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MIGRANTS take Care

COMPARATIVE ANALYSIS REPORT IN THE BASQUE COUNTRY (SPAIN), GERMANY, ITALY, GREECE AND NORTHERN IRELAND (UK)

Country Specific Analysis of the Care Service Sector

This Comparative Analysis emerged from a mutual need to understand better the National or Regional Care Service Systems where the partner organization resides. By independently analyzing and bringing together the information relevant to the structures of the public and private sector as well as the existent services offered in residential and individual care, the partnership was able to focus on the different "directions" that the guide should take, depending on their local context.

There is different information found in each of the analysed countries, demonstrating the complexity and diversity observed in the care service sector in a European level. This reflection has been very useful in order to understand the structure of the Online Handbook as well as the directions and policies that could be taken in order to develop and reinforce the existent National or Regional Care Service Systems in the various partner countries.

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A. The Basque Country (Spain)

A.1. Background

In order to better understand the system of care or attention paid to the so called “dependent adults” in Spain and the Basque Country, it is important to know that in general, "these are systems in which the family maintains the central role of care and in which the public care services are scarce " (Domínguez / Hernández, 2015).

Since the traditional structure of the family and the gender-based division of labour has changed - as in the past, the men were dedicated to produce labour and women to reproduce-, the fourth pillar of the welfare state has been introduced into the political programs, from the year 2000. This fourth pillar represented the public resources destined for the care of dependents, "with the objective of guaranteeing public participation in the care of those persons with dependency levels that prevent them from carrying out activities of daily life" (idem, 77).

Within the framework of this Law, the System for Autonomy and Care for Dependency (SAAD) was created, which intended to guarantee the coverage of the care needs for people lacking such autonomy, and which is articulated through different services of direct care and economic benefits. "In the application and financing of the services of the SAAD, the Administrations of the Autonomous Communities (e.g. the Basque Country) are responsible for fulfilling the role of the state. The presentations and social services to which the dependent person has a right are defined according to their degree of dependency, ranging from a low level of dependence (Level 1) to a High Level of dependence (Level III)" (Idem).

It has to be noted that due to the cultural norms present in the country, "On the part of the families, there exists a preference for organizing care for dependent family members in their own homes instead of externally such as in residences and Day Care Centres. This contributes to the employment of care workers who stay in the homes of dependent people from families with busy schedules, as well as the possible preference to claim financial benefits instead of the allowance of resources provided by the ‘Social Services Network’ for the care of dependents, which also includes domiciliary services, such as the Home Care Service (SAD)"(idem, 84).

Since the updated version of the law of Dependency (Law 39/2006, article 34) was passed in December 2017, starting from 2022 a family that hires a care worker can only receive economic benefits if the hired worker can provide a Certificate of Qualification in Health Care on EQF level II.

There exists an extensive Catalogue of Benefits and Services of the Basque System of Social Services, but in the analysis bellow, the comparison is made between the public and private sector as well as residential and individual care services.

A.2. The Home Care Sector - a public-private service

“The Catalogue of Social Services offers the possibility to finance care in the home by professional **care workers** belonging to care service providers, which are subcontracted by the municipality. The care workers will go to the home and fulfil the daily care necessities of the dependent person, and perform other domestic services, during a limited number of hours per day.” (Idem, 85).

Thus, subcontracting care service from a private care service provider, the municipality (which represents a public body) constitutes at the same time a private and public care service provider. However, the service comes with some restrictions for the care users such as the limited time of service provided, the impossibility of choosing the care worker who will be assigned to the dependent person and the fact that the user or the family have to pay a percentage of the service provided. All these factors have as a result that many families prefer to receive economic benefits for the support of the elderly person instead of receiving care services through the municipality. That way, the families can choose to hire directly an autonomous domestic care worker or contract the service of a private Care Service Provider.

Moreover, the services include:

- *Day Care Centres*

  "This service is external to the home of the dependent persons and offers a service during the night or day with the objective to improve or maintain the best possible level of personal autonomy and to support families or carers" (idem, 87). However, due to the schedule, the absence of places, the co-financing by the care service users, many families do not prefer to access to this service.

  There are public and private Day Care Centres. Most people would prefer to access the public Care Centres as this service is less expensive and the co-payment will be calculated based on the pension – however the waiting list is very long and it can take months before there is a free place.

- *Residential Care Services*

  The provision of this service can be permanent, when the residential centre becomes the habitual residence of the person, or temporary, when attending temporary recuperation stays or during vacations, weekends, illnesses or rest periods of non-professional care workers, like family members." "The residential care service is provided by the Public Administrations in their own and affiliated centres"(Article 25 LAPAD). This service is intended primarily for dependents of Level II or III. There are both private and public Residential Care Services, the latter with a long waiting list.

As mentioned above, the change of roles within families has created the need to outsource domestic care and the most frequent strategies by families are to seek recourse to migrant women who come mainly from Latin American countries. In the Basque Country it can be said that it is socially accepted to formally and informally hire a “Latin woman” (a girl) to take care of the elderly. However, to fully understand the situation in which these women find themselves, it is necessary to explain the normative framework of the regulation of foreigners and the domestic sector.

A.3 Regulatory framework for the regulation of foreigners:

Although there is the possibility of residing in Spain with a work permit when a labor contract can be presented before entering the country, the vast majority of Latin American women enter the country with a tourist visa that expires after three months and then they enter a situation of irregularity. Then, the vast majority of this group tries to regularize their situation through the "Authorization of temporary residence for reasons of entrenchment": Social entrenchment: It is

obtained from a three-year stay in the state and the signing of a pre-employment contract of at least one year duration. (Article 124, RD 577/2011) The typical migratory path is therefore: home care work for three years, living in many cases in the home of the elderly person and without a legal employment contract. Once the three-year stay is over, the migrant care worker tries to regularize her situation and then looks for a job with better conditions. It is obvious that during these three years of irregular situation, migrant women are in a vulnerable situation, exposed to multiple discriminations, exploited in most cases (that is, for hours of work, days off or financially), without contributions to Social Security, without access to public service training courses. However, it should be noted that there is legislation regarding labor rights that protects workers in an irregular situation.

A.4 Labor regulation of domestic services and care for dependency

Domestic work is defined as work with a special character since the activity is carried out in "the family home, so linked to personal and family privacy ..." (RD 1620/2011). In this way, their invisibility and specific labor relations are justified. However, fundamental aspects such as wages, rest time, Social Security contributions have been regularized. Hiring by families can be done through direct hiring or through public employment services or employment agencies

B. Germany

B.1. Background

The German care sector has been growing at a rate of almost five percent each year since 2005. Additionally, it is the third biggest segment in the German healthcare system. The care service "market" will continue to grow in the coming years in Germany. The German care ecosystem is heavily regulated and faces increasing levels of competition.[1] To overcome the increasing shortage in this sector, different ministries have been launching programs and announcing more financing for the care sector. However, a survey released in mid-January found that 74 percent of care workers, care receivers and their relatives, and doctors felt that care work was only of minor relevance in German politics.

Shortage & Reaction

Germany's caregivers' shortage has not only led to understaffing at residential facilities for elderly people, but also it has meant that patients are unable to get at-home health care without navigating a sector plagued by "legal grey zones" — such as a lack of standardized contracts covering hours, wages and labour conditions — that discourage on-the-books work.

Since the 2000s, transnational migration of health-care workers to EU Member States in Western Europe has significantly helped relieve shortages of professional personnel in this sector. Given the importance of migration for the sustainability of formal health-care provision, several institutional measures for the recruitment of foreign professional health-care workers have been taken in Germany. For example Germany is planning an agreement with Mexico for the recruitment of care workers[2].

Nevertheless, recruitment of foreign-trained health-care workers from other EU Member States is very challenging. It is common practice that companies recruit trained workers in other EU countries. However, this requires resources that are often not available to smaller health-care companies or institutions.----

Only a small minority of older people are in need of long-term care. But the number of those in need of care is increasing and will continue to grow because of population ageing. The 71 percent of long-term care recipients are looked after at home, around two thirds solely by relatives. The remainder receive support from outpatient services (Federal Statistical Office 2015). -

Current status

Under the provisions of the Long-Term Care Insurance Act (Pflegeversicherungs-gesetz), Germany has roughly 2.86 million people in need of long-term care. More than three-quarters of them are looked after at home. Most of the people requiring help (more than 80 percent) are cared for by family members. Even though people continue to be very willing to help their relatives, the trends towards smaller families and ever-greater mobility are leading to a situation where in the future, these support services will no longer be available to the same extent (source: Federal Statistical Office, Long-Term Care Statistics 2015).

[1] Cf. https://www.rolandberger.com/en/Publications/The-care-industry-in-Germany.html

[2] Cf. https://www.aerzteblatt.de/nachrichten/sw/Pflegenotstand?nid=106094

If someone is classified as being in need of long-term care under the provisions of the Long-Term Care Insurance Act (Pflegeversicherungsgesetz), the costs of the services rendered by a home care service are partly assumed by the long-term care insurance fund. An application must be submitted to your health insurance or long-term care insurance fund in order to determine a need for long-term care.
Instead of receiving care benefits in kind (Pflegesachleistung), people in need of long-term care can claim a "care" allowance (Pflegegeld) or opt for a combination of the two. They can decide for themselves how to use their care allowance and regularly pass it on as a token of appreciation to recognize the services of those who provide them with care and support.

More than two-thirds of people dependent on nursing care in Germany are cared for at home. It is most people's wish to be looked after at home and by family members should they become reliant on assistance and nursing care.
Caring for a relative is often physically and psychologically stressful for carers. Unpaid care is mostly provided by women, as a corollary of which women are less likely to work full-time and more likely to be in part-time and/or insecure employment. As a result, women are materially less well-placed on average than men. The unequal division of care responsibilities thus perpetuates social inequality. There is a similarly uneven apportionment of responsibilities for care between different social backgrounds: people with higher socioeconomic status are less likely to provide nursing care for relatives than people with lower socioeconomic status.

B.2. The home and residential care sector: charitable, private and public services

Some of the existing services are:

- *Mobile Nursing Services*

  It is not always possible for the families of people in need of long-term care to be on hand to help. This is where mobile nursing services come in to supplement family-provided care and arrange continued care in the home. These provide services involving basic care (personal hygiene, nutrition, movement and exercise) and curative nursing care (care prescribed by a doctor due to illness). In addition, these services frequently offer domestic support (meals on wheels, home alert and so on) and can also give advice on issues relating to home care. Care services are offered by non-profit organisations (such as the welfare associations) and also by commercial providers.

- *Stationary Nursing services*

  The alternative for receiving care at home is to receive care at a nursing home. The stay can be stationary or only during daytime. In these nursing homes, professional care workers take care of the people. They provide services involving basic care (personal hygiene, nutrition, movement and exercise) and curative nursing care (care prescribed by a doctor due to illness).

- *Stationary care at the hospital*

Receiving care services in a hospital is not a permanent solution and not aimed towards permanent care in elderly care.

C. Italy

C.1. Background

In Italy, the National Health System foresees a range of different services for the care service sector of the elderly. Nonetheless, the level and capacity of those services is quite low. As stated in a report published by the International Labour Organization: "Public care support for older person care principally consists of cash transfers, tax breaks and cash-benefits to persons in need and their families. The most common of these cash benefits is the "indennità di accompagnamento" (IA), an allowance granted to all older persons in need (i.e. those unable to work and in need of constant care in everyday activities), to purchase care services directly from the market or employ care workers, as they choose. Unregulated and with no controls governing how it is spent by recipients, the cash-for-care allowance has been credited for the increase in live-in migrant care workers, who can provide constant care and at a lower cost than residential care or home-care establishments" (King-Dejardin, 2019).

Due to the existent culture and the important role that the family has, members of the family (mainly the women) would assume the care responsibilities of dependent family members. The welfare provided by the state plays a subsidiary role in comparison to the family. The care model of "woman-in-the-family" has developed over the years to the "migrant-in-the-family" (King-Dejardin, 2019). As stated in the Routledge Handbook of the Politics of Migration in Europe, "These migrant care workers, called 'badanti' in Italian, often live-in with the elderly, providing them with continuous care. The 'migrant in the family' model of care has been facilitated by work permits and immigrant regularisations which have provided some opportunities for non-EU nationals to obtain a legal status as privately employed care workers" (van Hooren et al, 2019).

As stated in the paper Promoting integration for migrant domestic workers in Italy, "salaried caregivers – called badanti – often employed as live-in, are nowadays the backbone of the eldercare system in Italy, in a welfare mix that combines the help provided by relatives with the few opportunities offered by public and private care services at local level" (Castagnone et al, 2013). Most of these workers are migrant people without previous professional experiences in this sector and without regular residence permits. However, their services are considered essential for the Italian families.

During the last decade in Italy, Italian institutions registered an increase of irregular workers in this sector from Ukraine, Romania and Poland as well as from non-EU countries such as Ecuador and Perú. At the same time, the country is facing a human resource emergency in this sector. Indeed, in 2017 the Italian government approved a new kind of regulation (L.104/92) to enhance home care service, creating a special fund to support Italian families and employees in this sector in order to close the actual gap of the national situation. Furthermore, in order to improve the competences of migrant people with regular residence permit and to fight illegal employment, Italian Minister of Interns has begun to provide annual vocational training course for become OSS – Operatore Socio Sanitario, the Italian professional figure required to deliver home care services.

C.2 Home and residential care: public and private services

1. Residential Care

Socio-healthcare Residences / Residenze Socio-Sanitarie: These structures address dependent elderly and are equipped with specialized medical and nursing personnel. The services offered are characterized by a high level of social and healthcare combination with the aim to support the greater possible recovery rate of the psycho-motoric capacities of the users.

Health care residences / RSA (Residenze sanitarie assistenziali): They host, for a period that varies from a few weeks to an indefinite period, people who are not self-sufficient, who cannot be assisted at home and who require specific medical care from several specialists and comprehensive health care. The RSA are managed either by public or by private bodies that offer hospitality, health and welfare services, help for the functional recovery and social inclusion as well as prevention of major chronic diseases. The capacity of users differs in each of the facilities. Medical and nursing care is provided by the RSA as well as rehabilitation treatments to improve the state of health and well-being of the users while the capacity of users can reach the maximum number of 120 users, divided in smaller groups of about 20-30 users each.The RSA are usually managed and run by the Italian state. The expenses, established by the entities that manage the residences in agreement with the municipality, are partly paid for by the National Health Service, partly by the municipality and partly by the users themselves.

Protected Homes/ Case protette: They are residential facilities with a high level of social and healthcare support, intended to accommodate dependent users, temporarily or permanently. The users are not treatable at home but at the same time do not need complex healthcare assistance. These homes provide activities aimed at maintaining and activating the capacities of the users while they also aim to ensure an average level of medical, nursing and rehabilitative assistance. They also provide the opportunity for community life, recreational activities and services for the help in daily activities.

Assistance Residences / Residenze Assistenziali: These are mainly directed either to users that are independent or with a low degree of dependency. The elderly as guests of the residences benefit of the services as they receive complete assistance and are encouraged in taking part in recreational and cultural activities. In this category are included the nursing homes (case di riposo), hotels for the elderly (casa albergo per anziani), residence homes (casa soggiorno) and Holiday Houses for the elderly (casa vacanza per anziani), which supply hospitality and assistance. They guarantee the distribution of meals, recreational and aggregative activities, assistance in daily activities, nursing assistance and the administration of drugs if necessary. In depth about some of the subjects of this list:

Retirement Homes / Case di Riposo: The ideal model of retirement home is that every person or couple in the house has a furnished room or suite. Additional services are provided within the building. Often this includes facilities for meals, a meeting place, recreation, and some form of health care or hospice. The level of service and the capacity of users (could arrive to 120 users) varies between the public and private structures.

In a public structure, the user goes through an application process, which is finalized with the evaluation of a doctor-geriatrician, in order to assess the clinical conditions of the

future guest, which puts the user in the waiting list until a place is found for them. In public or affiliated facilities, the guest pays the fee based on his or her income.

In private facilities, it is sufficient to get in contact with them in order to get access and the user pays according to the fee decided by the structure.

Residential Communities / Comunità Alloggio: They are addressed to users with a low degree of dependency and who have a necessity of mutual solidarity and companionship. They differ from the retirement homes for the number of guests, as in this case there can be less people (maximum 12 users hosted).

- **2. Semi-residential Care**

Day-Care Assistance Centres/ Centri Diurni Assistenziali: They are considered semi-residential care facilities, as they are socio-healthcare structures that provide their services during the day and are addressed to elderly persons with different degrees of dependency. Their aim is to offer an aid to families, more than strengthening and compensating competencies and abilities connected to the autonomy and the identity. They are mainly public entities that can receive from 5 to 25 users, but at the same time there are private structures that offer the same services

- **3. Home Care**

Integrated Home Care / ADI Assistenza Domiciliare Integrata: The ADI is a set of social and health services and interventions provided to the patient in his or her home. It is carried out through services provided by various professionals (doctors, social health workers, physiotherapists, pharmacists, psychologists, etc.). Its objective is to avoid, as far as possible, the hospitalization of the patient or his placement in a residential structure beyond the time strictly necessary. The Municipality of residence of the patient usually supports the ADI service. The economical contribution of the family or the user, depends on the income conditions. It is also divided between:

Simple Integrated Home Care/ Assistenza Domiciliare Integrata Semplice: These are simple services such as dressing, blood samples or catheter changes, which concerns individuals who are not completely self-sufficient.

Complex Integrated Home Care/ Assistenza Domiciliare Integrata Complessa: It is a combination of medical, nursing, rehabilitation and welfare care that is provided to seriously dependent patients. The complex ADI must be requested from the Health District of residence, or by the general practitioner, by the patient himself, by his family members or by the Social Workers of the Municipality.

Other Private Home Care Services: A lot of associations and agencies provide also caregivers that are employed with a variety of options (morning/night rounds). The caregiver maintains a relationship of listening and mutual trust with the elderly and their families, respecting the lifestyle and the rules observed by the context of reference itself. They operate mainly alone and autonomously, dealing also with any other services that intervene in the nursing care of the user.

D. Greece

D.1. Background

The long-term care for elderly in Greece is mainly provided by the state, by private non-profit organizations, by private profitable organizations, local authorities and the family itself, due to the cultural values found in the country. Therefore, the health care system in Greece is consisted of a mix of services.

The majority of the elderly live alone in their home or with their children. If they have special needs and health problems, they receive care mainly from the family, friends and neighbours, as the family continues to play a key role in the care of the elderly. In addition, the proportion of the elderly living in residential care institutions is traditionally very small. One of the main reasons for this is the insufficiency and the low quality of institutionalized care but also the disdain of many people to this kind of care (Koumanakos, 2015).

Due to the cultural norms, institutionalized care is not socially accepted or praised in the country. Moreover, the employment of migrant care workers has been an important part of care giving in the country, as the cheaper labour was favoured even before the austerity crisis that hit from 2009. Both of these factors lead Greek families to hire privately migrant care-workers, who can be struggling to perform many of the tasks due to the lack of training that they have received

In this way, migrant women play a crucial role in taking care for elderly family members. In some particular cases, couples can be both working in the informal care service sector in Greek families, while being undocumented. They provide cheap service and usually adapt their daily life in accordance with the Greek family's needs.

Although, Home Care services are accredited by the new accreditation service of Greece – EKEPIS. Home Care Services remains a specialty that someone can acquire through informal vocational training. The overwhelming majority of caregivers in Greece are relatives of the family or migrants, which can be unqualified. The consequences of this can be more than serious from both ergonomic point of view and the significant risks for injuries.

D.1.1. Authorities, Ministry of Health and Social Solidarity

According to survey by the National Statistical Service of 2009, in Greece 229.400 people were employed in the sector of health and care services. There has been no estimation of the number of informal caregivers that are active in Greece as of 2019.

In the public sector, the Health Care budget is set annually by the Ministry of the finance, taxes account 70% of financing of the National Health System the other part comes from social security and out-of-pocket payments.

The private care-giving sector is financed by the individuals, their families or private health insurance that they might have. The costs depend on the health issues found in each individual.

D.2. The Care Sector – public and private services

D.2.1. Public Services

In Greece, the public system provides in-kind long-term care benefits and services in institutions, but there are limited formal home care arrangements. In theory, any old person has access to long-term care services in institutions, whether s/he is insured or uninsured by the social health insurance system.

There is no institutional discrimination or access restrictions, as long as the elderly are legal residents of the country. In practice, however, there are some deviations from this universal model, mostly due to the uneven concentration of providers across geographic areas, and also due to a shortage of special institutions (e.g. Rehabilitation centres). In these cases, the family network satisfies to a large extend the needs of the elderly.

The social security funds pay for long term care services as well as for specific medical charges for the treatment and rehabilitation of adults and children with either impaired physical mobility or mental deficiency problems. Medicines for chronic disease, including Alzheimer, are also provided free of charge by the dispensaries of public hospitals. Social security funds also provide cash benefits.

Public Services include: *Help at home*, *KAPI*, *KIFI*, *.Municipal Nursing Homes*

Every structure is consisted of a nurse as a domestic assistant and a social worker, while in many structures there are doctors and physicians. In the last years due to the crisis, these types of structures are massively closing down. Analysing some of the elderly care programs:

- **The '<u>Help at Home</u>'** service started in 2002 assisting disabled and elderly people two to three times per week at their homes. The service provided does not substitute the families' care but only complement and assist to it, due to the reduced visits that take place on a weekly basis. Through the service, around 3.600 employees are occupied, assisting to approximately 110.000 beneficiaries.

  As mentioned, the program provides for primary care to elderly and disabled people, while offering a variety of services to them and their families. Those can include: counselling, psycho-emotional support, provision of the elderly care services and social protection measures, nursing and safety care, monitoring of the vital functions, training of family for helping the elderly, household keeping and where necessary escorting individuals at the hospital or facilitating their communication needs with providing a space of companionship and conversations.

- **Home Care Pensioner Program**

  Beneficiaries include pensioners due to age, disability as well as uninsured older people of the former OGA (Agricultural Insurance Organisation) , who are experiencing temporary or permanent health or disability problems

- **KAPI (Elderly Entertainment Centres) and KIFI (Elderly Day Care Centres)** are open structures for daily hosting of elderly people who cannot look after themselves or are facing serious financial and/or health problems. These structure can usually be found in different neighborhoods of cities in Greece and accordingly the citizens registered in those can benefit from their services.

- **KAPI** is addressed to all residents over 60 years of age in the area where the Center operates, regardless of their economic and social situation, trying to empower them to stay active in the social environment, to avoid social exclusion, maintain their autonomy and to facilitate and harmonize the daily life for the rest of the family members.

- **KIFI** are day-care units for elderly people who are not fully self-sufficient (due to mobility problems, dementia, etc.), while their family members are unable to provide care either because they are working or because they are facing serious social, economic or health problems. The structures offer a variety of services, such as nursing care, practical need of living, personal hygiene, creative programs and the staff it is comprised of nurses, social workers, psychologist, physical educators.

E. Northern Ireland (UK)

E.1. Background

The United Kingdom (UK) has an ageing population as a result of people living longer due largely to the accomplishments of the National Healthcare System (NHS). There are nearly 12 million (11,989,322) people aged 65 and above in the UK of which 5.4 million people are aged 75 plus, 1.6 million are aged 85 plus. Over 500,000 people are 90 plus (Office for National Statistics, 2018). Subsequently significant challenges for Social Care have arisen due to increasing morbidity associated with aging.

In Northern Ireland over the last decade (2008-2018) the population aged 85 and over has increased by 30%. This population, referred to as the oldest old, has grown at a rate five times higher than the population of Northern Ireland as a whole. Women account for two thirds (66%) of the oldest old. By June 2018 the number of people aged 85 and over living in Northern Ireland had risen to 37,700 people. This is a 1.5%, or 600 person, increase on the mid-2017 statistic (Northern Ireland Statistics & Research Agency (NISRA), September 2019).

In the next 20 years, the number of individuals with complex care needs is projected to increase due to more people reaching ages 85 plus and these individuals having higher levels of dependency, dementia, and comorbidity (Kingston, Comas-Herrera, & Jagger, 2018). As the population ages and people's care needs become more complex, the need for social care services (formal and informal) intensifies (Kelly & Kenny, 2018).

E.2. Care services: public, private and charitable services

In 2017, the UK adult social care sector had around 21,200 organisations with 41,000 care providing locations (Skills for Care, 2018). 400,000 older people are in care homes in the UK (Laing-Busson, 2018).

Health and Social Care in Northern Ireland is provided by a range of statutory (Government funded), private and charitable organisations. Care for individuals who are elderly is in the first instance provided in their own home where possible and typically this care will be informally undertaken by a family member. However, with increasing needs associated with aging, a care support packages may be required. This usually starts with a formal carer who provides care in the individuals own home. This formal care is provided by the Government, private 'domiciliary care' organisations or charities and can include basic care needs. In addition to this, individuals who are elderly may attend a Day Centre where social activities are provided and some basic care needs are met. These settings are largely funded by the Government or charitable organisations.

With increasing care needs, an individual may progress onto a Residential Home where they remain somewhat independent however, with increasing 'nursing care' needs, an individual may progress onto a Nursing Home. At 30 June 2019, 12,154 residential and nursing home care packages were in effect. Of the 12,154 care packages in effect, over two thirds (70%) were nursing home care packages and under one third (30%) were residential care packages (Department of Health, 2019).

E.2.1. Regulation of Health and Social Care

Health and Social Care is heavily regulated in the United Kingdom with a range of mandatory conventions such as legislation, Inspector Bodies and Regulators. In Northern Ireland all social care workers must register with the Northern Ireland Social Care Council (NISCC). This organisation has produced Codes of Practice outlining required procedures and behaviours which must be followed. Failure to do so could result in disciplinary action or being struck of the social care register and therefore, unable to work in the Health and Social Care sector again.

In addition, the Regulation and Quality Improvement Authority (RQIA) is responsible for inspecting the quality of Health and Social Care services in Northern Ireland. The RQIA was established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It works to ensure that health and social care services in Northern Ireland are accessible, well managed and meet the required standards (published requirements for all settings including Community Care, Residential and Nursing Homes).

E.2.2. Workforce Considerations

"Skills for Care" estimates that there are 1.62 million jobs in adult social care. Overall, there were around 250,000 jobs in adult social care held by people with a non-British nationality (115,000 EU; 134,000 non-EU). The proportion of the adult social care workforce with a British nationality has been consistent over the past six years (from 2012/13 to 2018/19), rising one percentage point over the period. The proportion of EU (non-British) workers has risen three percentage points and non-EU workers has fallen three percentage points over the period (Skills for Care, 2019).

If the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population then the number of adult social care jobs will increase by 36% (580,000 jobs) to around 2.2 million jobs by 2035 (Skills for Care, 2019). Currently in the UK, there is a workforce crisis whereby not enough people are applying for Health and Social Care jobs and once employed, retention in these job role is problematic. This provides unique employment opportunities for Migrant Workers in Health and Social Care.

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