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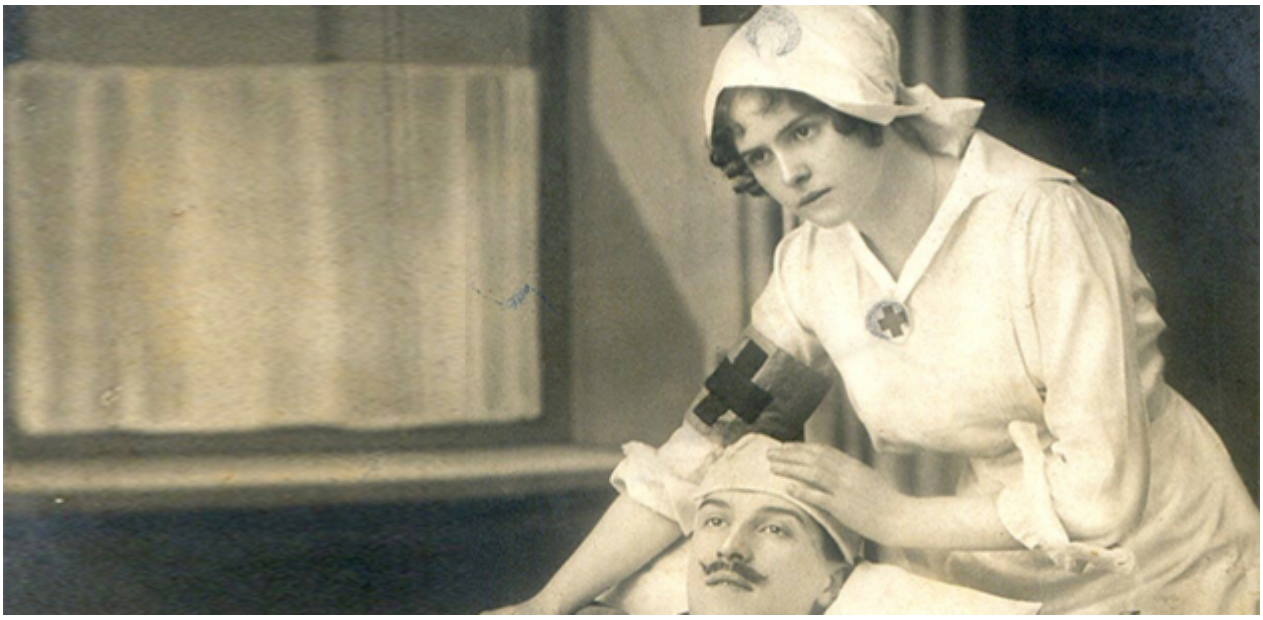

Western Europe's urge for a 'healthy' labour market and the race to the social bottom

Daniëlle de Winter | January 07, 2016

Western European states are facing continued budget cuts and restructuring of their health policies. The result is an increasingly informal, decentralized and often more expensive health care provision for those in need of care. As less public budgets are available to support care seekers in meeting their needs, health care workers willing to fill those vacancies are now travelling from Central and Eastern European countries for work. With an eager migrant workforce now fulfilling their domestic labour demands in the health sector, Western European countries are facing issues concerning international employment relations. Should we discuss fair competition between domestic and migrant workers, or should we be more concerned with upholding labour rights and quality standards?

While different *guesstimations* exist about the state of the health care workforce in 2030 across Western Europe, in general they show a cumulative trend of a demising number of health care workers in line with demographic changes. In 2012, research showed there was a labour potential of four workers for every elderly person in the Netherlands. In 2040, there will be only 2.2 potential workers for every single elderly person. This data reveals the rapid on-going shift in the relationship between the people who need care and those providing it. Similar trends have been found in Germany by the research bureau Price Waterhouse Coopers, which predicts a shortage of non-academic health workers in Germany to reach 140,000 by 2020 and to rise five fold to 786,000 by 2030.

As previously faced in Germany and the Netherlands, other countries are responding to similar challenges by introducing new ways of delivering health care that includes making policy decisions about how care is funded, the level of funding for care, and the settings of care. Health professionals are at the heart of these changes. *The European Observatory on Health Systems and Policies*reported that a host of problems 'ranging from looming shortages of some type of health care workers, accelerating labour migration, and distributional imbalances of various types (geographic, gender, occupational) to qualitative

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imbalances (under-qualification or mis-qualification of health care workers) of professionals' can undermine the capacity of health systems to respond effectively to the challenges governments face.

At home long-term personalized care services, or 24-hour live in care, has been identified as a field in health care that will require the appropriate response to the range of problems as presented in the *Observatory*. Migrant care workers often provide these services as local health care workers are less inclined to accept live-in work opportunities for relatively low pay. Therefore migrants are attracted to these job opportunities, especially if the minimum wage is generally higher than in their country of residence. This type of live-in migrant care (LIMC) is a recent response to the growing domestic labour gap in many Western European countries. [1] For example, the percentage of the migrant workforce hired in 2009 in the United Kingdom was 19% of all care workers, plus 35% of nurses employed in long-term care. This suggests a clear overrepresentation in the sector relative to the general workforce where 13% were born outside the UK in 2008. In Germany, over half of all personnel working in elderly care homes are EU nationals from outside Germany.

Recruitment agencies attracting foreign care workers report that most migrant health workers originate from Central and Eastern European countries such as Slovakia, Hungary, Poland and Romania. Increasingly, agencies are looking also towards countries with high unemployment rates such as Spain, Portugal and Italy to fulfil the demand of health care duties. In general, most of the live-in migrant care workers are women around the age of 40 with a background in health care and are typically trained as nurses or nurse assistants.

About Live-in migrant care (LIMC)

Live-in migrant care is a growing phenomenon in many western EU member states where foreign health workers are providing health care to clients living at home in exchange for a salary, room and board. These arrangements offer clients more independence in their care choices and are often less expensive than the going rates of services provided by local care providers. This approach also provides a solution to the declining supply of labour in the health sectors of many European countries. At the same time, it has allowed better job opportunities for migrant health care workers in comparison to vacancies in their home countries. This new trend however poses certain risks that accompany a lack of oversight concerning the quality and type of services offered, the fairness of the competition domestic care workers face from their migrant counterparts in terms of wages and working hours, and proper enforcement of the labour rights of migrant care workers.

As mentioned earlier, a growing number of European countries have been facing similar dynamics for some time now. As a response, Germany has started several pilot projects for international recruitment in the health sector from both EU and non EU countries. Young migrant health workers from especially Greece, Italy, Portugal and Spain were targeted in a special programme in 2013 called MobiPro-EU, which runs up to 2018. Recruits were offered vocational training in occupations with labour shortages including long-term care work. Similar pilot programmes were simultaneously launched in China and Vietnam with the aim to reduce labour shortages in Germany while at the same time gather experience in appropriate recruiting of migrant health care workers so that 'well-managed migration would have a positive impact on both sending and receiving countries' as argued by the Hamburg Institute of International Economics in their 2015 research report *Migrant Workers in the German Health Sector*.

About Au Care

Au Care is an example of an agency providing LIMC services in the Netherlands. They began investing in language courses for migrant personnel. After their training, migrant care workers were prepared to enter the Dutch home-based care sector. A few years after Au Care was established, massive lay-offs took place in the Dutch home-based care sector in response to national government budget cuts for services. Even recently in November 2015, one of the biggest care services providers in the Netherlands announced bankruptcy and turned 12,000 domestic care providers to the streets as 'a direct consequence of the public budget cuts'. Au Care has continued with the LIMC concept and up until now the demand exceeds the supply, according to Bill Wind, Managing Director. LIMC is now also attracting the attention of health insurers as an alternative to traditional models of 24-hour care provisions.

Jan Cremers, former European Parliamentarian and expert on European social policy, believes labour mobility is a positive outcome of EU expansion if it was not for certain loopholes in oversight and regulations that allows for misconduct in the market prone to attract an international workforce. Cremers has been involved in several past and current research projects on the posting of workers, the coordination of social security and workers rights in a cross-border context. He is also affiliated with the Amsterdam Institute for Labour Relations. Based on his experience, Cremers saw that the health sector, along with other sectors, are attracting large numbers of migrant workers (e.g. transport and construction sector) and those workers are later falling prey to ‘wrongful subcontracting’ schemes (‘schijnconstructies’). Migrant workers enjoy little social protection or benefits in these cases and often compete (unfairly) with skilled workers in the destination country. These relevant aspects of workers rights and provisions have been further described in the European Union overview *Free movement of workers and rights that can be derived* written by Cremers.

About 'bogus subcontracting'

The term wrongful or bogus subcontracting (in Dutch known as ‘schijnconstructies’) refers to companies that create certain schemes to circumvent labour regulations and/or collective bargaining agreements. It is important to note that these schemes are not necessarily illegal though they are undesirable from a social security point of view. In some instances however, regulators are confronted with cases of undeniable fraud. Bogus schemes, whether legal or illegal, can be characterized by complex international chains of employers, volatile entrepreneurship, and the rapid exchange of the same employees between different enterprises. This can lead to unfair competition between national and temporary workers from different EU member states in terms of unequal conditions, unfair pay, and illegal or unstable employment relations. There was an infamous case of bogus subcontracting in the Dutch transport sector in 2014. An employment agency located in Cyprus made the formal employment arrangements for Dutch truck drivers who were working for a Dutch transport company. The Dutch company no longer served as an employer but rather as a client of the employment agency. This scheme lowered the expenses of the transport company by more than one fourth due in part to the lowered costs associated with social premiums in Cyprus as compared to the Netherlands.

These types of arrangements also contribute to the *informalization* of the formal health care sector. Over a short course of time, the European social model has undergone changes in parallel with the growing need for a flexible workforce as a response to increasing globalizing production and the consequences of the economic crises (see table 1 for an overview of significant changes since 2008). Currently, the care market is characterized by an increase in flexible contracts and a move away from permanent contracts. The market faces insufficient or zero access to social security benefits for (informal) health workers. There is also no job or income security for flexible employment contracts for both domestic and migrant health care workers.

Most significant changes in the European Social Model, 2008-2015

Working conditions	Labour market	Social protection	Social dialogue	Public sector	Cohesion
• Limitations to the freedom of association • Lowering of the minimum wage or a wage freeze, as well as the introduction of a minimum wage and reduction in overtime pay • Weakening of health and safety legislation, or reduction in entitlement to medical leaves	• Deregulation accompanied by changes in provisions relating to individual and collective dismissals • Significant increase in the use of temporary contracts • Scaling down of active labour market policies	• Pension reforms • Reduction in unemployment benefits, housing benefits and child allowances • Reduced social security benefits and social allocations • Increased social protection in certain areas	• Reduced scope of collective bargaining due to the removal of extension procedures • Provisions for derogation from higher-level agreements • Structural changes to the institutions or mechanisms shaping the tripartite social dialogue or tripartism • Weakening of trade union rights • Increased social dialogue	• Cuts to public health and education budgets • Reduction in public sector wage and employment levels • Privatization programmes	• Lower regional cohesion • Reduction of gender inequality • Unequal tax increases

Source: EC (2014) Industrial Relations in Europe 2014

Oversight

To organize labour mobility in the EU, three types of worker employment relations have been identified: the employed; the self-employed; and those who are categorized as 'posted workers' or temporary migrant workers. The latter category of temporary migrant workers is the segment of the labour market that is most relevant to those sectors that attract a large international workforce including the construction, transportation and also the health sector. In addition, these types of employment relations fall under different EU regulations, respectively: free movement of workers; freedom of establishment and; freedom to provide services. The type of 'freedom' associated with a certain sector determines what type of social protection and labour standards workers are entitled to and in what country they can claim these rights.

In the case of LIMC, most employment relations deal with the last freedom of providing services. This type of regulation allows employment agencies to attract foreign workers to work across borders on a temporary basis, but with a contract registered in the home country. This implies that income taxes, social benefits and other public revenues remain within the migrant's official country of registration and/or residence. Such regulation allows for alternative labour constructions where employment contracts are established that benefit from the lowest taxes and social costs, a phenomenon also known as 'social dumping'. This could spur negative competition for domestic workers who are potentially more expensive because of local tax and social obligations. Such contracts are drafted along a chain of agencies, often including at least a recruitment agency and a care provision agency. When these agencies are located in different EU member states, it poses the challenge to regulate and oversee whether employment relations are being constructed fairly.

Depending on the chosen employment construction, either where the migrant works (which country) or *officiously* lives or where he/she is *officially* registered, the corresponding national authorities will have control over the supervision of the employment relation. This allows a range of possible situations that need to be explored by regulating bodies to ensure whether taxes and social security issues are properly respected. Even if managed accordingly, this oversight only covers the administrative relations between the foreign worker and his/her official employer; it does not control in any way the quality standards of the services provided, nor the upholding of the appropriate labour rights (such as overtime and fair remuneration) in the country where services are offered. As of yet, there is no straightforward solution in how to monitor sectors that are attracting large

numbers of foreign workers in regards to organizing the workers and protecting their respective rights, and in turn, protecting the clients.

In addition to a lack of oversight across borders (and cross-borders), the type of employment related to live-in care also has oversight challenges as most work takes place in a closed setting or 'behind closed doors'. As employment takes place in a personal setting rather than a public setting, the inability to oversee these working environments can negatively affect the quality of care. The question should then be asked, 'what institution would be suitable to tackle the issue of oversight in such an individual and home-based services sector that is prone to fall prey to false employment constructions?' During an expert meeting organized by Wemos and The Broker in September 2015, the suggestion was raised that service providers should work together to develop a framework that allows for better oversight as they are the institutions that have contact with each stakeholder: the recruitment agency; the caregiver and; the caretaker. However, as quality health care provision is a core responsibility of the government, the responsibility of the local and national government departments to ensure that citizens receive sufficient and adequate care should not be overlooked. More reflection will be offered on the potential roles and responsibilities later in this article.

Fair competition

When dealing with an expanding European Union, it is no longer possible to speak of a level playing field when it comes to regulations such as collective agreements or minimum wages as European regulations often overrule national policies and regulations protecting the social rights of workers. In fact, some argue that Europe is facing 'a race to the bottom' when it comes down to the protection of social interests. [2] If looked at from a purely economic perspective, an under-supply in labour should actually lead to a wage increase in the sector, and thus induce increased domestic supply of the health care workforce.

The case of live-in care workers is an odd one though, as stated by the International Organization on Migration in its 2010 report *The Role of Migrant Care in Ageing Societies*. The report found that wages are also part of the dynamic of the domestic labour shortage 'given that the long-stay sector may tend toward low-wage jobs that fail to attract natives in sufficient numbers'. Standard market mechanisms do not apply to this sector. As a reaction, governments seem to adapt policies so that any under-supply of domestic care workers is met with foreign-born workers rather than met with a wage increase. Such dynamics are also now underway in the Netherlands where budget cuts have resonated in the downfall of a number of leading domestic service providers.

Respecting labour rights

Besides issues of oversight and fair competition, there are few (legal) instruments in place to protect the rights of migrant care workers. FairWork is a Dutch-based social advocacy foundation that recently faced a case exemplifying the complex labour rights situation of migrant workers in the health care system. A Portuguese LIMC worker in the Netherlands filed a complaint with the Labour Inspectorate and started a civil law suit against her former employer. The accusation was that the employee had to work more than 40 hours a week without overtime reimbursements. However, producing the evidence to support this claim proved to be difficult. As the employment took place in an isolated setting, it was hard to prove accusations as no oversight procedures were in place. Due to the nature of these services contracts in this example, labour regulations for LIMC can sometimes be ignored with caregivers working overtime, without compensation, working extreme irregular hours and the boundaries of their workload are often only vaguely described.

This case shows the oversight struggles the sector is facing: international-oriented subcontracting schemes allow for 'flexible' contracts and low-cost workers, while a national regulatory body overseeing the work relation is absent. National labour inspectorates lack the capacity to oversee the upholding of quality standards, of working conditions and of proper working relations. Tilburg University finds similar trends in the construction sector in their comparative report *Liability in subcontracting processes in the European construction sector*. In the report, Western European countries 'reported facing serious problems regarding the enforcement and application of their liability arrangements on foreign subcontractors and/or temporary work agencies'. In the paper, the authors argued that the main obstacles were problems concerning the language, non-transparent or inaccessible legislative information, and difficulties in proving abuses and problems in cross-border judicial proceedings. Such obstacles are representative for the health sector dynamics as well, as the sectors share similar characteristics.

In principle however, all EU citizens should benefit from the so-called *European social model*. The basic premise of the model is respect for the regulatory framework for social policy (including social security and labour standards) that exists in the EU member states. However, each member state has a different institutional organization in which some states give priority to

strong collective regulation of employment relationships and social entitlements, while others prefer minimal state interference. This variety of institutional arrangements of social models across the EU allows for possible improvements. The harmonization of such models could ease the oversight of labour standards across member states.

Yet without any official authority monitoring employment relations and the quality of work, stakeholders have little to go on. By making a case, migrant workers in the current situation not only risk losing the lawsuit but also the chance of regaining their job, and often any other job in the same sector in that country. Such cases become even more challenging when dealing with *undocumented* migrant workers. Labour unions to date are limited in offering support in such cases as their core responsibility lies with representing groups of employees rather than individual cases.

Taking responsibility

In general and across Europe, changes made in recent years to stimulate economic growth have reduced worker protection in both standard and non-standard employment, which includes the flexible contracts of temporary migrant workers. However, the expected rise in employment opportunities as a consequence of these policy changes has not been achieved, and European member states have seen labour standards gradually deteriorate in the wake of dwindling regulations. In sectors that attract a large international workforce, such as the care sector, the consequences are clearly visible: loopholes in European regulations allow for shady employment constructions; there is a lack of oversight on the quality of work and; there is a limited form of control over fair labour practices and standards.

International institutions have stepped in to offer national authorities some guidance in how to deal with the increasing flow of migrating health workers worldwide. In 2010, the member states of the World Health Organization agreed on a Global Code of Practice on the International Recruitment of Health Personnel. This code aims to establish and promote voluntary principles for the ethical international recruitment of health personnel. For example, the code discourages active recruitment of health personnel from developing countries facing critical shortages of health workers. It calls on member states to ensure fair and equal treatment of foreign health personnel and to make agreements with the migrants' home countries on duration, training and return. However, this code principally targets health personnel in the primary care sector such as hospitals. Its applicability to the recruitment of (social) care workers is unclear.

Clarity in this light would be advisable as the argument has been made that LIMC takes place 'behind closed doors'; it is a sub-sector that remains particularly difficult to monitor who is involved in what and under what circumstances. This situation thus calls for public regulatory solutions, as well as greater oversight by the private care sector itself in order to ensure that labour and quality standards are upheld behind closed doors. This is especially relevant as LIMC has increasingly been seen as an interesting and potential future development in long-term care in many Western EU member states.

On the one hand, care provision agencies have a critical role in ensuring and verifying whether LIMC is provided in accordance with national regulations considering its placement in private households and difficulty in enforcing legislation and regulations. Such agents do more than just match demand with supply; they are also the first point of reference for conflicts between service providers and clients, as well as for professional and personal support to migrant care workers. A stronger link with the formal care sector, such as through a branch organization, could potentially increase trust in the quality and adherence to labour regulations by the sector, and reduce the uncertainty on the part of agencies regarding the regulation of their work. Such sector-based social responsibility initiatives could be developed through the regular social partner channels of consultation and negotiation, leading to binding agreements as recently seen in the construction sector in the Netherlands.

At the same time, the government has a public responsibility to ensure that private agencies comply with national and international labour regulations while simultaneously having the responsibility to facilitate and regulate new and innovative health services. National – and these days more often local – governments have to face the challenge of aligning the health care workforce with health system goals and 'to sustain changes that are needed for improving the organization and the delivery of health care', as argued by the editors of the comparative report *The Health Care Workforce in Europe – Learning from experience*. This includes a preemptive vision of what health challenges our populations will face and what care needs will be required in the near future.

What is important to realize though is that LIMC should not be perceived as a development that is replacing existing caregiving jobs, a fear expressed in the Netherlands for example. Rather, LIMC is filling a gap in the market that has remained unaddressed by the domestic labour supply as local professional care workers prefer steering clear of live-in care

arrangements. It has become clear that with a growing ageing population, domestic markets will not be able to meet the care demand of their own population. Decisions will need to be made on how to deal with the future challenges in terms of labour supply, oversight and quality of services. Both private sector agencies and governments have a role to play to ensure that those in need for health care will not suffer from a lack of intuitive foresight that is required to prepare a proper response for the not so distant future.

Photo credit main picture: John Toohey (via Flickr)

Footnotes

- 1. The term ‘live-in migrant care’ was introduced by authors of: Da Roit, B. and M. van Bochove (2015) Migrant Care Work Going Dutch? The Emergence of a Live-in Migrant Care Market and the Restructuring of the Dutch Long-Term Care System. Social Policy & Administration, Early View Online, DOI: 10.1111/spol.12174
- 2. see Cremers, Jan (2012) Free movement of workers and rights that can be derived. Free Movement of Workers. European Union, 2012. And, van den Burg, Ieke et al (2014) Voorbij de retoriek. Sociaal Europa vanuit twaalf invalshoeken. VanGennep: Amsterdam