuals pay for some of their care, costs to the state are still significant); and (2) the demand for services more closely tailored to needs of the individual (known as ‘personalisation’).

A further issue is that in most service areas, the majority of care is now provided by commercial companies subject to market forces.

### 1.9 Demand for skills

The sector’s current recruitment and retention strategy (2011) states:

*In order to meet the challenges of the future, we will need to attract a diverse workforce. Traditional patterns of recruitment, structures and working practices will all have to change. The citizen requires bespoke services and the system must deliver flexible responses.*

*This will lead to an incredibly diverse workforce that may well have portfolio careers that cross the continuum between health, social care, mutuality and support. Within the context of this diverse workforce, there will be a need to ensure consistency in terms of the quality of the workforce, the core values that underpin social care work and the skills and competencies that staff will need to acquire.*

*These skills and competencies will not be the old process-driven and service focused offering. The skills required by care workers will move towards enablement, empowerment and facilitation. The role will be about supporting people to be active citizens and to help them lead a life, not just delivering a service.<sup>1</sup>*

#### Notes

1. Skills for Care (2011), *Adult social care workforce Recruitment and Retention Strategy*. Leeds: Skills for Care. pp2, 3.

### 1.10 Supply of skills

Recruitment and retention is a serious concern for adult social care commissioners and employers. In 2014, annual turnover of staff in adult social care was estimated at 20%, compared to 15% nationally across all sectors. The vacancy rate (i.e. unfulfilled jobs) was 3-4% for adult social care compared to 2% nationally across all sectors. It is anticipated that these pressures will increase significantly as the demand for care increases in forthcoming years.

To meet this demand, the sector recognises that it must look beyond its traditional workforce to recruit and retain a larger workforce capable of delivering more complex care in more flexible, responsive ways.

The sector is working actively with schools, colleges and the public unemployment service to attract new workers. It is also likely that migrant workers will continue to play an important role. In 2013, despite government restrictions on low-skilled migrants entering the UK from outside the EEA, 16% (62 000) of all new workers in adult social care came from outside the UK. This was more than double the number of recruits new to employment (28 000) and more than all those joining from other sectors of the UK economy (55 000).

**Migrant workers:** In 2001, foreign-born care workers accounted for 7% of the total adult social care workforce. By 2011 (as noted in 4 above) that figure had risen to almost 20% (and non-British workers made up 40% of all registered nurses working in adult social care). About a quarter of these migrant workers were male, compared to 16% of UK-born care workers.

Official research in 2009 found that social care employers perceived migrant workers as enthusiastic, hard-working and generally more qualified, younger and are less likely to take time off work than UK-born staff. They recruited these migrants however due to difficulty in attracting UK-born workers.

### 1.11 Workforce development

Most support staff join the sector without relevant qualifications and rely on their employer for (employment-based) training and skills development.

The employer is required to ensure all staff meet national induction standards (EQF level 3) within the first 12 weeks of employment. Many employers encourage staff to then undertake the EQF level 3 diploma regarded as the

baseline qualification for occupational competence, as well as further CPD learning. Employers may offer staff with supervisory responsibilities opportunity to undertake an EQF level 4 diploma. Both diplomas are portfolio-based and include workplace assessment by occupationally competent assessors.

Employers ensure all staff undertake health and safety training as required by law.

Recently, the sector has launched a number of workforce developments initiatives focused on helping support staff to better understand and apply social care values.

## 2. Adult education

### 2.1 Organisation of adult education in England

Adult education in England evolved from self-organised adult learning dating from the 17<sup>th</sup>, 18<sup>th</sup> and 19<sup>th</sup> centuries that focused on three different areas: adult literacy for direct study of the bible; working class political educational; and trade schooling.

Today adult education is broadly divided between further education (FE) and adult and community learning (ACL).

FE is typically college-based and includes post-compulsory education and training for 16 to 19 year-olds and adults that is not delivered in higher education institutions (although increasingly FE colleges offer higher education programmes). There are some 400 FE colleges with about 4m learners on a wide range of full- and part-time courses. FE colleges are funded through a combination of government grant and learner-fees. The focus of FE is on vocational and 'second chance' learning (i.e. routes back into learning for young people and adults who have not achieved qualifications at school). Courses range from adult basic education to higher education (i.e. university) level and from support for those with learning disabilities to academic and highly technical areas. The characteristic FE learner is an individual who has enrolled to develop vocational skills.

ACL takes place in diverse settings and has traditionally been aimed at learning for 'leisure and pleasure' (e.g. learning related hobbies, handicrafts and personal interests). In addition to this, ACL has also sought to engage adults who do not normally participate in education and training. Over the past several years government has increasingly shifted public funding for ACL away from 'leisure and pleasure learning' and towards adults with low educational attainment. ACL is often a collaboration between local authorities, community organisations and FE providers.

Some trade unions provide learning programmes for their members. The union for public sector workers, Unison, is the union most directly associated with the adult social care sector<sup>1</sup> and it works closely with the Workers' Educational Association (WEA), a national voluntary organisation that had been providing learning for over 100 years.

There are also commercial adult education providers.

Regulation of adult education (FE and ACL) is based on a combined funding and quality assurance system. The government identifies qualifications it will support with funding then allows registered learning providers who meet government quality standards to draw down funding to deliver those qualifications. Funded qualifications reflect the government's perception of skills needs.

Individuals access adult education simply by enrolling on a given course. Some adult education remains free to the learner (e.g. adult basic education and some low-level vocational qualifications), but most programmes now are fee-paying.

#### Notes

1. Membership of trade unions declined in all sectors across the UK since the 1980s. In 1979 there were about 13m trade union members in the UK. By 1995 this had fallen to 7m and by 2012 to 6.5m – about 26% of the total workforce. In the adult social sector union membership is highest among professional workers (especially social workers and nurses) and workers employed by local authorities; it is lowest among



support staff and among workers employed in the private sector. In many adult social care workplaces none of the support staff may belong to a union.

## 2.2 Vocational education and training

Government policy differentiates two areas of VET: one is VET for 14-19 year-olds and the other is VET for adults. From 2000 until 2010 policy focused on improving adult skills (based on recognition that (a) very large numbers of workers had low or no qualifications; and (b) young people coming into work made up a small proportion of the working population). Since 2010, attention has shifted towards 14-19 year olds and apprenticeships.

Other significant policy trends include (1) reform to simplify the VET system around qualifications that match employer skills needs; (2) measures to ensure that all young people achieve English and maths qualifications at EQF level 3; (3) increasing involvement of employers in the design and delivery of qualifications with a view to creating an employer-led VET system.

FE and ACL focus on delivering learning to individuals. Most adult basic education is delivered through FE and ACL. Most pre-employment vocational education for 14-19 year-olds is delivered through FE and ACL.

Most of this learning takes place in colleges or community settings, however, FE (and to a lesser extent ACL) providers also deliver both adult basic education and VET qualifications (including apprenticeships, which are funded partly by government and partly by employers) to employees in the workplace.

## 3. Language learning for migrants

### 3.1 English language provision

Formal English language learning provision for migrants is termed ESOL (English for Speakers of Other Languages). ESOL is a well-established part of regulated FE and ACL provision (i.e. it attracts government funding and is subject to government quality standards). Programmes are based on an official ESOL curriculum (EQF levels 1 to 3/CEFR levels A1-C1) and lead to national qualifications. Learners are expected to contribute to the cost of their provision, unless they are in receipt of state welfare benefits. Participation is optional for migrants, although participation may be required in order for the migrant to access some state benefits (e.g. unemployment benefits). Broadly speaking, public funding for ESOL now targets social cohesion and seeks to ensure that all members of settled migrant communities speak English. In 2010, there were about 180 000 ESOL learners in England. In parts of the country where migrants cluster (e.g. London) demand for ESOL often outstrips supply and fee levels may be off-putting to those in low-paid employment.

**Migration to the UK:** From 2000 on, the UK experienced high levels of very diverse economic migration (about 500 000 migrants per year). Restrictions on low-skilled immigrants from outside the EEA were introduced in 2008.

### 3.2 English language provision at work (Workplace ESOL)

Teaching and learning of English for migrants has a long history in the UK, linked to waves of immigration, but ESOL in its current form dates back to the 1960s and immigration from the Indian subcontinent. These migrants were often low-skilled with little schooling. On arrival in the UK they were often subject to racism and ESOL in this period was strongly oriented to social justice and anti-racism. At this point ESOL provision was funded by local authorities and there was no official curriculum or qualifications. ESOL entered the workplace almost immediately with 'industrial English training (ILT)' programmes delivered to Asian migrants working in factories. In 1974 a National Centre for Industrial Language Training (NCILT) was established with funding from central government. Local ILT units were established with a mix of central and local government funding. These lasted until government policy changed in 1987 and funding was withdrawn. During the 1990s, workplace provision continued in many places, led by FE and ACL providers on an ad hoc basis. At the end of 1990s central government made reduction of low skills a public policy priority and in 2001 launched a national strategy to improve adult basic skills, including the English language skills of migrants. In particular there was a focus on the skills of adults in work. Over the next five years, central government funded the development of the ESOL curriculum, national learner qualifications, professional

standards and training for ESOL teachers and made substantial funds available for ESOL provision in FE and ACL. Until 2007, FE and ACL learning providers were able to offer employers free workplace ESOL courses for their staff. From 2008 on, employers have been expected to meet the cost of workplace ESOL courses. New work-specific ESOL qualifications have been developed. More generally, funding for FE and ACL ESOL has been reduced. This has reduced the amount of provision available, particularly in the workplace. In addition, funding and quality requirements tend to focus learning providers on delivering qualifications to staff as individuals, rather than addressing workplace needs holistically.

by Alexander Braddell (August 2014)

### Sources

Age UK *Social Care and Support* <http://www.ageuk.org.uk/home-and-care/social-care-and-support-where-to-start/>

Care Quality Commission (2011), *Guidance about compliance, Essential standards of quality and safety*. Newcastle upon Tyne: CQC

-- (2013), *Registration under the Health and Social Care Act 2008, The scope of registration: August 2013*. Newcastle upon Tyne: CQC

Centre on Migration, Policy And Study (COMPAS) University of Oxford *Migrant Care Workers in Ageing Societies UK* <http://www.compas.ox.ac.uk/research/labourmarkets/migrantcareworkers/uk/> See: ESRC Centre on Migration, Policy and Society (COMPAS) University of Oxford (2009), *Evidence submitted to the House of Commons Select Committee on Health for the Inquiry on Social Care: Memorandum to Social Care Inquiry, November 2009. Submitted by Alessio Cangiano, Isabel Shutes and Sarah Spencer*. [accessed 10 Aug 2014]

Kirsty McGregor in *Community Care* (27 April 2011), 'Alarm over lack of union membership among care workers'. <http://www.communitycare.co.uk/2011/04/27/alarm-over-lack-of-union-membership-among-care-workers/> [accessed 21 Aug 2014]

Department for Business, Innovation and Skills (2013), *Trade Union Membership 2012 Statistical Bulletin (May 2013)*. London: Department for Business, Innovation and Skills

European Qualification Framework [http://ec.europa.eu/ploteus/search/site?f\[0\]=im\\_field\\_entity\\_type%3A97](http://ec.europa.eu/ploteus/search/site?f[0]=im_field_entity_type%3A97) [accessed 10 Aug 2014]

The Guardian (14 April 2011), *Anger over English lesson funding cuts* <http://www.theguardian.com/education/2011/apr/14/english-lessons-funding-immigrants> [accessed 14 Aug 2014]

HM Government (2012), *Caring for our future: reforming care and support* <https://www.gov.uk/government/publications/caring-for-our-future-reforming-care-and-support> [accessed 11 Aug 2014]

House of Commons Health Committee (2010) *Health Committee Third Report Social Care* <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/22/2202.htm> [accessed 10 Aug 2014]

Joseph Roundtree Foundation/Sarah Carr (2014), *Pay, conditions and care quality in residential, nursing and domiciliary services*. <http://www.jrf.org.uk/publications/pay-conditions-and-care-quality-residential-nursing-and-domiciliary-services> [accessed 12 Aug 2014]

Jupp, T.C., S. Hodlin (1975), *Industrial English*. London: Hodder and Stoughton

Lang and Buisson (2012), *The Role of Private Equity in UK Health & Care Services*. London: Lang and Buisson

Leitch Review of Skills (2006), *Final report: Prosperity for all in the global economy – world class skills*. London: HM Treasury

National Audit Office (2014), *Adult social care in England: overview*. <http://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf> [accessed 11 Aug 2014]

NHS Choices *Guide to social care services* <http://www.nhs.uk/NHSEngland/AboutNHSservices/social-care-services/Pages/social-care-adults.aspx> [accessed 10 Aug 2014]

- *What is social care* <http://www.nhs.uk/CarersDirect/social-care/Pages/what-is-social-care.aspx> [accessed 10 Aug 2014]
- Professional Standards Authority for Health and Social Care <http://www.professionalstandards.org.uk/> [accessed 10 Aug 2014]
- Rosenberg, Sheila K. (2007), *A critical history of ESOL in the UK, 1870-2006*. Leicester: NIACE
- Skills for Care (2010), *State of the Adult Social Care Workforce report 2010*. Leeds: Skills for Care, p89
- (2011a), *nmds-sc briefing issue 14 migrant workers*. Leeds: Skills for Care
- (2011b), *Adult social care workforce Recruitment and Retention Strategy*. Leeds: Skills for Care.
- (2011c), *Capable, confident, skilled: A workforce development strategy for people working, supporting and caring in adult social care*. Leeds: Skills for Care
- (2012), *State of the Adult Social Care Sector and Workforce in England, 2012*. Leeds: Skills for Care.
- (2013a), *nmds-sc trend briefing Issue 1 - Care worker pay*. Leeds: Skills for Care.
- (2013b), *The size and structure of the adult social care sector and workforce in England, 2013*. Leeds: Skills for Care
- (2014a), *Guide to qualifications and standards in adult social care 2014/15*. Leeds: Skills for Care
- (2014b), *Recruitment and retention in the adult social care sector (nmds-sc infographic)*. Leeds: Skills for Care.
- Skills for Care (2014c), *Core skills, A strategy to support functional and employability skills in the adult social care workforce in England, 2014-2017*. Leeds: Skills for Care.
- *Workforce intelligence* <http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/NMDS-SC/Workforce-intelligence-publications/Workforce-intelligence-publications.aspx> [accessed 10 Aug 2014]
- *Care Quality Commission regulations*, <http://www.skillsforcare.org.uk/Standards/Care-Quality-Commission-regulations/Care-Quality-Commission-regulations.aspx> [accessed 10 Aug 2014]
- *Leadership and management*, <http://www.skillsforcare.org.uk/Qualifications-and-Apprenticeships/Leadership-and-management/Leadership-and-management.aspx> [accessed 10 Aug 2014]
- *Qualifications and Apprenticeships*, <http://www.skillsforcare.org.uk/Qualifications-and-Apprenticeships/Qualifications-and-Apprenticeships.aspx> [accessed 10 Aug 2014]
- *Standards*, <http://www.skillsforcare.org.uk/Standards/Standards.aspx> [accessed 10 Aug 2014]
- Smith, M. K. (2004), *Adult schools and the making of adult education*. the encyclopedia of informal education [www.infed.org/lifelonglearning/adult\\_schools.htm](http://www.infed.org/lifelonglearning/adult_schools.htm) [accessed 13 Aug 2014]
- Social Care Commitment <https://www.thesocialcarecommitment.org.uk/> [accessed 12 Aug 2014]
- Social Care Institute for Excellence, *Personalisation*, <http://www.scie.org.uk/topic/keyissues/personalisation> [accessed 11 Aug 2014]
- The King's Fund/Richard Humphries (2013), *Paying for social care, Beyond Dilnot* [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_summary/social-care-funding-paper-may13.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/social-care-funding-paper-may13.pdf)
- UK Office of National Statistics, *Population estimates for the UK* <http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/2013/sty-population-estimates.html> [accessed 10 Aug 2014]
- *Migration Statistics Quarterly Report, May 2014* <http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/may-2014/index.html> [accessed 14 Aug 2014]
- Unison <http://www.unison.org.uk/about/our-organisation/our-members/> [accessed 21 Aug 2014]
- Wolf, Alison (2011), *Review of Vocational Education – The Wolf Report*. London: Department of Education

## **P3: The Basque Country and Spain**

### **1. How adult social care is organised**

#### **1.1 How care is paid for**

In Spain (population 47 million) as a whole, regional governments have responsibility for funding adult social care and funding arrangements vary by region. The social care state is based on the principle of universality and citizens are not excluded by their income rate.

In the Basque Country (population 2 million), local authorities are responsible for the care of elderly people with disabilities. Care is means-tested so the person pays proportionate to their person's income and assets.

#### **1.2 How care is regulated**

Spain is a constitutional monarchy with a national parliamentary government and 17 Autonomous Communities and two Autonomous Cities (i.e. regional governments). Autonomous Communities operate within a legal framework established by the national government, but regional governments (the Autonomous Communities) have many decision-making powers. The Basque Country is one of these Autonomous Communities.

Regarding the regulation of adult social care, in 2006 Spain's national parliament passed the '*La Ley de Promoción de la Autonomía y Atención a las personas en situación de dependencia*' ('Promotion of Independence and Care for people needing support Act'). This law set out new parameters for adult social care and provides a framework for the provision of care throughout Spain. The Act established the Territorial Council of Social Services and the System for Autonomy and Care for Dependency, a national body made up of central government officials and directors of social services from regional government, to oversee social care. Each Autonomous Community, however, is able to decide how to implement the law (including what budget to allocate) in its region. As a result, there are significant variations in the provision of adult social care between regions.

The Basque Country is an Autonomous Community with its own (regional) government, including a parliament with 25 representatives drawn from the three provinces that make up the region.

In the Basque Country, adult social care is provided within the parameters of the 'Promotion of Independence and Care for people needing support Act'. The Basque Regional Government sets the region's overall budget (raised from a combination of local taxation and central government grant) for adult social care. How that budget is spent is decided by the local authority for each of the three provinces.

The three local authorities are responsible for directly providing or commissioning other organisations to provide services. Local authorities are in charge of primary services such as home delivered services and day care centres, specialized services (care homes, programs for carers...) and the provision of financial support.

The quality of these services is monitored through annual inspection by the Basque Government ('*Alta Inspección de Servicios Sociales*') and by the local authority ('*Inspección de entidades, centros y servicios de Servicios Sociales*' by the Diputación Foral de Gipuzkoa).

#### **1.3 How individuals access care**

To access care services the elderly person or his/her family apply to the local authority, who administer a 'dependency and disability assessment' to establish the person's level of need and what services they should receive (e.g. alarm system, home assistance, day care centre or nursing home).

#### **1.4 Size of the adult social care workforce**

The adult social care sector in Spain employs 342 000 people (2008). This was projected to almost double by 2015 to 635 000. Of these, 42% work in elderly care. This workforce includes a range of professional roles such as nurses, occupational therapists and physiotherapists, but the majority of employees work in support roles as care workers or

auxiliary nurses. Migrants make up 12% (i.e. 40 000 in 2008) of the total adult social care workforce. It is not clear how many of these migrants are in professional roles and how many in support roles.

The number of paid workers in the adult social care sector in the Basque Country is just over 9 000. Of those just over 6 000 work in direct care of the elderly. Of these 6 000, over 90% (5 600) are women. Within the Basque Country's adult social care workforce, most staff are in support roles.

### **1.5 Skills of professional staff**

There are different ranges of staff in elderly care. Professional staff (doctors, nurses, psychologists, etc.) are required to hold a university degree.

### **1.6 Skills of support staff**

There are different ways for support staff to gain a qualification. The standard vocational qualification for support staff is the (EQF level 3)<sup>1</sup> 'Technician in Assistance to People in Need of Care,' which can be obtained at VET Schools. This national qualification comprises 2000 hours of classroom learning. There are also two different occupational qualifications (also EQF level 3) awarded by the Employment Ministry which are more specific, one for 'Assistance to People in Need of Care who live in Nursing Homes' and 'Assistance to People in Need of Care who live at home'. These qualifications can be achieved either through college-based programmes or through accreditation of prior learning by the Agency for Validation of Professional Competence when individuals can show that they have acquired the competences specified for the qualifications.

In practice, it is rarely possible for an existing worker to gain a qualification wholly through accreditation of prior learning: almost always the worker will be required to undertake some college-based learning to meet at least some of the specified competences.

Notes

1. European Qualifications Framework; see appendix for EQF level descriptors

### **1.7 Regulation of skills**

Related to the Law of Promotion of personal autonomy and attention to dependent people the Territorial Council of Social Services and the System for Autonomy and Care for Dependency (the national body that oversees social care) has stipulated that all staff in the adult social care sector must hold an officially recognised qualification at EQF level 3 by 2015.

### **1.8 Demand for care**

The number of elderly people is increasing in Spain. By 2050, people aged over 65 will represent 17.6% of the population and people aged 85+ will represent 10.4%. It is this 85+ group that is most likely to require care and support

Increasing of elderly people is a reality in the Basque Country. People over 65 but, specifically elderly people 85+ will be the sector that will increase more and will represent the 16,4% in 2015. As recognised, this is the population that suffers more from dependency. Forecasts say that the workforce will increase (with the present crisis there have been cuts to social services).

### **1.9 Demand for skills**

Recruitment is an issue for the sector, particularly recruitment of qualified staff. The sector is currently reliant on unqualified support staff, many of whom have worked in the sector for twenty years or more. The requirement that all staff hold a relevant qualification at EQF level 3 or above by 2015 will impact on recruitment of unqualified individuals. It is anticipated that the sector will need to become a more attractive employer (particularly to men) if it is to achieve the expansion that projections suggest will be required as the demand for care increases.

The requirement that from 2015 all support staff are qualified to at least EQF level 3 is a quality assurance measure by government designed to raise the skill level of care workers.

### **1.10 Supply of skills**

In 2003, about 23 000 students were enrolled on adult social care qualifications in VET institutions. By 2008, this increased by 40% to 32 000. From the other side, the number of unqualified but experienced workers gaining qualifications through accreditation of prior learning has also increased. In both, about 80% of learners are female. The proportion of mature learners has been increasing as the number of younger learners declines.

### **1.11 Workforce development**

Following the requirements of the new law, all support staff will have to have a EQF level 3 qualification. It is difficult to quantify exactly the number of staff not qualified as the information is scattered, but the situation is so urgent that authorities are now talking about delaying the deadline. (There are particular problems around the supply of assessors for the occupational/ accreditation of prior learning route , which the government is now seeking to address.)

The situation in the Basque Country is similar to that in Sweden. Qualifications for support staff are delivered by VET institutions (including top-up learning workers gaining qualifications through accreditation of prior learning).

## **2. Adult education**

### **2.1 Non-formal adult education**

In the social care sector, a number of registered voluntary organisations (including e.g. faith groups, organisations for older people) offer training to support staff. Previously, this training was typically based on courses designed in-house, but more recently the government has promoted national (i.e. officially recognised) qualifications, including both the longer 'Technician in Assistance to People in Need of Care' qualification the two shorter occupational qualifications ('Assistance to People in Need of Care who live in Nursing Homes' and 'Assistance to People in Need of Care who live at home') and, when authorised, voluntary sectors are now more likely to provide these qualifications.

### **2.2 Formal adult education**

In the late 60s a new formal education system was designed in which Vocational Education and Training (VET) was given a national structure. This system is mainly publicly funded and offered in state colleges and also in private schools which are highly subsidised by the state. VET qualifications (at EQF level 3) for adult social care support have only been introduced in the past ten years (following legislation on qualifications in the adult social care workforce). Previously staff were either unqualified or held nursing qualifications.

### **2.3 Role of adult education in VET**

The Education Ministry offers the following certificate in the caring profession: Technician in Assistance to People in Need of Care through formal education at colleges and awarded by the Education Ministry. Nowadays this qualification is the main way into the caring profession for young people in Spain.

In addition, there are a number of other more specific and shorter qualifications (also EQF level 3) aimed at support staff. Carers train to work either in residential/day care or to provide homecare. This occupational qualification is awarded by the Employment department and mainly taught in VET colleges. A full national qualification (such as the 'Technician in Assistance to people in Need of Care') takes 2000 hours of classroom-based learning; these shorter occupational qualifications take just 400-600 hours and are therefore a more popular option for adults wanting to train quickly to enter an occupation or to retrain to get a job. This scheme is newer; it has started to be implemented mainly in the last five years.

### **2.4 How individuals access adult education**

For several years, the Education Ministry has offered free VET qualifications in state-funded colleges and at subsidised prices at private colleges in VET studies for EFQ level 3 and 5. However, due to the economic crisis,

qualifications at EQF level 5 are no longer subsidised in private schools in some areas of Spain, even where demand for courses outstrips supply.

As noted above, the Spanish authorities passed a law requiring all carers to be qualified at EQF level 3 or higher by 2015. However, the ministries of Education and Employment have not funded enough places to qualify the workforce. With only six months left to fulfil the requirement some local institutions are asking for an extension of the deadline.

For the Occupational Certificates the Employment Ministry is offering free courses to the unemployed and there have been up to now limited places that have not fulfilled the demand to get qualified in the Caring Profession. The Employment Ministry is now allowing educational institutions to offer them privately and also on-line, so more spaces are becoming available.

The situation in the Basque Country is the same as in Spain generally.

### 3. Language learning for migrants

There are Spanish Language courses for migrants offered by Adult Education Centres and Official [i.e. publicly-funded] Schools of Languages (most courses are offered at basic levels but there is also a more restricted offer up to CEFR level C1) subsidised by the Education department. Taking part in these courses is optional for migrants. To the date there is no general legal minimum language requirement to access jobs or nationality. There are some minimum requirements for specific professions, such as in the health sector. However a new law is being drafted which will set CEFR level A2 as a minimum general requirement to access Spanish nationality and it seems that this might become a new requirement to get a job in Spain.

There are Basque Courses of all levels (CEFR level A1 to C2) for non-Basque speakers (Spanish nationals and migrants) which are very often subsidised by different institutions (Basque Government, local authorities, etc). Learners who do not meet funding criteria can access these courses privately. Typically, these courses are for Spanish nationals who do not speak Basque, and there are very few programmes aimed specifically at people whose first language is not Spanish.

Even if taking part in these courses is optional, most jobs offered by State institutions have Basque Language requirements. Private institutions also often require different levels of language to access jobs.

In Spain, Official Schools of Languages and Adult Education Centres, funded by the Education Ministries of regional governments, offer Spanish Language courses for migrants.

Most work-related language training happens outside the workplace in colleges or Language schools.

HABE is the Institution of the Basque Government that promotes learning of the Basque Language for adults. This institution is responsible for the design of the curriculum, creation of materials, teacher training and organization of provision. They also finance state-funded and semi-privately funded Basque Language schools for adults.

The use of Basque is promoted in many companies and institutions in the Basque Country and this is very often regulated in a Workplace Language Plan that sometimes includes language teaching at work, although formal learning of the language mainly takes place in schools and colleges.

**Note on workplace language learning** in the Basque Country: Many companies include a plan to promote/protect the Basque language within their overall management plan. Larger companies may offer in-house Basque tuition, while smaller companies typically refer staff to external schools and colleges. Although tuition is generally classroom based, companies typically nominate a member of staff to act as an untrained volunteer Basque language champion or advocate. These advocates will help staff learning Basque to practise and improve their Basque.

*By Egoitz Pomares and Nereba Peña (October 2014)*

## Sources

- Altia consultores (2009). Detección de necesidades formativas en atención a la dependencia. Logroño: Gobierno de la Rioja. [http://www.larioja.org/npRioja/cache/documents/509522\\_Sector\\_Atenci\\_n\\_a\\_la\\_dependencia.pdf](http://www.larioja.org/npRioja/cache/documents/509522_Sector_Atenci_n_a_la_dependencia.pdf)
- BOE, Ley 39/2006, de 14 de diciembre, de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia (15/12/2006). <https://www.boe.es/buscar/doc.php?id=BOE-A-2006-21990>
- Diputación Foral de Gipuzkoa. Inspección de entidades, centros y servicios de servicios sociales. San Sebastián. [https://w390w.gipuzkoa.net/WAS/CORP/LIATramitesWEB/cambiarLocale.do?cambiarLocale=true&idioma=es&tipoBusq=busq\\_mat&ms=1399945934945&ver=1640](https://w390w.gipuzkoa.net/WAS/CORP/LIATramitesWEB/cambiarLocale.do?cambiarLocale=true&idioma=es&tipoBusq=busq_mat&ms=1399945934945&ver=1640)
- Enterprising Solutions for Health (2010). Cuidadores profesionales en España: formación, empleabilidad y oportunidades de empleo. Madrid: Fundación Caser para la dependencia. [http://www.fundacioncaser.es/documentos/20110201\\_002](http://www.fundacioncaser.es/documentos/20110201_002)
- Geerts, J. (2011). The long-term care workforce: description and perspectives. Assessing needs of care in European nations (ANCIEN), European Network of Economic Policy Research Institutes. <http://www.ceps.eu/book/long-term-care-workforce-description-and-perspectives>
- Gobierno de La Rioja (2011). Las trabajadoras y trabajadores profesionales del cuidado ante la próxima convocatoria de reconocimiento de competencias profesionales. Jornadas de difusión. [http://www.larioja.org/npRioja/cache/documents/558148\\_PRESENTACION\\_DEPENDENCIA.pdf](http://www.larioja.org/npRioja/cache/documents/558148_PRESENTACION_DEPENDENCIA.pdf)
- Gobierno Vasco. Alta inspección de Servicios Sociales. <http://www.gizartelan.ejgv.euskadi.net/r45-inspecss/es/>
- Gutiérrez, L.F. et al (2010). The long-term care system for the elderly in Spain. Assessing needs of care in European nations (ANCIEN), European Network of Economic Policy Research Institutes. <http://www.ancien-longtermcare.eu/home>
- Jiménez, S. (2007). Estudio de las necesidades formativas de los profesionales que prestan servicios de atención a la dependencia. Ministerio de Trabajo y Asuntos Sociales, IMSERSO. <http://www.imserso.es/InterPresent2/groups/imserso/documents/binario/necesisformativas.pdf>
- Instituto Nacional de Estadística. Cifras del padrón por municipios. [http://www.ine.es/inebmenu/mnu\\_padron.htm](http://www.ine.es/inebmenu/mnu_padron.htm)
- Ministerio de Educación, cultura y deporte. Reconocimiento, evaluación y acreditación de cualificaciones [http://www.educacion.gob.es/educa/incual/ice\\_recAcr.html](http://www.educacion.gob.es/educa/incual/ice_recAcr.html)
- Ministerio de Sanidad, Servicios Sociales e Igualdad. Sistema para la autonomía y atención de la dependencia [http://www.dependencia.imserso.es/dependencia\\_01/index.htm](http://www.dependencia.imserso.es/dependencia_01/index.htm)
- SIIS-Centro de Documentación y Estudios. II Informe del Consejo Vasco de Servicios Sociales. La situación de los Servicios Sociales en la CAPV. Vitoria-Gasteiz: Eusko Jauraritza-Gobierno Vasco, 2012. <http://www.siais.net/documentos/ficha/200609.pdf>
- SIIS- Centro de Documentación y Estudios (2014). La demanda potencial de servicios sociales en Gipuzkoa en 2017. [http://issuu.com/siais\\_estudios/docs/demanda\\_potencial\\_de\\_servicios\\_soci/1?e=11253171/8576909](http://issuu.com/siais_estudios/docs/demanda_potencial_de_servicios_soci/1?e=11253171/8576909)
- Valcarce, A. (2008). La Ley de promoción de la autonomía y atención a las personas en situación de dependencia. Presupuesto y gasto público, 50, 201.204. [http://www.ief.es/documentos/recursos/publicaciones/revistas/presu\\_gasto\\_publico/50\\_LeyPromocionAutonomia.pdf](http://www.ief.es/documentos/recursos/publicaciones/revistas/presu_gasto_publico/50_LeyPromocionAutonomia.pdf)



## P4: Belgium

*Note: the information concerning the Belgian situation is mostly gathered from the 2010 report 'The Belgian long-term care system' by Peter Willemé, Federal Planning Bureau (<http://www.plan.be/admin/uploaded/201004230943350.wp2001007.pdf>)*

### 1. How adult social care is organised

#### 1.1 How care is paid for

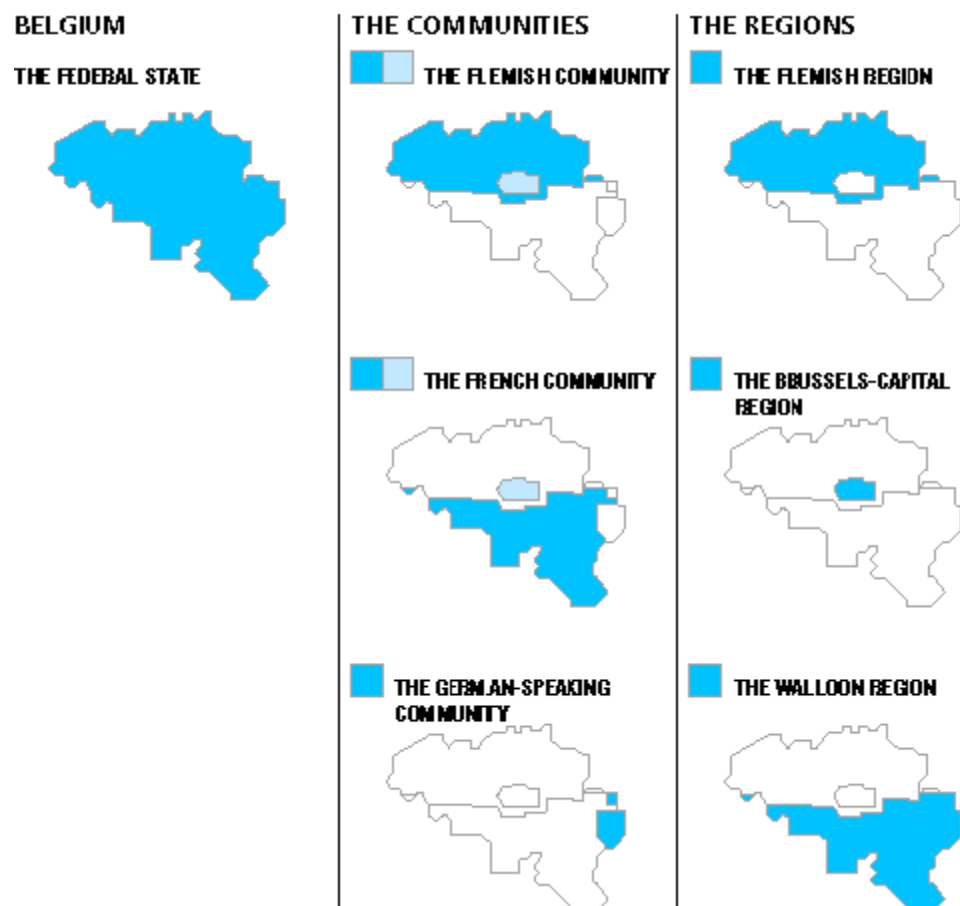
Long-term care (LTC) in Belgium (population 11.2 million) is paid for partly through public funding and partly by private contribution (i.e. direct payment).

Regarding public funding, in Belgium the division of responsibilities between the federal and the regional levels concerning LTC makes the financial flows diverse and complex<sup>1</sup>. Workers, employers and retirees pay social security contributions that finance residential and home nursing care. The remaining LTC services and allowances are financed by general taxes, which are mainly collected at the federal level. The social security contributions paid by workers, employers and retirees are not exclusively used for provision of LTC or supporting healthcare in general. Only the Flemish long-term care insurance (a contribution paid annually by every adult resident) is. (Willemé, 2010:6)

Regarding private contributions, service users make some level of contribution (i.e. direct payment) for all kinds of care, but the level of contribution varies depending on kind of care (e.g. different rules apply to nursing and social care), the level of care (which is assessed on a scale), income and category of service user (e.g. able bodied or disabled).

#### 1.2 How care is regulated

<sup>1</sup>Belgium includes three communities and three regions (source: <http://hleo.revues.org/docannexe/image/172/img-1.png>)



In Belgium, health care, including LTC, is a federal responsibility, while personal care is a regional one. Several actors are involved in health care. First of all, the federal parliament issues the main laws governing the system. The ministries of Health and Social Affairs are responsible for, amongst other aspects, the total budget for LTC and the capacity planning, together with the National Institute for Health and Disability Insurance (called NIHDI, in Dutch *'Rijksdienst voor Ziekte- en Invaliditeitsverzekering'*, RIZIV/INAMI). Besides these actors, the sickness funds serve as intermediaries between the administration, the providers and the patients. Certification, monitoring and quality control of residential care services is organised partly at the federal and partly at the regional level. For example, at the federal level, part of the budget corresponding with the maximum number of beds is set and then allocated to the regions, which can then decide on the allocation over services in different semi-residential and residential settings or to supporting home care.

Regionally, home care services are regulated and organized by local Public Centres for Social Welfare (abbreviated as OCMW in Dutch and CPAS in French) and both non-profit and for-profit private organizations provide residential care services.

Qualified nurses provide home nursing care. These nurses can be either self-employed or employed by private non-profit organizations or Public Centres for Social Welfare (mentioned above). These home care services are all subsidised by the federal government (Willemé, 2010:4).

### 1.3 How individuals access care

The individual (referred to as 'the patient') usually takes the initiative to request LTC services. In order to do so, the patient contacts a medical doctor (usually a GP), a qualified nurse or a social worker (depending on the type of care the patient is looking for). This health practitioner assesses the severity of Instrumental Activities of Daily Living (IADL) limitations, using an official scale (IADL coding ranges from 0, indicating 'independent', to 4, 'total dependence'). The health practitioner carrying out the assessment may be one of the subsequent service providers. In Belgium, there is no independent entity assessing the condition of the patient prior to providing him/her with LTC services. However, random ex-post-evaluations of the dependency category are routinely carried out.

The scales used are all extensions of the Katz-scale. For residential and home nursing care, the level of care that the patient is entitled to and which will be covered by the public health insurance scheme, is determined by the patient's score on these scales. If the patient is able to stay at home, home care needs are assessed by a social worker using an extended scale which includes IADL limitations. Based on this assessment the amount of care financed by the regional authority to which the patient is entitled is determined. In addition, the level of public financing is means-tested and based on household income. The BEL-scale<sup>1</sup> is used in the Flemish region and adds 'domestic', 'social' and 'mental' criteria to the usual six items of 'physical' ADL limitations. If patients score 35 points or more on this BEL-scale, they are entitled to receive a fixed monthly cash benefit. However, if they can prove their dependency in another way, a formal assessment is not required. The 'Allowance for Assistance to Elderly Persons', financed and organized at the federal level, uses a separate scale with both ADL and IADL items as well as a medical assessment by a doctor appointed by the Federal Social Security Service. This allowance is means-tested.

Given the complexity of different needs being assessed with different instruments, 'integrated home care services' are being established. These services co-ordinate efforts of multidisciplinary teams and aim to reduce redundancy and inefficiency (Willemé, 2010:2).

Notes

1. *Beoordeling Eerste Lijn or 'primary care assessment'*

### 1.4 Size of the adult social care workforce

The adult social care sector in Belgium employs a workforce of 400 000 people. This is more than 9% of the active adult population (approx 4.5m). This workforce includes a range of professional roles, including doctors and people from pharmaceutical companies. About 120 000 of these 400 000 employees are nurses or midwives. (Wets et al, 2011:27)

*Note: The paragraphs below focus on conditions and educational systems in the Dutch-speaking Flemish part of Belgium, where recruitment efforts have been directed at migrants. They do not touch on the French and German-speaking regions, where, according to the head of the Department of Strategies for Health Care Professions, no such recruitment efforts have taken place.*

### 1.5 Skills of professional staff

Professional roles require staff to hold appropriate qualifications and undertake continuing professional development. These skills are developed and maintained through higher education programmes delivered in universities. Nurses, however, can also graduate as a bachelor in nursing sciences from a college of further education (i.e. as opposed to a university).

### 1.6 Skills of support staff

Support staff include three types of care worker: logistics assistant (*Logistiek assistent*), carer (*Verzorgende*) and health care assistant (*Zorgkundige*). The logistics assistant supports nurses and carers in tasks such as preparing and serving meals, cleaning dishes and performing simple administrative tasks. They do not provide direct care to patients/clients. The carer (*Verzorgende*) does provide direct care, but works only in domiciliary care and disability contexts (and thus not in residential elderly care). The healthcare assistant (*Zorgkundige*) provides direct care and is licensed to perform 18 nursing activities under supervision of a nurse. It is the healthcare assistant (*Zorgkundige*) who provides support in residential elderly care.

All three roles require some level of qualification (see table 1 below), which must be gained before the person can be formally employed. People who are not native Dutch speakers are also required to demonstrate an adequate level of Dutch in order to be employed in these supportive roles. This language requirement is addressed at the point of entry to the vocational courses that lead to the qualifications required for the three roles. To enrol on the relevant vocational courses, a non-native Dutch speaker requires Dutch at CEFR<sup>1</sup> level B1 or B1+. Adults with Dutch at a lower level are referred to a Dutch course to help them reach the required level. How a VET provider assesses a person's level varies locally. Some assess language levels via a formal test; others do so by more informal means, e.g. an interview.

The qualifications required for these roles can be gained in two ways. (Qualification requirements are described in the table below.) The first way is through secondary school. The second way is through a qualification programme undertaken outside of upper secondary school. Such programmes are delivered by various types of learning providers, such as VDAB (*Le Forem* in the French region of Belgium)<sup>2</sup> and CVO<sup>3</sup>.

A lot of the students participating in these courses are combining a family or a job with their training. Therefore, students can choose to adapt the course to their individual needs if necessary, for example, studying part time instead of full time. Some of the organizations providing courses for support staff match the availability of the courses to labour market requirements, to make sure that relevant jobs will be available for the people they train. On account of this, courses may not always be available.

Table 1. Training and qualification requirements for support staff

Role	Training and qualification requirement	EQF level <sup>4</sup>
Logistics assistant ( <i>Logistiek assistent</i> )	Outside of secondary school, this course is a certificate course, to be completed in half a year (full-time) or one year (part-time), with one day per week of classroom study and between 250 and 300 hours of practical internship. The classroom element focuses on knowledge, communication skills and practical skills, such as lifting techniques.	<i>Estimated at level 3-4</i>
Carer ( <i>Verzorgende</i> )	Outside of secondary school, this course takes about two years to complete, combined with 600-650 hours of practical internship. Courses focus on hygiene, information about the job market and how to deal with the specific needs of the people these carers will work for/with.	4
Health care assistant ( <i>Zorgkundige</i> )	The healthcare assistant is allowed to perform the same activities as the carer, but is also qualified to perform 18 nursing activities. During their training (when outside of secondary school) they have about 700 hours of practical internship.	<i>Estimated at 3-4</i>

## Notes

1. Common European Framework of Reference for Languages
2. Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding (Flemish Employment and Vocational Training): public employment service
3. *Centrum Voor Volwassenenonderwijs* (Center for Adult Education): CVOs provide numerous courses, at different levels and in different subject areas. There are more than 100 CVOs in the Flemish region of Belgium.
4. European Qualifications Framework; see appendix for EQF level descriptors

### 1.7 Regulation of skills

In Belgium, health care employers are **required** to hire staff with diplomas and/or certificates allowing them to work in the health care sector. Some departments are required to hire a certain amount of specialist nurses (e.g., in geriatrics, psychiatry, etc); these people require appropriate qualifications and are required to undertake a continuing professional development (CPD) once in role.

### 1.8 Demand for care

Demand for care is forecast to increase as the number of people aged over 65 increases.

### 1.9 Demand for skills

As the number of elderly people in Belgium increases, the demand for care skills will increase. There is already recognition that more nurses will be needed. Currently, however, policy makers believe the supply of skills is adequate to meet demand (see section below).

### 1.10 Supply of skills

Policy makers believe that currently the supply of care skills in Belgium is sufficient, at least at the aggregate level. Even with a very broad definition of care needs (i.e. 'anyone who has experienced at least one ADL or IADL limitation expected to last at least three months'), the number of existing carers is considered adequate. (Willemé 2010:16) This macro level analysis was corroborated by a Eurobarometer survey asking residents, 'In the future do you think that you would be provided with the appropriate help and long-term care if you were to need it?'. The majority of Belgian respondents (88%) answered positively, the second highest of the countries surveyed. (Willemé 2010:16) However, this sort of macro analysis may very well conceal imbalances between supply and demand at the micro level, i.e. unmet needs may exist locally and/or for specific groups. (Willemé 2010:16)

Clearly quite a few hospitals and nursing homes currently experience some level of staff shortage. For example, in 2012 in the Flanders region 42 358 staff were employed in residential care with staff turnover for that year at 7.39%. (Agentschap Zorg & Gezondheid)

Furthermore, any adequacy of the current LTC workforce, both in terms of size and skills, provides no guarantee for the future. Since demographic ageing is predicted to double the dependent population by 2060, maintaining current levels of care provision and quality standards will not be an easy thing to do. In order to do so, a sustained and increasing financial effort as well as careful human resource planning to ensure the needed infrastructure and workforce are required. (Willemé, 2010:16-17)

Employers and policy makers (including the public employment service) recognise the need to make the provision of nurses and care workers in the LTC sector more attractive for recruitment purposes. Towards this end, they are trying to reduce the work load of professional staff and to create new assistant-professional roles (e.g. the carer ('*Verzorgende*') and health care assistant ('*Zorgkundige*') roles). Also, recruitment efforts are directed at specific population groups, such as migrants and people who have been unemployed for quite some time. These and other recruitment initiatives typically target women, rather than men.

### **1.11 Workforce development**

Workforce development for non-professional staff takes place mainly through the routes described above: vocational training within compulsory education and vocational training in post-compulsory education. In addition, many care providers employ an in-house training manager, who keeps track of relevant courses and monitors the learning needs of both professional and support staff.

Currently, some 20 000 diplomas in care are awarded each year – about double as many as were typically awarded previously. It cannot, of course, be assumed that all of these 20 000 diploma-holders will actually go on to work in the health care sector. Moreover, a significant proportion are thought to be current workers wanting a further qualification. Thus while the stock of qualifications is increasing, this does not translate neatly into new entrants to the sector. The sector is aware of this, which is reflected in the recruitment initiatives referred to above (i.e. towards migrant workers and the long-term unemployed).

## **2. Adult education**

### **2.1 Non-formal adult education**

Non-formal adult education exists in Belgium (e.g. VormingPlus), but mostly focusses on creative (e.g. music, artwork) or personal development (e.g. mindfulness, how to be assertive) topics. Non-formal adult education is accessible to all, regardless of previous (formal) education.

### **2.2 Formal adult education**

Besides university college and university programmes, there are several forms of formal adult education in Belgium, organised by VDAB (the public employment service), private services for care, OCMW<sup>1</sup>, Centres for Basic Education or Centres for Adult Education.

Notes

1. *Openbaar Centrum voor Maatschappelijk Welzijn (Public Centre for Social Welfare)*

### **2.3 Role of adult education in VET**

Formal, publicly-funded educational initiatives aim to enable adults to study for national qualifications at the post-compulsory upper secondary school level, including vocational qualifications in areas such as health and social care. It has also provided a vehicle for the government to deliver labour market training to combat unemployment, assist in retraining and adaptation of the Belgian workforce to economic changes, and to support full employment.

### **2.4 How individuals access adult education**

There are several possibilities to enter adult education programmes across Belgium, organised by both public and other organisations. People can sign up for the course(s) they want to attend.

For courses in the Flemish part of Belgium, organised by the Centre for Basic Education, no registration fee is charged. In the Centres for Adult Education, the courses concerning general education are free of charge. For all

other courses a registration fee is required. The course 'Dutch as a second language' has a registration fee as well, but this fee is not as high as for other courses. Typically, adults in receipt of state benefits, people with a disability, migrants and prisoners are partially or fully exempted from registration fees. Sometimes people who have progressed from adult basic education to a fee-paying vocational course in a Centre for Adult Education are granted partial exemption from fees. Finally, learners who successfully complete a diploma course through a Centre for Adult Education can apply for reimbursement of registration fees.

### 3. Language learning for migrants

#### 3.1 Languages in Belgium

There are three official languages in Belgium: French, Dutch and German. About one third of the population speaks Walloon as their mother language, a local variant of French. Over 60% is native Flemish speaking (the local variant of Dutch). German is the native tongue of 1% of the Belgian population, mostly people residing in the east of the Walloon region. (BBC)

#### 3.2 Migrants in Belgium

There are 1.19 million foreign nationals residing in Belgium (making up to about 10% of the total population). This includes 427 000 foreign residents in Flanders; 338 000 in the Walloon region and 352 000 in Brussels. The top five countries-of-origin of these residents include Italy, France, Netherlands, Morocco and Poland, with significant numbers also from Turkey, Spain, Portugal, the UK and Germany. (FOD Economie)

#### 3.3 Dutch language learning for migrants working in social care in the Flemish part of Belgium

Various training programmes and courses support migrant workers to improve their Dutch skills. Courses and training programmes are available at different levels, ranging from a level where people do not know Dutch at all, up to a level where they are already quite fluent in Dutch.

As mentioned above, linguistic skills are essential for anyone undertaking a course related to health care work. When someone starts a job, the language level needed for this particular job is assessed. For non-Dutch-speaking residents seeking care work in Dutch-speaking areas of Belgium, there are three paths of support: (1) Dutch language courses; (2) coaching; (3) care portal (for jobseekers). Courses in Dutch as a second language are available at Basic Education centres.

At work, attention is paid to cultural diversity, with training available for employers to understand the problems of the migrant. There are also specific language training programmes, for example, HELP (how to efficiently listen and speak), workplace training to help Belgian employees communicate effectively with migrant colleagues; and training in intercultural communication to counter prejudice. (Huis van het Nederlands, 2013)

The Belgian government also provides some support to overcome barriers between Belgian and immigrant colleagues. This includes a 'communication table' in the workplace ('FRIEND And Language') to stimulate social contacts between colleagues; help for employers to simplify their paperwork; guidance (e.g. flyers, brochures); workplace language training<sup>1</sup>.

#### Notes

1. See Nederlands op de werkvloer: <http://www.vdab.be/hraanbod/nederlands.shtml>

*By Ingrid Dreesen and Jesse Verschuren (June 2014)*

#### Sources

Agentschap Zorg & Gezondheid. [http://www.zorg-en-gezondheid.be/v2\\_default.aspx?id=33767](http://www.zorg-en-gezondheid.be/v2_default.aspx?id=33767)

BBC, *Languages across Europe: Belgium*.

[http://www.bbc.co.uk/languages/european\\_languages/countries/belgium.shtml](http://www.bbc.co.uk/languages/european_languages/countries/belgium.shtml) [accessed 4 October 2014]

FOD Economie, KMO, Middenstand en Energie. <http://economie.fgov.be/nl>

Huis van het Nederlands (Provincie Limburg), (2013), *Maak van taal werk, Van drempel tot springplank*.  
<http://www.huisnederlandsbrussel.be/en/>

Wets, J., de Bruyn, T., and Geets, J. (2011) *Migratie: de oplossing voor het personeelstekort in de zorg- en gezondheidssector?*. Brussels: Koning Boudewijnstichting. [Available at:  
[https://hiva.kuleuven.be/resources/pdf/publicaties/R1433a\\_nl\\_MigratiePersoneelstekortGezondheid.pdf](https://hiva.kuleuven.be/resources/pdf/publicaties/R1433a_nl_MigratiePersoneelstekortGezondheid.pdf)]

Willemé, P. (2010), *The Belgian long-term care system – Working Paper 7-10*. Brussels: Federal Planning Bureau.  
[Available at: <http://www.plan.be/admin/uploaded/201004230943350.wp2001007.pdf>]

## Appendix: Descriptors defining levels in the European Qualifications Framework (EQF)

Source: <http://ec.europa.eu/ploteus/en/content/descriptors-page>

Each of the 8 levels is defined by a set of descriptors indicating the **learning outcomes** relevant to qualifications at that level in any system of qualifications

EQF Level	Knowledge In the context of EQF, knowledge is described as <i>theoretical and/or factual</i> .	Skills In the context of EQF, skills are described as <i>cognitive</i> (involving the use of logical, intuitive and creative thinking), and <i>practical</i> (involving manual dexterity and the use of methods, materials, tools and instruments)	Competence In the context of EQF, competence is described in terms of <i>responsibility and autonomy</i> .
Level 1	Basic general knowledge	Basic skills required to carry out simple tasks	Work or study under direct supervision in a structured context
Level 2	Basic factual knowledge of a field of work or study	Basic cognitive and practical skills required to use relevant information in order to carry out tasks and to solve routine problems using simple rules and tools	Work or study under supervision with some autonomy
Level 3	Knowledge of facts, principles, processes and general concepts, in a field of work or study	A range of cognitive and practical skills required to accomplish tasks and solve problems by selecting and applying basic methods, tools, materials and information	Take responsibility for completion of tasks in work or study; adapt own behaviour to circumstances in solving problems
Level 4	Factual and theoretical knowledge in broad contexts within a field of work or study	A range of cognitive and practical skills required to generate solutions to specific problems in a field of work or study	Exercise self-management within the guidelines of work or study contexts that are usually predictable, but are subject to change; supervise the routine work of others, taking some responsibility for the evaluation and improvement of work or study activities
Level 5 <sup>[1]</sup>	Comprehensive, specialised, factual and theoretical knowledge within a field of work or study and an awareness of the boundaries of that knowledge	A comprehensive range of cognitive and practical skills required to develop creative solutions to abstract problems	Exercise management and supervision in contexts of work or study activities where there is unpredictable change; review and develop performance of self and others
Level 6 <sup>[2]</sup>	Advanced knowledge of a field of work or study, involving a critical understanding of theories and principles	Advanced skills, demonstrating mastery and innovation, required to solve complex and unpredictable problems in a specialised field of work or study	Manage complex technical or professional activities or projects, taking responsibility for decision-making in unpredictable work or study contexts; take responsibility for managing professional development of individuals and groups



#### TDAR WP 4. Evaluation || Context analysis report: Partner Country Profiles

<b>EQF Level</b>	<b>Knowledge</b> In the context of EQF, knowledge is described as <i>theoretical and/or factual</i> .	<b>Skills</b> In the context of EQF, skills are described as <i>cognitive</i> (involving the use of logical, intuitive and creative thinking), and <i>practical</i> (involving manual dexterity and the use of methods, materials, tools and instruments)	<b>Competence</b> In the context of EQF, competence is described in terms of <i>responsibility and autonomy</i> .
Level 7 <sup>[3]</sup>	Highly specialised knowledge, some of which is at the forefront of knowledge in a field of work or study, as the basis for original thinking and/or research Critical awareness of knowledge issues in a field and at the interface between different fields	Specialised problem-solving skills required in research and/or innovation in order to develop new knowledge and procedures and to integrate knowledge from different fields	Manage and transform work or study contexts that are complex, unpredictable and require new strategic approaches; take responsibility for contributing to professional knowledge and practice and/or for reviewing the strategic performance of teams
Level 8 <sup>[4]</sup>	Knowledge at the most advanced frontier of a field of work or study and at the interface between fields	The most advanced and specialised skills and techniques, including synthesis and evaluation, required to solve critical problems in research and/or innovation and to extend and redefine existing knowledge or professional practice	Demonstrate substantial authority, innovation, autonomy, scholarly and professional integrity and sustained commitment to the development of new ideas or processes at the forefront of work or study contexts including research

#### Compatibility with the Framework for Qualifications of the European Higher Education Area

The Framework for Qualifications of the European Higher Education Area provides descriptors for cycles. Each cycle descriptor offers a generic statement of typical expectations of achievements and abilities associated with qualifications that represent the end of that cycle.

1. The descriptor for the higher education short cycle (within or linked to the first cycle), developed by the Joint Quality Initiative as part of the Bologna process, corresponds to the learning outcomes for EQF level 5.
2. The descriptor for the first cycle in the Framework for Qualifications of the European Higher Education Area corresponds to the learning outcomes for EQF level 6.
3. The descriptor for the second cycle in the Framework for Qualifications of the European Higher Education Area corresponds to the learning outcomes for EQF level 7.
4. The descriptor for the third cycle in the Framework for Qualifications of the European Higher Education Area corresponds to the learning outcomes for EQF level 8.