

[OLDER PERSONS AND (MIGRANT) CARE WORKERS IN ITALY, POLAND AND ROMANIA]

Background research report

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INTRODUCTION

This report aims to provide background information concerning social policies, social services, VET policies and migration policies in the countries involved in the IQEA project: Italy, Romania and Poland.

Purpose of the document is to better understand the context in which the testing of IQEA will take place and support its evaluation.

The main source of information for this report have been the outcomes of the European project ANCIEN (www.ancien-longtermcare.eu), which have been validated and integrated by project partners when needed.

LONG TERM CARE SYSTEMS – OVERVIEW

ITALY¹

The LTC system in Italy is characterized by a high level of institutional fragmentation, as sources of funding, governance and management responsibilities are spread over local (municipalities) and regional authorities, with different modalities in relation to the institutional models of each region.

The actors directly involved in the organization of LTC services are municipalities, local health authorities (*aziende sanitarie locali*, ASLs), social service providers and the National Institute of Social Security (Istituto Nazionale Previdenza Sociale, INPS), but other players are involved in planning and funding these services – i.e. the central state, regions and provinces.

Additionally, in Italy a significant share of LTC expenditure is funded directly by households. Moreover, a large part of caregiving is still provided by informal carers, especially in regions where public services are less advanced and in families that cannot afford the cost of private services. Privately purchased home care is often provided by immigrants.

In Italy, public long-term care for older persons includes three main kinds of formal assistance: community care, residential care and cash benefits. The Italian National Health Service (Servizio Sanitario Nazionale, SSN) plans and manages, through local health units (*aziende sanitarie locali*), home health-care services – the so-called ‘integrated domiciliary care’ (by the *assistenza domiciliare integrata*, ADI)– and other health services provided in residential settings. Personal social services, both domestic and personal care tasks provided at home (by the *servizi di assistenza domiciliare*, SAD) and institutional social care are managed at a local level by municipalities, although this should be planned in coordination with the ADI. Long-term care is delivered by both public and accredited private providers of health and personal social care.

The health care services provided by the SSN are free of charge, whereas social care is means-tested and users can pay up to the full cost of it. National and local taxation are the main funding sources of public long-term care.

¹ Tediosi F., Gabriele S., *The long-term care system for the elderly in Italy*, ENEPRI research report no. 80, June 2010

The National Institute of Social Security provides a cash benefit (*indennità di accompagnamento*) to disabled persons, independent of their financial situation. This cash benefit is not directly linked to

an obligation to purchase goods or services, and it is aimed at improving one's personal condition and can thus be used to compensate the household for informal care. Nevertheless, the *indennità di accompagnamento* is usually considered part of LTC expenditures in Italy, unlike invalidity pensions. Other cash benefits are provided by some municipalities, but these are usually means-tested.

LTC in Italy is also characterized by a wide variation among regions and areas in both funding levels and the structure of the services provided. In Italy, rather than one national LTC system there are many regional LTC systems. Generally speaking, in northern Italy the culture of public service in LTC is rather widespread, partly owing to the high level of participation by women in the labour market. These regions and municipalities – have been making an effort to improve their LTC system, thanks also to their more developed management capabilities and their larger economic resources. In the south, by contrast, the care burden rests mostly on families, with poor public support.

ROMANIA²

The long-term care (LTC) system in Romania includes all medical and social services delivered over a long period of time to those in need, such as the chronically ill, terminally ill, disabled and dependent elderly people who need help with activities of daily living or instrumental activities of daily living. The term 'elderly' is defined by the Law 17/2000 as referring to all persons at or over the official Romanian age of retirement.

Concerning non-disabled elderly people there are six acts of legislation that regulate entitlements and the organisation of services:

1. Law 17/2000 on the Social Assistance for the Elderly (Legea privind asistenta sociala a persoanelor varstnice) with the additional modifications (Law 281/2006, Law 270/2008 and GO 118/2008) and
2. Law 47/2006 establishing the National System of Social Assistance (Sistemul National de Asistenta Sociala).

² Popa D., *The long-term care system for the elderly in Romania*, ENEPRI research report no. 80, June 2010

The **medical services** for all categories of people, including the disabled and the non-disabled elderly, are supported by the social medical insurance and are regulated by:

3. Law 95/2006 on Health Reform (Legea privind reforma in domeniul sanatatii) which set the grounds for national reform in the health care system and established the national social health insurance system.

The regulation of **quality assurance** is covered by the following decrees:

4. Decree (Ordin) 318/2003 refers to the norms regarding the organisation and functioning of home care services as well as the authorisation of people who provide these services.

5. Decree (Ordin) 246/2006 which established the minimum specific quality standards for home care services and residential centres for the elderly in terms of organisation and administration, human resources, access to services, service provision, rights and ethics.

The **decentralisation** of the administrative bodies is legislated by:

6. Law 435-XVI/2006 (Legea privind descentralizarea administrativă nr. 435-XVI/2006).

At national level, the authority responsible for social care is the Minister of Labor, Family and Social Protection. At regional level, the authorities responsible for social care are the Regional Departments of Social Assistance. At local level, the authorities responsible for social care are the General Department of Social Assistance for Bucharest (with Departments in all 6 districts of Bucharest) and the Public Service of Social Assistance for the other cities of the country.

The right to social assistance is guaranteed to all Romanian citizens and to all foreign and stateless persons who have residence in Romania and are elderly people (defined as persons who have reached the standard retirement age). They must be without family or legal guardians, without a home or the possibility to ensure one with their own resources. They must not be earning income or have insufficient income to cover the appropriate care, and must be unable to ensure (i) ADL or need specialized care or cannot meet their socio-medical needs because of illness, physical or psychological status (Law 17/2000, art. 3 and Law 47/2006, art. 7).

Privately purchased social care is common. Many elderly persons, who do not gather the conditions to benefit from public social care, purchase the care services from authorized social services providers or from non-authorized persons.

POLAND³

In Poland's long-term care (LTC) system, the family is still identified as the main caregiver for elderly persons with limitations in the activities needed for daily living. In the field of social protection, Poland belongs to the EU group of countries with a family-based welfare model. The development of formalized, non-family LTC is in the initial stages and is similar in both sectors: medical and social.

The health care system reform of 1999 provided an opportunity for the development of public LTC institutions that are separate from hospitals. As a result, hospital departments were transformed into nursing and care institutions. Institutional care is simultaneously provided in the social sector. Residential and daycare homes are administered as a part of the social assistance (welfare) scheme.

They care for the elderly whose daily living activities are limited, and who do not have families or need institutional care for other reasons, such as poverty.

At the present stage of LTC development, there is no specific regulation that comprehensively covers the issues of care services for the elderly, the institutions providing these services, the rules of access to them or the ways of financing them. The LTC category is used exclusively by experts in the health sector and the National Health Fund (NFZ – established in 2003). In the social sector category, LTC is used very rarely because the concept of social assistance (1991) emphasizes assistance that allows individuals to remain independent. In the social assistance sector, however, practice is often different from theory and legal assumption. In social welfare homes, the majority of residents are dependent with a wide range of LTC needs.

The Ministry of Labour and Social Affairs sets up strategy for social care development as well as standards for social care. The regional authorities give and withdraw permissions to run social care establishments and register them. They also are responsible for quality control and monitoring. Social care homes are run by public bodies – territorial governments and by non-governmental organizations: foundations, associations, churches and religious organizations. Since 2004 they can also be established by private persons. Territorial governments are also responsible for anticipation of needs for LTC in their area and assuring the needed number of places, they direct people requiring such help to LTC establishments and have to participate in the cost of LTC.

In 2005 there were 686 public and 510 private (including those run by NGOs) social care establishments, in 2011 the numbers increased to 756 and 758 respectively.

³ Golinowska S., *The long-term care system for the elderly in Poland*, ENEPRI research report no. 83, June 2010

AVAILABLE LTC SERVICES

ITALY⁴

In Italy the LTC system, including health and social care services and cash benefits, consists of three main components:

- health services for elderly and disabled persons, including outpatient and home-based care services, semi-residential and residential services, psychiatric services and those for drug and alcohol addicts;
 - cash benefits (*indennità di accompagnamento*) provided (and funded) directly to all disabled persons by the INPS, independent of their age and financial situation. This monetary aid is not directly linked to purchasing LTC services, but is generally considered part of the LTC system.
 - social care services provided at the local level. Social care services are provided in institutions, such as nursing homes for the elderly or semi-residential institutions, or as home-based care services. In this services are mainly employed workers qualified as OSS (Social and Health Care Worker)
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- in addition to these three components, the invalidity pensions provided by the INPS could be included as part of the LTC system as they are, de facto, a long-term income support mechanism for dependent persons.

Italy does not have any national legislation concerning cash benefits to households in order to support the care of relatives, even if several regions have developed these schemes so far. These cash benefits were originally thought of as a measure to support relatives – typically the spouses or daughters/sons of the elderly person – while now they are mainly targeted at co-funding private home-helpers and carers (Beltrametti, 2008). The majority of home helpers still do not have any formal qualification, even though the number of workers who have attended training as Family Assistants (or similar) is extending.

⁴ Tediosi and Gabriele, *op. cit.*

ROMANIA⁵

The available settings for LTC are institutional and home-based, the latter being either formal or informal. The various types of service include:

- home care – temporary or permanent services: home caregiver
- nursing home care (old-age home) – temporary or permanent services: health care assistant
- institutional care (residential care) in day care centres, clubs for the elderly, temporary care homes, assisted living arrangements, social apartments and accommodation, as well as other similar settings (Law 17/2000): health care assistant

Currently, Romania has a major shortage of institutionalised services. Home care is the most commonly used care option for dependent elderly people because of the comfort the family provides and the reduced costs as compared to institutionalized care. This, however, raises many problems. Most family caretakers are women; the wives or daughters of the dependent. Many caretakers are elderly themselves and may also become dependent. Family care is more common in rural areas, where traditions and moral values are maintained to a greater extent (Strategic National Report Regarding Social Protection and Social Inclusion 2008-2010 – Romania).

Community services for elderly people include:

- *social services*, particularly for the prevention of social marginalization and to support social reintegration; legal and administrative counseling; payment of some services and current obligations; home and household attendance; help for the household, and preparation of food;
- *medical-social services*, especially help with personal hygiene, adaptation of the home to the elderly person's needs, encouraging economic, social and cultural activities plus temporary attendance in day care centres, night shelters or other specialised centres;
- *medical services*, such as medical consultations provided in public health institutions or in the home by the general practitioner, dental consultations, medicine administration, supporting sanitary materials and medical devices.

⁵ Papo D., *op.cit.*

POLAND⁶

Residential LTC in Poland is situated in the health care system as well as in the social sector (social assistance system). Earlier it was located only in the health care system.

The representatives of both occupations - Care Assistant in Social Welfare House and the Elderly Assistant – work in all kinds of LCT institutions in health care system and in social system.

LTC within the health care system

The following kinds of residential LTC are provided by the health care system:

- care and treatment facilities (*zakład opiekuńczo – leczniczy, ZOL*)
- nursing and care facilities (*zakład pielęgnacyjno – opiekuńczy, ZPO*)
- palliative care homes.

LTC within the social system

Another form of residential care exists in the social sector, mainly in the social assistance (welfare) system. There are two kinds of social welfare homes: residential (DPS) and adult daycare homes (DDPS). The adult daycare homes are for persons living with a family, in which the members are not able to provide care for the older person because of the professional activities of the family members (most often women: wives, daughters or daughters-in-law). In the working hours of family members, i.e. 5 days a week for no more than 12 hours a day, the dependent person can go to an adult daycare centre that provides all the necessary living and care services.

A residential social welfare home is defined as an institution that provides round-the-clock living conditions and protection as well as supportive and educational services at the level of current standards. In the residential care homes, there are those who never leave institutional care. In Poland there are several kinds of residential homes, separated according to the kind of person receiving care.

Private residential LTC

Private residential LTC in Poland already existed during communist times, and was mostly administered by religious organizations. In the 1990s, other types of private residential homes were established by both non-profit and for-profit organizations based on the economic law that granted people the freedom to create their own businesses. Specific regulations for LTC regarding private

⁶ Golinowska S., *op.cit.*

ownership of facilities were established later. The new Social Assistance Act (2004) confirms that there are no legal obstacles to establishing private and profit-making residential homes and it regulates the functioning of private residential homes that provide care services for the elderly and/or chronically ill. Still, every residential home must have permission from the *voivoda* (i.e. a governmental representative at the regional level from the territory where a home is located) and it has to be registered every year. The basic conditions for obtaining permission are adjusting to the required standards.

Home care

In the Polish tradition, the family has always fulfilled the bulk of the care functions for the elderly, handicapped or chronically ill. Although recent years have brought significant changes, families still take care of dependent family members. Assistance for families is rather limited. Care services may be granted to individuals who require help from others in cases where there is no family or if the family is unable to ensure such help. In recent years, as a result of the health care reform (1999) together with the development of primary care and the institution of the family doctor, the institution of the 'environmental nurse' began to develop. This kind of nurse arranges for his or her own contracts with the NFZ for care in the patient's home.

Apart from formal nursing care, in every community the local centre of social services provides care services in cooperation with the appropriate non-governmental, non-profit organizations or even with for-profit organizations. Such home care services are fully provided and financed by local authorities.

Services offered

Some facilities of the health sector provide LTC services of a similar range, but which differ in terms of the accessibility and scope of medical and nursing care services. The main kinds of services in particular units are specified below:

- hospital departments for LTC and palliative services, which provide medical treatment and nursing;
- ZOL (care and treatment facilities), which provide nursing, rehabilitation and pharmacological treatment (previously provided during hospital treatment) for patients who do not need further hospitalization, but who are dependent and suffer from a partial or advanced disability and therefore need nursing and medical rehabilitation as a first priority. The services are provided on a 24-hour basis mainly by nurses and

physiotherapists; ZPO (nursing homes), which offer nursing and 24-hour care, including appropriate feeding, depending on the health status and health literacy of a client.

Moreover, ZPO offers the services of physiotherapists and psychologists;

- hospices and palliative facilities, which provide nursing and pharmacological treatment, physiotherapy, psychological and religious services; and
- environmental nurses, who offer nursing and care assistance in patients' homes.

In the social assistance homes (DPS), the LTC services are in addition to other services for the patient. Apart from accommodation and nutrition, the patients can receive the following services: nursing, care assistance, physiotherapy, occupational therapy, social work, health education, psychological work and religious services. Additionally, social assistance homes provide cultural and integration programmes and activities. The LTC services are provided by an environmental nurse (nursing team) or nurse employed by the DPS (a so-called 'own nurse').

REGULATION OF PROFILES OF (NON MEDICAL) CARE PROVIDERS IN LTC SERVICES

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ITALY

- Residential and Semi-Residential Care Services: the specific requirements concerning professional profiles are defined at Regional level. Generally speaking, in order to be legally authorized, residential LTC services need to have, among the non-medical staff, at least the great majority of workers with the qualification of Operatore Socio Sanitario (Social and Health Care Worker), while a minority can have lower qualifications.⁷
- Formal home care services (provided by local authorities): requirements are defined at Regional level and varies a lot. Generally speaking, workers can have the qualification of Operatore Socio Sanitario (Social and Health Care Worker) but also lower or no qualification.
- Informal home care services (privately purchased by households): there are no legal requirements, even if some municipalities have started to link the provision of economic

⁷ Lower qualifications (named ASA/OSA/OTA/ADB...) in a medium term perspective will disappear, as all the newly offered training course in the field should provide the new, higher qualification of OSS. Only some Regions have kept lower profiles in their VET regulation.

support to buy these services to the employment of persons with the qualification of Family Assistant (or similar) and to promote the qualification of those working in this sector.

ROMANIA

- Residential and Semi-Residential Care Services: the specific requirements concerning professional profiles are defined at national level – there are Minimum Quality Standards for Residential Centers for Elderly. All residential services must have medical and non-medical staff qualified (nurses, health care assistants and caregivers). Staff has the obligation to follow continuous training during their work.
- Formal home care services (provided by local authorities): requirements are defined at national level – there are Minimum Quality Standards for Homecare Services for Elderly. The workers have to be qualified as home caregivers for elderly (and other staff: nurse, psychologist, physiotherapist etc.).
- Informal home care services (privately purchased by households): If the households purchase the care services from legally authorized private services providers, there are the same requirements as for the formal home care services. If the persons who offer the care services are not legally authorized, then there are no legal requirements.

POLAND

- Residential and Semi-Residential Care Services: the specific requirements concerning professional profiles , standards of services are defined at the national level by means of legal acts and regulations of relevant ministers- the Minister of Health in case of LTC services in the health care system and the Minister of Labour and Social Affairs in case of LTC services in the social care system.
- Formal home care services (provided by local authorities): as above
- Informal home care services (privately purchased by households): If they are financed/subsidized by local authorities there are the same requirements as formal services. However, more than 80% of LTC is provided within the family, a phenomenon due to the culturally strong family ties. The main care givers are women, particularly the daughter or daughter-in-law, who are educated to a secondary level in cities and to

elementary level in rural areas. Quite a lot of well-off families unofficially hire not qualified caregivers, very often immigrants from Ukraine.

INCIDENCE OF MIGRANT WORKERS IN THE SOCIAL CARE FIELD AND RATE OF EMIGRATION OF CARE WORKERS

ITALY

According to available data⁸, the incidence of non-Italian workers in the social and health care field is relevant in the lower qualified professions, less in those requiring higher qualifications:

- 0,5% of medical doctors
- 10,2% of registered nurses– mainly from Romania (37%) and Poland (16,3%)
- 15% of health and social care workers
- 70% of family assistants / privately hired caregivers

No data have been found concerning Italian care workers working abroad.

ROMANIA

There are no data available on the incidence of non-Romanian workers in the social and health care field.

Data available on migration in Romania from the study “Employment and working conditions of migrant workers –Romania” (European Working Conditions Observatory - study designed by Luminita Chivu in 2007):

“On 1 September 2006, according to information provided by DMS, the number of work permits granted to foreigners working in Romania totaled 5,302 with the following distribution by areas of activity: 31% trade, 29% productive activities, 21% in services.

Out of the total number of permits, 29.9% were for managerial positions.

No data available in order to evaluate the specificity of over or under representation of migrant workers by sector or occupations.”

⁸ Piperno F, *Welfare e immigrazione. Impatto e sostenibilità dei flussi migratori diretti al settore socio-sanitario e della cura*, CESPI, Working Papers 55/2009, March 2009 and *Mercato occupazionale sanitario e migrazioni qualificate. Infermieri, medici e altri operatori sanitari in Italia*, EMN, Rome, 2006

CRCE 2010 Colloquium – Migration in Europe: Romania (Oana-Valentina Suci: Migration and demographic trends in Romania: A brief historical outlook):

“In 2007, the total number of foreign citizens (either from third countries and EU/EEA) with valid permits amounted to 49,775, 4,225 less than in 2006. However, the number of persons with permanent permits rose by about 18% (from 5, 429 in 2006, to 6, 652 in 2007). The main origin countries of temporary migrants remained Moldova (11,852), Turkey (6,227) and China (4,336). Temporary residents from EU/EEA come mainly from Italy, Germany and France. Most of the permanent migrants originate from China (1,070), Turkey (976), and Syria (757). As far as the number of work permits granted to foreigners is concerned, official data from the Romanian Office for Immigration (created in 2007), 3, 638 work authorizations (as work permits were renamed) were issued to foreigners in the second half of 2007, with a high increase in 2008 (14,389 work permits), only to decrease to the level of 2005 (approximately 4,000 work permits) in 2009. The applicants are mainly Turkish citizens (49%), followed by Chinese (17%) and Moldavians (15%). Both in terms of number of authorizations granted, and of countries of origin, the situation is stable. About 74% of the work authorizations issued in the second half of 2007 were for permanent workers, 21% for posted workers .”

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In 2007, a study on Romanian migration in the EU (Nitulescu, Oancea and Tanase, 2007) showed that Romanians who intended to work abroad had as main destinations were Italy (23%), Spain (20%) and Great Britain (18%). Therefore, the two main destinations for Romanian emigration were Italy and Spain. About 80% of the Romanian residents are living in Italy and Spain. In 2009, there were 3.250.000 Romanian migrants working abroad, from which 2.800.000 were in the European countries (Sondaj CURS, 2009).

In 2009, in Germany, according to the Federal Employment Agency around 90.000 work permits were issued to workers from new EU countries (mainly to Polish citizens (45%) and Romanian citizens (23,5%). While the number of Polish workers since 2007 is declining, the number of Romanian ones increases (2008: 21,3%). Also, the number of Romanian seasonal workers increases significant, it has almost sevenfold (about 31,7% from all seasonal workers in Germany) (EIRP Proceedings, Vol 6 (2011)).

According to official statistical data from Instituto Nacional de Estadística from Spain, in 2009 there were 731.806 Romanians in Spain (190 000 in Madrid). (Instituto Nacional de

Estadística:<http://www.ine.es/>)

In Italy, according to the Caritas Report, in 2008 there were 1.016.000 Romanians (749.000 Romanian workers - 73,7%, 239.000 family members - 23,5% and 28.000 (2,8%) other categories). (Caritas Italiana. Romani a immigrazione a Lavoro in Italia. Statistiche, problemi e perspective a curadi di Franco Pittau, Antonio Ricci, Alessandro Silji, 2008)

Regarding the activity sectors of the Romanian working abroad, about 59,6% work in services, 36% in industry and 4,3% in agriculture.

In the period 2000-2005, there were 10,9% doctors working abroad of the total of active doctors, and 4,9% nurses of the total of registered nurses.

In 2011, 2841 doctors left Romania to work abroad. In 2012, 1605 have already left Romania to work in other countries. There were 11200 Romanian doctors working in the developed countries of OECD at 1st of January 2012.

There are no official information available about the Romanian health and social care workers or about the Romanian privately hired caregivers who work in other countries.

POLAND

According to the Demographic Yearbook 2012 published by the National Statistical Office (GUS) in 2011 19 858 people left Poland to look for jobs abroad. The biggest group (39,19%) emigrated to Germany and 22,32% to Great Britain. The other most popular countries of destinations were : the Netherlands -4,5%, Ireland -3,6% and Italy -2,6%. Unfortunately the data on the structure of occupations of those emigrants is not collected.

In the same year 15 524 came to Poland from other countries, of which 609 came from Ukraine and 209 from Belorussia. Many women from those countries find jobs unofficially in Poland as caregivers of elderly or housekeepers but this is usually not registered employment so there is no official data about the scale.

