PRO-DOMO

DG Istruzione e cultura
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COMPARISON REPORT

SITUATION OF CARE IN THE PARTNER COUNTRIES

Survey carried out by

Katholische Universitat Eichstatt-Ingolstadt

in collaboration with the

Centre for Research and Economic Studies

(Centro Documentazione e Studi Economici)in Ferrara

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ProDomo Project

The conclusion of the Work Package 2 (WP2) was the result of research concerning the home healthcare sector and the targets and vocational needs of caregivers in all six partner countries. The ProDomo partners gather information and best practices in their countries and specifically in: Municipality of Parma (IT); Granada City Council (ES); Region of Ingolstadt (DE); Birmingham City Council (UK); Nyíregyháza City Municipality (HU); and Koper City Municipality (SLO). Objects of the next phase (i.e. WP3) is to conduct a comparative analysis based on the situation of the various home healthcare services, so as to create a framework, to be completely or partially transferred, for the needs of home healthcare workers with regard to the development of their competences. The aim of the phase is to locate and exchange positive experiences with innovations and the quality of home healthcare services and vocational training needs in order to create the conditions for the right active labour market policies management and to fill current training gaps. These activities are intended to ensure secure and high-quality employability and to accredit competence to home healthcare workers.

The following document, compiled by the Catholic University of Eichstaett - Ingolstadt (DE) in collaboration with the Centro di Documentazione e Studi Economici - CDS (IT), presents a summary of the reports drafted by each of the ProDomo partners. The comparative analysis is composed of four main topics: general organisation of the homecare and health sector; people carrying out the care service; funding of the care service; and the current status of training for caregivers. At the end of each chapter, a table visually compares the main content(s) of the chapter. Moreover, each national sub-chapter concludes with some key concepts that highlight its most important aspects.

1. Introduction

The ageing of the population (a phenomenon present in all partner countries) creates a series of challenges for the community and local public agencies. In order to guarantee better opportunities to self-sufficient elderly people and assistance to the non-self-sufficient, their actions should be based on one principle: people should be aided in their homes for as long as possible (i.e. “outpatient before inpatient”). In this sense, homecare/domiciliary care[1] enables people to be supported while remaining in their own homes as an alternative to residential care or to short hospital stays, helping or merely supporting patients in their everyday lives and taking care of social contacts and health aspects.

In this context, the concept of personalisation of the care service (to be understood as a good (new) way for the organisation of care assistance) reinforces the idea that

[1] There are some nomenclature differences, like home care, domiciliary care, domestic help service, and social servicing.

beneficiaries of the service (or their family) should be the first to know what they need and how those needs can be best met. People can be responsible for them and can participate in taking decisions about what they require; in order to do that, they should have the right information and support. Moreover, through the personalisation of the service, we are achieving a so-called humanisation of the care services; this means having qualified home caregivers who can improve not only their job-related competences, but also their so-called soft skills during their period of qualification.

2. Welfare system, legislation and carers

2.1 How is the social service system (i.e. homecare system) organised? How do citizens receive homecare service?

ITALY

Since 1972 the health care system has been the responsibility of the regional governments, implementing an even stronger federalist way in 2004: the Local Health Authority (ASL/USL) nowadays represents the executive arm of the Regional Sanitary System and the District represents the local knot where the integration of social and healthcare activities are conducted[2]. Until 2001 the homecare services in Parma were characterised by outsourcing through three social cooperatives united in a temporary agency association that distributed the work of the city districts amongst themselves. Through the newly implemented system, based on the accreditation of the health structures, new openings have been guaranteed to other bodies[3] who can compete to offer services as long as they possess the characteristics and guarantees requested by an appointed commission[4]. Accreditation of the health structures is a process that leads to the recognition of the status of potential service suppliers in the health sector and on behalf of the National Health Service, with the aim to achieve and maintain high quality levels but also fixed costs of the services. This model foresees the synergies[5] within all the formal and informal resources of the community (social services, health and hospital services, voluntary work, organisations, profit agencies or cooperative groups, etc.). Through the accreditation process the suppliers, if chosen by the citizens, commit themselves to supplying care services at the price and conditions indicated by the Municipality of Parma, being based on the various forms of services offered (i.e. number of services and care packages) and their quality, and not on their costs. For the accreditation every supplier is evaluated according to the following criteria: (a)

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2 The region Emilia-Romagna is organised in 38 districts.

3 The Regional Health System works through a network that involves public and private structures managed by profit and non-profit agencies.

4 Composed of the director of the local district social sector, the director of the service for the elderly, and the general town clerk.

5 In 2003, there was a first change in the organisation of the social and healthcare system with the aim to create a public network of residential and non-residential care services, transferring the responsibility of organising social and healthcare services to the municipalities. Moreover, 2008 saw the introduction of a new three-year Health and Social Plan, based on the integration of social and healthcare services.

organisation and business solidity (i.e. turnover, balance sheet, etc.); (b) employment (i.e. organisational skills, planning capacity, etc.); (c) quality of internal organisation (i.e. organisational structures, management and staff training, information system, etc.); and (d) quality of completed services (i.e. application of individualised care plans, quality of relationship with the beneficiaries and their families, etc.).

In order to access the homecare services citizens must contact the Elderly People's Service of the Municipality for the production of the Individualised Caring Plan (PAI). If the citizen and their family are unable to carry out all the procedures by themselves, the Municipality, through a commission,[6] assumes all the duties regarding protection and accompaniment in the choice of the right accredited supplier. The draft of the PAI is produced by social workers and by the person responsible for the care activities in the Elderly People's Service of the Municipality, along with the opinion of a general practitioner (the family doctor of the applicant) and, if needed, involving other professionals (e.g. a professional nurse, rehabilitation therapist, or psychiatric health service) and also making use of the evaluation geriatric unit service. The PAI indicates through a multidimensional evaluation of the patient the kinds of services needed by the elderly person (typology, quantity, intensity). The validation commission examines the applications and evaluates them within 60 days of their receipt. On the basis of the PAI, the beneficiary receives a voucher from the Municipality which can be used to buy services from a panel of suppliers accredited by the local administration. The citizen, in possession of the PAI and the voucher, can choose their own supplier directly and freely, stipulating a contract that must follow the outline imposed by the local administration. Two of which are the homecare services proposed by the Municipality, as alternative forms of assistance in care institutions or hospitals: the Integrated Home Assistance (ADI) and the Home Assistance Service (SAD).

KEY CONCEPTS:

Local Health Authority (ASL/USL); District; Accreditation; Municipality as Service Quality Supervisor; Public and Private Sector's Synergy; Service Personalisation (PAI).

SPAIN

According to a law of 1988 (2/1988, 4th April), the Social Services of the regional government provided a classification of social community and specialised services, describing social services as the basic structure of public social services in Andalusia with the aim of defining an integrated and versatile care, in order to allow the beneficiaries to have better living conditions. In a second motion, a further Decree (11/1992, 28th January) identified the nature and basic benefits of social communitarian services (including the assistance at home service), promoting decentralisation in local administration as well as competition for the management of community social services and accounted for delegation of the regional government to

[6] Composed of one geriatric doctor (and in some cases the family doctor), one social worker and one person responsible for care activities.

municipalities with over 20,000 inhabitants.

In 2006, Law 29/2006[7] extended the protective action of the State and the Social Security System for the citizens affected by ageing, illness, disability or forms of limitation. This law provides a series of rights necessary to be fulfilled in order to receive the service: (a) to be in a dependency situation on one of the established levels for no less than three years; (b) to have lived in Spanish territory for five years; two of which must be immediately prior to the date of submitting the application form; (c) people without Spanish nationality are governed by Spanish law on the rights and freedom of foreigners in Spain and their social integration, international treaties and agreements established with their country of origin; and (d) likewise, the Government may adopt protective measures in favour of Spanish non-residents in Spain and the access conditions for returning Spanish immigrants. According to point (a), the priority of access is determined by the level of dependency and by the applicant's financial capacity (based on incomes and patrimony).

Law 39/2006 defined the promotion of personal autonomy and care to people in dependency situations,[8] establishing the possibility of access to a Catalogue Service (including assistance at home) and benefits for those people for whom this situation has been recognised. The System for Autonomy and Dependence Care (SAAD), which must ensure the basic conditions and forecast levels of protection in the care sectors, are in accordance with this law. Moreover, a Territorial Council of the SAAD[9] has also been created in order to: (a) recognise a new right of citizenship at national level through the collaboration and participation of all public administration and the guarantee of State General Administration; and (b) regulate the basic conditions to guarantee citizenship equality in the right of promotion of personal autonomy and care to dependent people. The government will determine a minimum level of protection for the beneficiaries of the system, which may be increased by agreements between the National Government and the regional government, although the Territorial Council of SAAD shall establish criteria to determine the strength of protection for each of the catalogue services, and if they are compatible, the regional government (Autonomous Communities) can define additional levels of protection. Catalogue services are a priority and will be delivered through the public offer of the Social Services Network of each regional government and through public social service centres.

According to an Order of 2007 (15th November), which regulates the assistance at home service in the autonomous community of Andalusia, the assistance at home is

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7 The law defines terms like: Autonomy; Dependency; Basic Activities of daily life; and Support needs to maintain personal autonomy, stressing the importance of personal autonomy; as well as professional and non-professional care, professional assistance and third sectors.

8 Definition by the law: "Dependence is the permanent state in which they find people who, for reasons connected with age, illness or disability, and related to the lack or loss of physical, mental, intellectual or sensory autonomy, require care from one or more other persons or substantial benefits to carry out basic activities of daily life or in the case of people with intellectual disabilities or mental illness, other support to maintain their personal autonomy."

9 Cooperation among public institutions, the intensity of the catalogue services, the conditions and amounts of financial benefits, criteria for participation of beneficiaries and the scale for the recognition of the dependency situation.

public and their organisation is the responsibility of the local authorities of Andalusia, who can manage them directly or indirectly. In the direct management system, the organisation, monitoring and supervision of services is carried out by local corporations, recruiting also directly among the staff of the municipality. In contrast, in the indirect management system, a local corporation provides beneficiaries with the resources necessary to hire caregivers directly. In the case of the Granada Council, the management (i.e. the functions of coordination, monitoring, supervision and overall evaluation of the service and staff) is done by the local government, while the provision of services at home is contracted from one company according to the regulations concerned (i.e. in Granada, an indirect system exists and a mixed system for delivering the care service). The contracted company must be available throughout the term of their accreditation as an entity providing the service through a very stable workforce to make the service viable.

At national level three dependency degrees[10] have been defined (see note 8) based on the autonomy or need of help of the beneficiary. The average time for the assessment of the state of dependency is three months. It is estimated within an average time of 12 to 18 months from application to the application of the service in the cases that obtain an assessment of dependence with a sufficient degree and level. The “agility” of the system is divided into the time between the assessment of dependency and the development of a Personalised Attention Programme[11] (PIA), e.g. what has come to be called “The Limbo of Dependency”[12], a period in which people have reached a degree and level of dependency strong enough to have the right to receive support, but in which they are the victims of a policy “to limit the expedients” and find themselves in an excessive waiting situations.

KEY CONCEPTS:

Regional Government and Delegation to Municipalities; (Territorial Council of) System of Autonomy and Dependence Care (SAAD); Direct and Indirect Management of Home Service; Public and Private Sector's Synergy; PIA.

GERMANY

The State Health Insurance (1883) was developed by Bismarck as the first social insurance in Germany and in Europe; other social insurances followed, such as the insurance of accidents (1884), the insurance of pensions (1889), the insurance of unemployment (1927) and the insurance of care as part of the health insurance (1995).13 With the introduction of the social insurance of care the last big gap of social insurances was closed and a new basis for the need of care's risk coverage was founded. In addition to benefits, the duties of social insurance are the prevention of

10 Moderate dependence, strict dependence, heavy dependence.

11 This programme determines the real service or benefit that the beneficiaries will receive.

12 Since 2008 ca. 240,000 people have been kept in a situation of recognised dependency not receiving any assistance at home (Law 39/2006).

13 Members of state insurance of illness are automatic insured at the insurance of care.

illness and rehabilitation; moreover, the social insurance of care helps the needy and their affiliates[14] to take care also of personal and financial burdens. Health insurance is the only insurance where policy holders can choose between the compulsory health insurance system and private insurance. The insurance of care is not an insurance policy at full value; it is more a social safety net in terms of added protection, which does not make the personal contributions of the insured and other providers expendable. If no or false benefits of the insurance of care are delivered and those in need or their affiliates who are legible for support do not have enough personal contributions to take care of the remaining costs for the needed and adequate care, also the benefits of the social welfare may be used to take care of the individual fulfilment of demand.

The state leaves the management of the services in the hands of self-governing corporate bodies and alliances, mostly the state health insurances[15] and the hospital operator's alliances. The German system is dominated by small enterprises[16] which provide care assistance. The provided services in the healthcare system consist of outpatient healthcare, care at hospitals, nursing homes and federal facilities. In addition, there are alliances between public welfare and private care providers among the providers of care in Germany. The lawgiver sets the rules according to which insurance companies have to carry out their duties, and the federal agencies administrate the corporate bodies; also the care provider's professionalism is supervised and regulated by the federal agencies. The public healthcare system may allow the provision of care services (both at home or in care homes) only by care providers with whom a care provision contract exists: only if such a contract between public healthcare and care providers exists, may the supplier act and charge costs to the public healthcare's account (i.e. if they are accredited care providers). A care provider is only allowed to get an accreditation for the health fund if: (a) the company has at least four employees; (b) the healthcare services, as well as the representation of qualified nurses, have work experience in outpatient and inpatient facilities; and (c) the company has at least two full-time staff members.

Benefits and conditions of the care insurance are regulated by the SGB XI. The Medical Review Board of the Statutory Health Insurance Funds (MDK) assesses the quality of the care providers and which benefits shall be delivered to those in need. The MDK's duties are regulated by the SGB V. The MDK is part of the state insurances and is, in every federal state, organised as an autonomous joint venture. The MDK is funded by its carriers, the health and care funds on federal state level, and the costs refer to the number of members. As the medical services work for the health funds as well as for the insurance of care, the health and care funds each pay 50 per cent.[17]

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14 88% of citizens have state insurance; nearly 12% have private insurance.

15 The insurances of illness are corporate bodies under public law, which get an allowance by the state for doing federal work.

16 In general, care providers aided 43 people who were in need of care.

17 In 2008, the state health insurances and care's total expenditure was ca. €540m.

The federal states, the municipalities, the care facilities and the health funds have to work very closely together with the MDK to assure a capable, locally structured, close-to-home and concentrated out- and inpatient care for the people. The federal states are in authority of an expostulation of a capable, numeral fair and commercial caring provision. The municipalities have to attend in terms of services for public (indemnification of the provision with fair social infrastructure) the socio-spatial design; in the future, it will be the municipality's duty to upgrade the provision of care for those in need. Also networked bargains and incompetent-work may only be regulated by municipalities. Another important duty of the municipalities in the future will be to coordinate together with the elderly all offers of care and support. The duties of the local authorities are stipulated in the German law on the care for the elderly.

To fulfil different demands, the lawgiver has defined three levels of care: the term "care level" of the insurance of care complies with the custodial and budget-side necessity of help of at least 90 minutes each day (Level 1) up to 5 hours per day (Level 3). The state insurance of care comes to aid if common activities of daily life cannot be performed for an estimated period of at least six months - to the full extent in the case of illness or disability.

In 2008 the insurance of care system underwent some changes. The most important changes are: (a) the upgrade of the benefits for people with disabilities; (b) the upgrade of the benefits for day- and night care; (c) the activity's dynamic sampling; (d) the introduction of a nursing care time for employees; and (e) the improvement of quality management and the development of transparency. Moreover, the coalition parties which form the federal Government agreed (October 2009) on a plan that aims for a new, differentiated definition of high maintenance[18] and to apply approaches already in existence to the assessment. The new instrument aims for a broad regard of high-maintenance, so it avoids the cutback of high-maintenance to the need of help in some certain action of daily life. A major improvement has already been achieved with the new reform package for the care by affiliates. An employee may get up to six months of free time if he or she cares for an affiliated during that time. This is called nursing care time.

KEY CONCEPTS:

Care Insurances; Public and Private Sector's Synergy; Care Provision Contracts (i.e. Accreditation System); Municipalities as Care Service Organisers; Role of MDK.

ENGLAND (UK)

In 2007 the 'Our health, our care, our say' White Paper[19] and the Comprehensive

[18] Since insurance of care's introduction it's animadverted that the term of high maintenance is argued somatically too narrow and one-sided in the SGB XI. Prevalent aspects would be blanked out of the discussion and not enough allowed for, for example the communication and social access and the need for common assistance, supervision and guidance, in particular for people with limited daily living skills. So there's a danger to segregate people from the benefits of SGB XI, for example people with dementia.

[19] Momentarily under discussion as there was a change of Government in May 2010.

Spending Review announcement outlined the key elements of a reformed adult social care system in England (due to the ageing of society and the new, more personalised expectations of beneficiaries). The Paper was above all unique in establishing a collaborative approach between central and local government, the sector's professional leadership, providers and the regulator, who recognised that real change would only be achieved through the participation of users and carers at every stage: it sought to be the first public service reform programme to be co-produced, co-developed and co-evaluated. It acknowledged that local government would need to spend resources differently, and the Government should provide specific funding to support system-wide transformation through the Social Care Reform Grant. Local authority leadership accompanied by authentic partnership would work together with the local National Health Service (NHS), other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high-quality care system which is fair, accessible and responsive to the individual needs of those who use care services and their carers. Local authorities and their partners would jointly agree how this funding would be spent to develop the personalised system. The personalisation of the care service, the central point of the NMS, represents an innovative way of thinking of the care process. The concept starts from the point of "thinking about public services and social care in an entirely different way – starting with the person rather than the service. It requires the transformation of adult social care".[20] More concrete personalisation means a service which: (a) finds new collaborative ways of working and developing partnerships, producing a range of services for people to choose from; (b) tailors support to people's individual needs; (c) recognises and supports carers, enabling them to maintain a life beyond their caring responsibilities; (d) accesses service and resources to everyone; and (e) supports early intervention and prevention.

All the homecare agencies as well as the home care provisions are regulated by 27 standards, called National Minimum Standards (NMS), established by the Department of Health and regulated by the Care Quality Commission (CQC) since 2000. Brevity and summary of the standards ensure: (a) the access of the beneficiaries to information related to the service as well as to the provider; (b) the personalisation of the service; (c) the transparency and the beneficiary's knowledge about the carers' skills and training levels; (d) the transparency about the functioning of the management, business and planning ability of the providers; and (e) the high regard of the beneficiaries' privacy. Moreover, the CQC points out five strategic priorities,[21] two of which are based on an increasingly improved joint approach between health and social care as well as intensive partnership work with external agencies (i.e. health centres, leisure centres, etc.).

The majority of people in receipt of homecare receive their services via local social

20 Definition of the Social Care Institution for Excellence.

21 The other points are: the beneficiary at the centre of the service; promoting high-quality service, eliminating poor quality care.

services, which assess the need for help according to eligibility criteria related to the person's needs. There are two different ways to evaluate the eligibility of the beneficiaries: in the case of the "personalisation" of the service the responsibility lies with the local government and the services are carried out through "hubs"[22]; in the other case, the eligibility of the beneficiary will be assessed by local authorities through social services. If the beneficiary is eligible to receive homecare service, the social worker will arrange for this to be provided. The social worker will draw up a care plan together with the elderly person, taking into account their specific needs. After the service has been arranged by the social worker, a homecare organiser will visit the beneficiary in order to: (1) discuss and agree with the elderly person how best to provide them with the service, using an Individual Service Statement; (2) conduct a risk assessment which will look at health and safety issues relevant to the elder person and the staff member; and (3) assess any manual handling issues. The homecare service is available throughout the day and evening. Most councils outsource the supply of homecare services to the independent sector, which now provides over three quarters of publicly funded homecare. Social care funding in England is due for a major government review and the current agenda is to ensure that service users who are eligible for state-funded care are allocated an up-front "personal budget" that allows them to design their care packages more freely (i.e. employing their own staff, using a homecare provider of their choice, etc.).

Current situation[23]: The government's vision for the transformation of adult social care, called "Putting People First" (2008), expressed the hope that every local authority would create forums, networks and task groups involving staff across all sectors, people who use services and carers as active participants in the change process. The document was followed by a Department of Health Adult Social Care Workforce Strategy "Putting People First – Working to Make it Happen", which identified the key issues for the workforce as set out in Putting People First and then elaborated them into broader strategic priorities for the workforce.[24] The document also formed the basis of the wider stakeholder's – whether public service or private and voluntary sector – engagement with the development of the strategy: less direct management control over people's lives by social care professionals, but still ensuring they carry out their duty to care. This approach recognises that people who access social care have different levels of capabilities (i.e. some are able to exercise full choice and control and understand the consequences of their actions; others may need greater support and guidance in some areas of their lives to be able to participate as active and equal citizens). Putting People First was then followed by the promised Government Green Paper "Shaping the Future" (2008); with this document the government recognised an

22 They assess the person's needs and then allocate the work to the appropriate or chosen homecare agency.

23 It is referred to the state of art before the election; due to the change occurring in the Parliament, the foreseen action of the previous government might not be undertaken by the new one.

24 Strategic priorities: recruitment, retention and career pathways; workforce skills development; workforce remodelling – new models of personalised care; leadership, commissioning & management skills; joint and integrated working; regulation (quality improvement).

urgent need to begin the development of a new, more personalised and high-quality adult care system. Over the coming years, the role of local authorities will increase in importance in making sure that there are high-quality services available in their area, working closely with providers – including those from the third sector and private sector.

KEY CONCEPTS:

Independent Sector; High Personalisation of Care Plan; National Minimum Standards (NMS); Increasing Role of Local Authorities; Private and Public Sector's Synergy.

HUNGARY

The homecare services (i.e. the costs of the services, the framework for the eligibility of the assistance, the number of visits, the reporting system of produced services, etc.) have been uniformly regulated on a national level since 1996 by an act of law. Being ensured by the National Health Insurance Fund (NHIFA) is obligatory for every citizen; therefore, everyone has the right of free provisions in case of necessity. Moreover, the NHIFA is also responsible for the drawing up of the reporting system of purchased care services valid for all the country.

The providers, who belong to the Health Ministry, in order to conduct business in the homecare sector, must adhere to an inner quality assurance system. The operational standards are related to the assistance centre equipment, i.e. office rooms, computers, printers, in addition to the completeness of nursing instruments and equipment, i.e. nurse bag. This means that the pool of providers comprises only providers that have been already proofed and accredited by the Public Health Institute. Within a settlements more providers organise, in competition with each other, the homecare service, receiving government funds from the NHIFA. The choice of the provider is the free decision of the patient; however, funding is limited by a given number of visits, which is nationally defined by an act of law, as stated above.

On the territory are present two different levels of homecare activities, both defined by acts of law: homecare assistance and domestic care assistance. Regarding homecare assistance, the eligibility of the service is related to an independent and professional committee's decision, composed of the family doctor, a nurse and a social worker. In contrast, the family doctor and the notary of the local government[25] submit an application for the request of domestic care activities, which are discussed and organised in collaboration with a nurse or a nursing assistant and a social worker.

Once started, the process of homecare provision (both for homecare and domestic care) is continuously monitored by the leader of the homecare service and the family doctor, who check the nursing activities after every 14 visit, producing an updated nursing plan for the beneficiary. Some limitations in delivering the care services exist in

[25] As the service is directly organised by the local government.

rural areas where the local authorities do not have enough financial sources to provide the services.

KEY CONCEPTS:

Role of National Health Insurance Fund (NHIFA); Public and Private Sector's Synergy (i.e. only Accredited Service Suppliers).

SLOVENIA

In Slovenia, various services and financial allowances are provided as part of the existing social protection system (i.e. health, social security, pensions and disability insurance). However, the system of long-term care for senior citizens (also for other categories) is not uniformly regulated, with the result that care providers are not well coordinated and the consequent drop in the quality of the services. Generally, services in the domestic living environment are still relatively badly developed, which poses an additional pressure on the prolongation of costly hospitalisation and extension of institutional forms of care.

Under the Social Assistance Act (SAA) of 2007, domestic assistance is one of the social security services. It comprises of the provision of social care (i.e. housework assistance, assistance in maintaining personal hygiene and assistance in maintaining social contacts) and medical assistance for persons with disability, the elderly over 65 and chronically ill persons, substituting institutional care. The service starts at the request of the beneficiary or their legal representative and comprises of two parts. The first part is the determination of service eligibility (proofed by a social worker or the head of home help), the preparation and the conclusion of the agreement as to the extent, the duration and the method of service provision, the organisation of the key members of the environment and the implementation of the introductory meetings between the provider and the beneficiary or their family. The second part is the direct execution of the (social and medical) service at the home of the beneficiary according to the agreed programme. The Rules on Standards and Norms of Social Security (Rules on Standards) stipulate that the direct execution of the service per beneficiary lasts approximately for up to four hours per day or for up to 20 hours per week.

Domestic social help falls under the competence of municipalities: the municipality may select the service provider(s) and by means of the amount of the municipal subsidy affects the price of the service paid by the user, influencing significantly the level of accessibility to the service. At the same time, this means that various municipalities have quite varied policies regarding the implementation of domestic social help. In 2004, the national Social Security Act was modified, introducing an at least 50% obligatory subsidisation of the service on the part of the municipality, which was an important step towards more stable financing of the service. In consequence, the prices

for care services have considerably decreased since 2003[26].

The majority of organisations (88.5%) providing domestic help is of public institution status: in 2007, there were 63 public institutions providing domestic help, whereas in 2008, there were 69. These institutions were mainly centres for social work (71.1% of all providers) holding the status of a public institution and elderly homes (14 elderly homes). In addition, a good proportion, i.e. 11% (9), of domestic help providers were concessionaires (i.e. the municipality covers a part of the costs related to the economic cost of aid given at home) in 2008.

KEY CONCEPTS:

Social Assistance Act (SAA); Rules on Standards and Norms of Social Security; Municipalities as Service Coordinators.

[26] The differences in prices among municipalities exist partially due to various municipalities' policies regarding this service, but partially also due to the fact that not all providers of domestic help employ "subsidised employees" on the basis of the measures of the active employment policy.

SUMMERY CHARTS

Tab. 1 Typologies of homecare service management (social health services)

	IT	DE	HU	ES	UK	SLO
Public management						
Public/private management	**X***	**X***	**X***	**X***	**X***	**X***
Private management						

* Public accreditation of private care assistance structures.

Tab. 2 Typology of intervention carried out by accredited providers

	IT	DE	HU	ES	UK	SLO
Social assistance	X	X	X	X	X	X
Health assistance						
Integration social-health assistance	X	X	X	X	X	X

Tab. 3 Person(s) responsible for the eligibility of homecare assistance

	IT	DE	HU	ES	UK	SLO
Commission (i.e. GP, social worker, nurse)	X*	X*	X*	X	X*	
Social worker			X			X
GP/civil servant			X			

* In collaboration with the beneficiary and/or their family.

2.2 Which professional or non-professional people carry out the homecare service?

ITALY

The first base of care and nursing for the elderly remains the family, conducted particularly by the female members. Although due to the transformation of Italian families,[27] some changes related to the care organisation within families have occurred. In this context, the 'do it yourself ' approach is increasing in families, promoted by the increasing presence of huge numbers of women coming from Eastern Europe who offer to nurse old people at costs sustainable for families. The carer does not fulfil the entire process of assistance to the elderly, but they have some prerogatives particularly important to families: (a) a service of alleviating the responsibility of care of family members, especially for the female members of the family; (b) the permanence of the person in their own home or among the family; and (c) the cost, even if it weighs on the family budget, can be considered low (an average of €700-800 per month[28]). These figures are often criticised although the profession of the carer could be improvised; on the other side, the treatment[29] needs specific vocational training. In response to this criticism, the municipality of Parma has defined the guidelines for the future Register for Family Assistants and its relative front-desk in an experimental way. The register, a public list of professionals providing homecare assistance services, has the objective of ensuring the care and protection of elderly and disabled users, and of improving the quality of the service. The register presents itself as an instrument able to aid employment, offer qualification opportunities to registered staff and consequently, to help discover undocumented work. Authorisation of entry in the register will be given only either by fulfilling specific requirements or after taking part in a vocational course and successfully completing a final exam.

In the area of professional assistance, as mentioned above, it is possible to distinguish two homecare services; both are related to an intensive number of voluntary workers: (a) the Integrated Home Assistance (ADI), organised by the Local Health Authority; and (b) the Home Assistance Service (SAD), which is organised by the municipality. The ADI supplies both health and social aid and is thus based on professional health and social figures. The service comprises of three different levels of care intensity, based on the needs of the patient. Although each case is personally organised. In the majority of cases, the family doctor decides for the activation of the service and the service is then carried out by nurses and social workers with the help, where necessary, of some specialists (i.e. physiotherapists, specialised doctors). The service is guaranteed only during ordinary working hours.

In contrast, the SAD worker provides assistance for elderly people with their normal daily activities (i.e. personal hygiene, meals supply, social secretary, home help, but also psychological, care and social support such as organisation of recreational events)

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27 I.e. the increase presence of women in the labour market and the consequent less time dedicate to care-assistance.

28 Excluding other costs such as incontinence pads, medication, equipment that eases the movement of the elderly person, and so on. The average total expense for an elderly person's assistance is of about 1.100-1.200 Euro per month.

29 An action/a subject that presuppose an evaluation of the status of need, an analysis of the resources so to order a therapeutic intervention plan.

with the aim of helping them stay in their own home. The assistance is carried out with the synergy of social workers responsible for the care assistance activities (RAA) and social-health assistance workers (OSS). SAD is guaranteed 24 hours a day, 365 days a year and is organised in such a way that it can be activated within 24 to 48 hours, with no waiting list for the beneficiaries.

KEY CONCEPTS:

Family (Female Members); Sole Traders Caregivers (mainly Women from Eastern European Countries); Register of Carers; SAD; ADI; RAA; OSS; Social Workers; Volunteers.

SPAIN

The service of homecare can be carried out by: (a) non-professional carers (caregivers who look after those who are in a dependent situation, i.e. family members, not linked to a professionalised service); (b) professional carer (provided by municipalities or organisations with or without profit or self-employed); (c) personal assistants (service provided by staff that assist in tasks of daily life of individuals in dependency situations in order to promote independent living, to promote and enhance the individual's personal autonomy); and (d) third sector (private organisations which emerged from the civil or social initiative, meeting criteria of solidarity and with no profit interest).

Staff with different profiles is working in the Department of Social Welfare on the services of social services with specific duties and sectors of intervention. Similarly, in each of the Municipal Centres of Social Services, interdisciplinary teams are at work, consisting of social workers, psychologists, educators, etc. In addition, to enable comprehensive action, other staff may participate in social services (psychologists, educators, etc.) as well as the required personnel for administrative and organisational tasks. The educator supervises guidance in the creation or modification of convivial habits to support integration and socialisation of the user of home assistance services (i.e. promote and maintain personal autonomy, encourage adequate habits of behaviour and acquire basic skills for both personal development in the family unit, at home and in their relationship with the community).

The basic equipment for the service consists of social workers and auxiliary assistants at home. The social worker is asked to study, assess and manage the demand to aid the diagnosis and design the adequate project of intervention. During the assistance time, the social worker is also in charge of monitoring and assessing the adequacy and effectiveness of the service and to advice, monitor and evaluate interventions in relation to voluntary service. Furthermore, trying to coordinate other services and resources of the social services network or to collaborate with other systems of social protection is also a task foreseen for social workers. A final and important further task of social workers is to facilitate and to promote the training and retraining of home assistance staff. Home assistance staff members are people who are in charge of carrying out tasks organised by social workers. Auxiliary staff of home assistance is

competent to carry out the actions of a domestic and personal nature (i.e. assist in the integration in individual situations or in groups, facilitate the user's communication channels with their environment and with the technical staff in charge of the service; document in the register that corresponds to the model for the service; participate in coordination and monitoring services, providing the necessary information about users). The auxiliary of home assistance can be part-time public servants or "hired" staff from private suppliers. They are mostly composed of women coming from South America, who have already practised either legally or illegally the work of a carer.

KEY CONCEPTS:

Family; Professional Private or Public Carers; Third Sector; Role of Social Worker; Auxiliary Staff (mainly Women from South America).

GERMANY

About one half of all people in need are aided at home by relatives (mostly females) in Germany, the other half receives professional care. In both situations, those in need are able to receive financial benefits from the public healthcare system. If a care service is used, the benefits will only be paid if it is an accredited care service provider. Accredited services are governed by special quality criteria checked through regular inspections. Therefore, it is guaranteed that only qualified personnel are employed and that only proper aid and benefits are delivered. The costs of 24-hour care make demands on the care level and hence on the support expenses. The costs are currently between €2,700 and €3,200.

If the care is provided by non-accredited personnel (relatives, neighbours, etc.) or care providers, there is only a claim for the public health care. The costs which are generated by the care can be brought in the health care, while you have to detect the costs by a bill of charges. Should medical actions be necessary, such as changing of dressings, these are met, if approved by the health insurance. Those who use funds from the insurance of care have the choice between two forms of benefits. The nursing allowance can be used for the care by relatives, neighbours or non-accredited employees of care providers. These carers receive a monthly fixed amount and the individual can also assign an accredited provider of care. Public healthcare, for as long as care is provided, the carer is paid by the public healthcare system up to an amount determined by the designated care level. As long as the person in need uses an outpatient care provider via self-organised care providers, a combination of non-cash benefits (cash benefits is possible). The part of the money decreases by the percentage in which benefits of accredited providers are accessed. For example, a user can apply for 40% of the benefit money if they claim for 60% of the care benefits amount.

In 2005. there were about 11,000 accredited outpatient care providers in Germany, 57.6% of which were private and 40.6% charitable ones. Public providers had – according to other providers' precedence relating to SGB XI – a lower contingent

(1.8%). Approximately 14,000 people were employed by these providers; 87.7% were women, and nurses were the main group in respect of job-related qualifications. Outpatient care takes place in the household of the individual in need and a professional care provider supplies local support. Outpatient carers' benefits are provided by organisations of public welfare (Caritas, Bavaria Red Cross, outreach ministry, central welfare commission for German Jews, etc.) as well as by communal welfare centres or private, commercial providers of care.

A nursing allowance is paid if the person is cared for at home by relatives or another person of the individual's choice (neighbours, friends) in a capable way. Frequently, the effort of caring relatives is annealed by the needy of care.

In 2007, 23,600 people were employed in the outpatient sector; 88% of them were female and 71% worked part time. 69% of the employees had their primary work in basic care and the majority had been trained as health caregivers and nurses or as elderly care nurse. Compared to 2005, the impact of the outpatient services grew, with a boost in employment of 10% (Federal Agency for Statistics).

Elderly care nurses work in many areas – mainly in nursing homes, outpatient services, short-time care services and daily care homes. They are also employed in geriatric gerontopsychiatric professional hospitals, hospitals, hospices or in facilities of sheltered living. They work as a team – with co-workers as well as professionals in other healthcare jobs or social work; for example, in care and rehabilitation, they work very closely with doctors.

The assignment of a caregiver from a foreign country (mostly female carers who come from Eastern Europe) is an alternative to German nursing homes and outpatient care providers or the individual care provided by relatives, due to the high costs of care in Germany. In fact, the assignment of a foreign caregiver is often the only alternative for relatives as care from care providers is too expensive. However, it is crucial to gather enough information prior to assigning care responsibilities to a foreign carer as their legal status may need clarification. The caregiver should have a work permit from the Federal Employment Agency and not only a tourist visa. If a caregiver comes to Germany for three months to work and then switches position with another caregiver, this could be an indication of illegal work on a tourist visa. It is very important to find a good agency to make sure the staff is qualified and to assure a good level of communication as different languages may be spoken. The person in need of care must carry the financial costs of a foreign carer alone, but may use their individual care level allowance towards these costs. In addition, they must provide or find funds for accommodation, at least a room in the case of 24-hour care.

There are many private agencies which are specialised in supplying carers from outside Germany. These companies establish the contact and take care of the formalities. The official path leads to the ZAV, the central intercession agency for foreign workers of the Federal Employment Agency. At the local Federal Employment Agency, a person in need of assistance can apply for a home help if necessary. Since

January 2010, home helps have been allowed to do simple care tasks and unskilled work. Should a suitable carer not be available on the German job market, the agencies may turn to foreign candidates. The person in need of care may also seek a suitable home help and then inform the agency. These helpers are allowed to stay in Germany for up to three years and must be paid the same rate as German home helps; depending on the federal state, the average gross income is about €1,300 per month, including social security taxes. Even on the internet many companies advertise to bring foreign home helps to Germany. They are not allowed to work as officially as caregivers but in most cases they do. There are no statistics to indicate how many illegal caregivers are currently employed in Germany. Estimates vary from about 60,000 up to 150,000 caregivers, who are predominantly from Eastern Europe and support people in the home care of their relatives or are employed as full-time aid. A home help living in a German home is available 24/7 and supports the daily needs of the person they care for.

Another example of illegally employed caregivers is executed through a care provider in another country being placed in a German office. Although instructions from a German client are not allowed it is daily practice.

KEY CONCEPTS:

Family (Female Members); Private Suppliers; Charitable Providers; Nursing Allowance; Foreign Caregivers (mainly Women from Eastern European Countries); ZAV; Carers Recruitment through Providers Abroad.

ENGLAND (UK)

It is estimated that the domestic care workforce in England makes up around one third of the entire social care workforce. In 2003/4, an estimated 922,000 people were employed in traditionally defined 'core' social care (i.e. including local authority social services staff, residential, day and domestic care staff, agency staff and a limited number of National Health Service staff[30]); of these, an estimated 61% (ca. 559,000) were working in services for elderly people. In 2008, the service was provided in England by 4,960 homecare registered agencies, of which 4,146 (84%) were based in the private and voluntary sector. The social care workforce is predominantly female (83%, increasing to 95% in sectors such as residential and domestic care) and mainly part-time workers. The workforce includes people of all ages, but especially 35-49-year-olds who account for 40% of the total, compared with 35% under 35-year-olds and 25% 50-year-olds and over. However, establishments for the elderly tend to employ older workers (compared to other care sectors): men aged 75 and over were more likely than women of the same age to be carers (4.6% compared with 2.4%, respectively). Social workers' pay levels are among the lowest of the professional occupations, although recruitment problems seem to have put pressure on rates of pay and led to some improvement in recent years. The average pay of care workers is

30 12% of employees in the care sector are born outside the UK.

about £6.80 hourly; although the pay range of care workers is much wider, reflecting the diversity of seniority, experience, qualifications, settings and employer types among care workers.[31]

The importance of the independent sector must be emphasised as the main provider of social care services: ca. 65% of the homecare workforce, i.e. an estimated total of 306,000[32] people, are employed by independent providers and 44,000 are employed by local authorities (however, reliable statistics on the number of workers employed do not exist). The number of workers in the statutory sector is reported to have fallen as local authority in-house provision has decreased; the total number of people employed across all sectors of domestic care in England is now estimated to be 163,000, compared to 202,500 in 2000. At this point, each worker is on average delivering 25% more hours.

In the UK, the phenomenon related to qualified carers working outside their place of employment also exists; they provide additional hours and are unofficially paid by an elderly person or their family. The existence of a robust black market of non-qualified home carers (friends, neighbours, etc.) has also been acknowledged, but it is extremely difficult to find information and statistics to quantify it (as by definition, it is a market hidden from regulation authorities and no statistics are therefore available). Although the government recognises that family and friends play a vital role in caring for people in need of care and support, informal or unpaid carers represent a huge share of the total social care workforce capacity: in 2001, 4.8 million carers aged 16-74 and more than 340,000 people aged 65 and over provided 50 hours of unpaid care per week; the majority of informal carers in England provide between one and 19 hours of care per week, a quarter of them provide round-the-clock care; a quarter of English families receive care from grandparents; in England there are 5 million older[33] volunteers in the care services; 4.2% of women aged 65 to 74 are providing unpaid care assistance compared to 3.8% of men in the same age group.

KEY CONCEPTS:

Home Care Registered Agencies (Private and Voluntary); Independent Qualified Carers; Non-Conventional Unpaid Carers (Family, Neighbours, Friends).

HUNGARY

Homecare, which can be private or public, is paid by health insurance companies and the service is delivered only by special and highly qualified nurses for a yearly maximum time of four cycles, each composed of 14 visits, for a maximum three hours a day.[34] The home nursing service supplies both health and social help; thus, the service

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31 There is little evidence to suggest that NVQ-qualified care workers are paid more than unqualified ones.

32 271,000 are care workers in the private sector; the rest are engaged in the voluntary sector.

33 The definition varies from agencies to agencies: old age is usually 65+ and older 60+, but in some agencies the term old refers to 50 or 55.

34 In case the 14-visit cycle is not enough, the family doctor, in cooperation with a nurse, can decide to continue the service for another 14 visits.

is based on professional health and social figures. In the majority of cases, it is the family doctor who decides for the activation of assistance and then the service is conducted by professional nurses in collaboration with the family doctor and, if needed, some specialists (i.e. physiotherapists, speech therapist, dietetic experts). Nurses and caregivers are in most cases part-time employees or healthcare freelance workers. The workers' pay is fixed individually by each private provider, or regulated by national rules in the case of public servants.

As an alternative or addition to the homecare service, the law foresees the so-called domestic care based on housework and daily life support activities. The service is organised by the local government, delivered by accredited suppliers and ordered by the family doctor (sometimes at the family's or patient's request). The costs are entirely carried by the beneficiaries and depend on the client's income. The service foresees help with basic needs and is thus carried out by helpers or nursing assistants with a lower qualification level (in comparison to home carers). The service is available from Monday to Saturday from 8am to 4pm.[35] The organisation of the assistance is carried out in collaboration between social workers, the family doctor and the patient's family and/or the patient. Domestic caregivers, i.e. people who actually provide domestic aid, are not considered homecare workers.

Even if the two bodies are occupied in different tasks and have different status, there are often difficulties to differentiate between health and social sector's responsibilities, so that the two are often confused with each other. Generally, the confusion is related to the fact that domestic carers complete the work of professional carers in after-care activities. Moreover, a form of cooperation between home nursing carers and domestic carers is foreseen in homecare packages, which include a broad spectrum of health and social assistances.

In conclusion, the employers in homecare are represented by the Council of Hungarian Health Care Workers and Community and Hospice Professional Care Branch, an organ that collects the data about homecare services and which produces annually an obligatory report on the homecare services (i.e. the number of care patients, visits by gender and age group, foundling's form of the activities, etc.).

Regarding the aspect of informal carers, there is no formal recognition of these figures. The law foresees the possibility of giving an allowance to family members who are assisting a relative at home.

KEY CONCEPTS:

Public and Private Home Care (free of charge); Public or Supplied Domestic Care Service (to be paid); Collaboration among Care Figures; Allowances; Non-Conventional Care (Neighbours and/or Qualified Workers employed illegally).

□ SLOVENIA

35 During the remaining time, as well as at weekends, private suppliers will provide the service, although there is a lack of private providers.

In Slovenia, part of the care service is provided by institutional forms of health care in the form of non-acute hospital care; moreover, in the framework of the social security system, the users are cared for with various services, such as daily and all-day forms of institutional care, (social) assistance at home, the right to a homecare assistant, care in sheltered housing and various social security programmes of personal assistance specifically for disabled persons. The "burden" of social homecare is supposed to be taken over by the local community; however, this is being currently carried out to the least possible extent. The fact is that the major form of assistance with the everyday life of a senior citizen is provided by the person's family, in particular by female relatives.

The number of elderly people is growing and the state cannot satisfactorily meet the needs of senior citizens; therefore, a common phenomenon in the sector of homecare is also taking place in Slovenia: people who need several hours of daily assistance often opt for neighbours, friends, females recommended by acquaintances to perform the service of security and care on the basis of "cash in hand".[36] It must also be mentioned that various societies, such as the pensioners' society, the society of the deaf and hard of hearing, and various organisations for disabled people provide various forms of assistance to their members. Assistance in societies and various religious organisations is mainly based on voluntary work and aimed at preventing loneliness.

Considering the professional domestic social care services, care is provided by qualified professionals as well as by qualified assistants and by laymen under the management of qualified professionals. Domestic social care is, in compliance with the Rules on Standards, aimed at persons who are provided with residential and other conditions for living in their environment, but who, due to old age or severe disability, cannot look after and care for themselves, neither can such care and nursing be provided by their relatives. Domestic social care includes the cooperation[37] of the manager and the coordinator of the service, the provider of the service, the beneficiary, the responsible family members and volunteers.

Complementary forms of domestic care are provided by social services. These are defined as special services (i.e. housework, maintaining personal hygiene, companionship, etc.) and are provided to give assistance to people in need, also to the elderly, especially to help them remain at home for as long as possible and to assist the elderly person's relatives. Social services are not performed as a public service,[38] which means that the beneficiary must pay the whole cost.

In addition to public institutions which implement the domestic help service to the greatest extent, recently, the field of senior care has been opened as a profit-earning area. Increasingly, more people decide to become sole traders, providing either

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36 There is no data about figures or percentages, but it's a growing phenomenon.

37 According to the Rules on Standard, one carer is foreseen to look after five beneficiaries, one person responsible for the management of the service for 100 beneficiaries and one person responsible for the determination of the eligibility and preparation of the agreement for 200 beneficiaries.

38 Social services can be also implemented by those licensed to work with the Ministry of Labour, Family and Social Affairs.

domestic social care or domestic medical care and nursing. A further category is defined by the “senior security” assistant: people offering care assistance as supplementary work qualifications are required. For the personal care of the elderly as well as for the supplementary work of carer, qualifications are required.

It is possible that people become homecare assistants to remove their name from unemployment lists. The home are assistant may also be employed for fewer working hours than those of a full-time worker. The homecare assistant has the right to partial payment for lost income at the level of a minimum wage or to a proportional part of the payment for lost income in the case of part-time work. The person in need retains, in the event of choosing a homecare assistant, the entitlement to an attendance allowance; however, on the basis of a written statement submitted with the application to increase the rights of a homecare assistant, the person needing assistance agrees that during the period when assistance is being provided, this allowance is paid to the municipality which finances the homecare assistant.

KEY CONCEPTS:

Public Care Service (local communities' task); Family (female members); Non-Conventional Care Service (neighbours/friends paid illegally); Volunteers; Domestic Social Servicing (to be paid); Independent Caregivers.

SUMMERY CHART

Tab. 4 Bodies carrying out homecare assistance services

	IT	DE	HU	ES	UK	SLO
A body integrating social and health assistance	X	X	X		X	X
Social workers			X	X	X	X
Nursing (assistant)		X	X	X	X	X
Relatives (*through allowances)	X*	X*	X*	X	X*	X
Persons not qualified,	X	X	X	X	X	X

external to the family						
Qualified persons working illegally	X	X	X	X	X	X
Charity work associations	X	X			X	X
Independent qualified workers				X	X	X

2.3 How is the homecare service financed? Which costs compete for the beneficiary for the family?

ITALY

The Regional Health Service is funded by resources derived from the IRAP revenue (regional tax on productive activities), from the regional additional to IRPEF (personal income tax), from the share of the excise on fuel and from a regional share of IVA (value-added tax). To these sources of finance must be added the Local Health Authorities' own incomes and the credit balance of the Health Mobility (reimbursement to the Local Health Service of the Emilia-Romagna region for the treatment services provided to citizens of other regions). Within the Regional Health Service, great importance has been given to the homecare sector.[39] In 2009, a target-specific three-year regional fund (the Regional Fund for non-self-sufficient people) was created to increase the synergy among health, social-health and social services under the

[39] Including principally: general practice assistance (57,2%), nursing care (36,4%), social welfare (4,9%) and specialist care (1,5%).

supervision of the municipalities.

The Municipality of Parma supplies an economic contribution, foreseen by the Region Emilia-Romagna, with the aim of maintaining non-self-sufficient citizens in their households. The allowance, which is assigned on the basis of an Individual Caring Plan (cf. Ch. 2.1), can be used to buy services from a panel of suppliers accredited by the local administration, and it can be paid to: (a) the beneficiary themselves, in case they can manage decisions about their care assistance; (b) the beneficiary's family who guarantee social assistance service directly or through the help of non-family members; or (c) the beneficiary's guardian. The service costs for the assistance are fixed by the local administration, and they are the same for everyone living in the district of Parma.[40] The costs are determined by the hourly rate of the agency of the employed operators, by the average of the annual cost of the vehicle used, by the cost of the operator's travel and by staff costs. Citizens contribute to the total service expenses according to their own income, with the amount varying from a maximum of €6.89 for every home assistance and €8.26 for several home assistances (for citizens in the 6th income bracket - over €619.75) to the exemption of citizens who fall within the 1st income bracket, i.e. up to €335.70.

KEY CONCEPTS:

Health Service Public Financed; Allowance from Municipality; Municipality fixed Service Costs; Beneficiaries' Contributions (for Social Services).

SPAIN

The implementation of the Community Social Services has been carried out with the financial contribution of the Ministry of Social Affair since 1988, through the “Programme for the Development of Basic Benefits of Social Services of Local Administrations”, an agreement signed between the Ministry and regional governments, aiming to ensure basic benefits to citizens from Andalusia in care situations. In Andalusia, Decree 203/2002 regulates the funding system of social communitarian services, distinguishing the credits from the State and those from the Autonomous Community, without setting the assumed share of funding local entities.

Order 15 November 2007 regulates the assistance at home services in Andalusia; Article 22 calculates the contribution of the individual user to the cost of the service, after determining the personal economic capacity. The personal economic capacity is determined according to the income and the patrimony. The law regulates the assistance at home in the area of Granada Council, providing “the duty of co-responsibility for the cost of the service based on their [the users’] personal financial capacity”. For family units, users of the social assistance service overseen by the Granada Council takes into account the annual per capita income, defined as the sum of income of each member of the family unit divided by the number of its members. On exception one may receive financial benefit to be attended by non-professional staff if

40 The same prices are guaranteed also for persons not entitled to the voucher.

the appropriate conditions of coexistence and habitability of housing and it's established in the Individual Programme exist.

KEY WORDS:

Social Services Publically Financed; Beneficiaries' Contribution; Allowances; Personal Economic Capacity.

GERMANY

In 2008, a total of approximately 10.7% of the GDP (Gross Domestic Product) was spent on healthcare. The German healthcare system is funded predominantly by the state health insurance's earnings and federal money. The social insurance is funded predominantly by the insured's contributions and, at times, taxes, as well as by employers and employees in equal parts. The contributions depend on the insured's gross income: in 2010, the social insurance contribution was about 31.25% - 33.35% of the income of middle- and low-wage employees. By payment of contribution and premium pay, the insured acquires a claim for help if classed as high maintenance; therefore, their business situation is irrelevant because the insurance of care benefits are independent of income and asset.

The public healthcare pays different benefits for those in need of care. These benefits are received as cash or non-cash benefits with which the basic care and budget is funded. The needed help can be delivered privately and unbureaucratically with the caring allowance. The non-cash benefits pay professional nurses; as this is much more costly than private help, the non-cash benefit's budget is considerably higher than for the nursing allowance. Both benefits can be combined. Furthermore, the insurance supports courses for care, flat renovations, maintenance utilities, short-term care, etc.

According to the levels mentioned on page 7, different public contributions are foreseen, defined by the law, paid by the insurance for homecare services. This refers both to allowances to be used for professional workers[41] as well as to the allowances foreseen for relatives[42] taking care of a person in need of care. A contribution from the beneficiaries or from the family is also foreseen.

KEY CONCEPTS:

Care Service Publically Funded (Federal Funds and Health Insurance's Earnings); Fees from Wages (Employers and Employees Contribute Equally); Caring Allowances; Beneficiaries' Contribution.

41 The highest public contribution, which means care for a person with high needs, was €1,432 per month (costs for professional assistance were between €2,700 and €3,200 per month) in 2007.

42 The highest public contribution, which means care for a person with high needs, was €665 per month (costs for non-professional care were ca. €1,200 per month) in 2007.

ENGLAND (UK)

The social care is publically financed by a combination of central government grants, council tax revenues, and user charges: in 2006, net spending by public authorities on care services for the elderly was £5.69 billion, while the private payment, including personal contributions to services partly funded by the state, was estimated to be £5.89 billion. Under Section 17 of the Health and Social Services and Social Security Adjudications Act (1983), local authorities are given discretionary powers to charge for non-residential social services. Moreover, in 2001 the Department issued statutory guidance on charging for home-based care and non-residential social services to all local councils, based on fairer and well-designed charging policies. In particular, service users on low incomes are protected from any charges levied on disability benefits and are subject to an assessment of disability costs to ensure that they are reasonable. Currently, anyone with assets valued at over £23,500 receives no state assistance. In the current system, people who have the highest needs and lowest means get some help through the social care system or through the disability service. But by 2026, 1.7 million more adults will need care and support: 20% of people will need care that costs less than £1,000 – but another 20% will need care that costs more than £50,000.[43] In England, the policy dealing with adult homecare is based on increasing the personalisation of the care service. The individual budget (IB) is considered a way to reach a higher level of autonomy among beneficiaries. This way of payment is the alternative to direct payments, a means-tested cash payment made in place of regular social service provision to an individual who has been assessed as needing support. Following a financial assessment, those eligible can choose direct payment and arrange for their own support instead; the money included in the direct payment only applies to social services. Unlike direct payments, an IB sets an overall budget for a range of services,[44] not only from adult social care, from which the individual may choose to receive as cash or services or a mixture of both. IB holders are encouraged to devise support plans to help them meet desired outcomes, and they can purchase support from social services, the private sector, voluntary or community groups or families and friends. Assistance with support planning may come from care managers, independent support planning/brokerage agencies, or family and friends. The local authority is primarily responsible for ensuring that an appropriate range of

[43] Up to £100,000 could be the cost for a person spending years in a care home. If someone is in a care home and no one is living in their house, they are expected to use their savings and the value of their house to pay for care and accommodation.

[44] Integrated community equipment service, disabled facilities grants, housing-related support, access to work, independent living fund.

support is available to the people using the services.

KEY WORDS:

Social Care Publically Funded; Beneficiaries' Contribution; Protection of Low-Income Users; Direct Payments vs. Individual Budgets (IB).

HUNGARY

In 2005, the total expenditure on health amounted to 8.5% of the GDP: 2.8% of the total health expenditure for stationary care activities and 0.2% for homecare. In the same year, the total expenditure on care for the elderly amounted to the 0.38% of the GDP.

The National Health Insurance Fund (NHIFA) is responsible for funding homecare services: the Country Health Insurance Budget (i.e. NHIFA) sends the money to Regional Health Care Centres[45] which then divides the funds among County Health Insurance Centres. At this point, each county will transfer the money to the providers.

Funding for care providers is fixed, dependent on the number of (insured) inhabitants in the area where the provider works; the payments match the exact number of reported visits, which means that the funding resources are limited to a pre-determined number of monthly visits (laid down in Act 43/1999, Governmental Decree). The providers write a report at the end of each month and send it to the County Health Insurance Centre; if the insurance body approves of the report, the providers will get the money for their services (i.e. for every visit undertaken).

The financing of visits is entirely different by the funder: in professional health care, the visits are free of charge (98.1% of professional health care visits are funded by the NHIFA). On the other hand, in the case of domestic help, patients have to pay directly for the service and the costs depend on the beneficiary's pension. Normally, the money is not enough to cover the complete costs of the service, which is why the local government (to whom the domestic care assistance belongs and receives money from the state budget for this service) supports the beneficiaries.

Moreover, the healthcare and social services may work at the same time, which means that there is not a progressive and complementing system with a direct influence on aspects related to the funding of the services.

KEY CONCEPTS:

Health Services funded by the NHIFA (free of charge); Monthly Providers' Report; Domestic Help (to be paid).

SLOVENIA

45 Hungary has 7 regions and 19 counties.

Services and benefits related to homecare assistance are partially financed by taxes[46] and partially by social insurance contributions.[47] Beneficiaries[48] are obliged to pay for the costs of direct provision of domestic social care according to the agreed programme and the agreed extent. Beneficiaries who are incapable of making a payment, or whose ability to pay does not reach the value of service, may file an application at the Centre for Social Work for a partial or total exemption from the payment for the service. When it is determined that external assistance is needed,[49] the beneficiaries may also obtain monetary benefits which enable them to obtain informal methods of assistance. Moreover, for some groups of people (i.e. the elderly, people with disabilities, widows) an attendance allowance has been foreseen, which is a monthly monetary income paid by the government, in order to guarantee care and assistance. The allowance is given by approval of institutions' experts[50] or, under the law, due to certain medical circumstances, stating that the said person, in order to perform basic vital needs, inevitably needs constant assistance and attendance of another person, also valid for relatives. When determining the price of standard domestic care performed by a public service, the total cost of the service are taken into account in the following way: the amount is reduced by the subsidy provided by the municipality (at least 50% of the total cost), and the residual balance is then reduced by the subsidy provided by the state. This subsidy is determined by the Government of the Republic of Slovenia within the framework of the measures of the active employment policy. The provider of the service is paid by the Employment Service of Slovenia.

KEY CONCEPTS:

Home Care Publically Funded; Contribution by Social Insurance; Beneficiaries' Contributions; Partial or Total Exemption for Some Groups; Allowances.

SUMMERY CHART

Tab. 5 Assistance service's funding (social-health services)

	IT	DE	HU	ES	UK	SLO
With beneficiaries' contribution	X	X	X**	X	X*	X
Without beneficiaries' contribution						

* For workers earning more than £ 23,000 no free state assistance

** For homecare nursing, the beneficiaries do not have to pay. For domestic assistance, the beneficiaries have to pay; the amount depends on the beneficiary's pension.

46 Provided for in the state and municipal budgets.

47 Provided for in the framework of compulsory health insurance and compulsory retirement and disability insurance.

48 Persons liable for the payment of the cost of the service are, in addition to the beneficiary, also persons who are obliged to provide the beneficiary with means of subsistence as derived from the law or a contractual relationship.

49 As persons with disability, unemployed due to severe disability or war veterans.

50 Pension and disability insurances have their own medical commissions.

2.4 Training: What kind of training/qualification do the caregivers require? How is it structured?

ITALY

The caregivers' training for the Home Assistance Service is differentiated according to three main bodies already mentioned: the social worker, the OSS and the RAA (see p. 14 for the definitions).

Social workers obtain their qualification within a university degree divided into Bachelor and Master. The obtained qualification allows the social workers to be employed in various assistance fields, one of which is the homecare assistance for elderly people. The social worker is able to analyse and prevent potentially discomforting situations and difficulties of social integration.

The OSS needs to attend a vocational training course comprising 1,000 hours divided into practice and theory. If a person has skills in the care field, they can, after taking a skills examination, attend only the necessary courses (i.e. not the entire curriculum) in order to obtain their qualification. The qualification allows the caregivers to work in various fields related to social-health assistance, for example the care assistance of the elderly at home. The necessary knowledge refers to skills which allow the OSS to carry out medical and care tasks (i.e. giving medicine, maintaining personal hygiene), supporting tasks within the household (i.e. cooking, cleaning), as well as social tasks (i.e. maintaining social contacts and social activities).

The RAA is a specialisation based on previous qualifications in the sector of social-health assistance (i.e. OSS). In order to obtain this qualification, the person needs to attend a 200-hour course. The RAA knows the caregiver’s work, and their roll is to organise the various activities or groups of social and OSS workers. The RAA has got the same skills and knowledge as the OSS plus all the competences to organise the work of caregivers (i.e. of OSSs).

The provider of the homecare services is responsible for the continual training of its staff and certifies the qualification of its staff through self-evaluation; for this reason, the municipality is responsible for controlling the quality of the care service and the qualifications of the care staff. Additionally, the beneficiaries, who are allowed to change providers, pointing out the reasons for their dissatisfaction, function as a further indirect controlling body on the qualification of the providers' staff (comporting a more detailed control from the municipality on the qualifications and skills of the providers' staff).

Relating to the independent caregivers, the Municipality of Parma is planning a system of qualification in the sector of care assistance in order to support the families to choose the correct person. Family assistants who are of age, have completed their compulsory schooling, are European citizens or are in possession of a regular residency permit and have no criminal record can enrol in a public register held by the

municipality. The register is a public list of professionals accredited to work in the sector of (home) care assistance. The qualifications necessary for enrolment in the register are technical competence in assistance of the elderly, certified by a training course of at least 30 hours or with certified work experience of at least 120 hours. In addition, a good command of Italian (which is to be certified by the municipality staff) is necessary and a certificate of suitability for care assistance. Should the candidate not possess the required qualifications at the time of enrolment in the register, they receive information about educational measures in order to gain the necessary qualifications.

KEY CONCEPTS:

University Curriculum 3+2 (social workers); Vocational Qualification (OSS); Specialisation (RAA); Suppliers Responsible for Staff Training; Municipality as Qualification Controller; Training Course for Independent Caregivers' Qualification.

SPAIN

The local authorities, through the several training plans, facilitate and promote the participation of professionals in training activities; their participation is very important as they can teach the tasks to develop within the carers' jobs. All professionals working within interdisciplinary teams of municipal social services have the qualifications and knowledge necessary for the appropriate development of its functions. Graduates are also represented (psychologist, sociologist, lawyers, etc.), media graduates (social workers, educators, etc.) and administrative staff.

Home caregivers should develop their skills by means of a specific professional qualification that leads to the Professional Certificate of “Social and Health Care at Home” (which replaces the Certificate of Assistance at Home). Auxiliary staff of assistance at home, according to an Order of 2007 (15th November), must possess a Compulsory Secondary School degree, a diploma in Education Secondary School or a certification in Primary Studies and have the professional qualification for the execution of their tasks, as laid down by a Royal Decree (331/1997) on the Certificate of professionalism of the occupation of auxiliary staff of assistance at home or according to the Royal Decree 295/2004 of 20 February on the professional certification for “Social and Health Care at Home”.

In the case of Granada Council, an example of mixed management in which the service is carried out by a lending company, the homecare staff must have special training in assistance at home, which ensures an optimal level of quality and efficiency in the service delivery. Therefore, in addition to the training requirements specified in a Royal Decree (331/1997), the company also provides additional and specific training considered appropriate to provide an adequate service. The training course is based on 425 hours, consisting of a mix of theory and practice in the field of care assistance.

An innovation in the system is seen by the Royal Decree 1224/2009 of 17 July. This established the acknowledgement of professional skills of auxiliary home assistance staff, which were acquired not only through qualification but also through work

experience. The Ministry of Education and the Ministry of Labour will issue a certificate of “recognition” after passing a national exam. Through the recognition, the regional government has the possibility to recognise skills of persons who learned the care assistance job through experience or in non-conventional work situations, thus reducing the number of black market workers and increasing the number of qualified carers.

KEY CONCEPTS:

Professionals in Training Activities; Home Caregivers through Professional Certificates; Auxiliary Staff Basic School Level + Professional Qualification; “Recognition”; Local Authorities Promoting Training (carried out also by care companies).

GERMANY

The education of nurses or caregivers is regulated by the Federal Government and thus is the same in all federal states. The training takes three years and encompasses about 2,100 hours of theoretical and practical courses as well as about 2,500 hours reserved for practical experience. The prerequisite for admission to a course to become an elderly care nurse is an intermediate secondary school degree or a vocational training degree with at least two years’ work experience. The theoretical education is given at public or private accredited schools specialised only in the care profession. In both cases, the schools collaborate strongly with the facilities where the students obtain their practical training: the practical training takes place in inpatient care facilities and at outpatient care providers. Parts of practical training can also be carried out at hospitals with a geriatric care unit. The practical training's carrier enters into a contract with the students and pays an adequate fee for the training period. The training can be completed either in a full-time or in an extra-occupational form. The training aims at gaining the knowledge and skills that are needed for the autonomous, integral and individual care, advice and assistance of elderly people in inpatient facilities and in outpatient care.

Topics of the training are, for example, duties and conceptions of the care of the elderly (including basic theory, care of the elderly, gerontologically based work, communication, medical diagnostics and therapy, documentation, development of quality), the support of the elderly at life design, judicial and institutional basic conditions of nursing, nursing as a job (to develop a job-related self-image, to manage slumps, to master difficult social situations and to strengthen one’s own health).

In outpatient and inpatient facilities of elderly care, both practical and theoretical knowledge is imparted. This includes the teaching of institutional and judicial basics and professional concepts, the work with the elderly and, in parts, the advice, support and assistance and the work with the medical diagnostics and therapy under guidance or rather charge, help with structuring the elderly person’s day, maintaining social contacts and supporting autonomous work in projects, for example at the development of homecare situations. Training in outpatient care is normally a part of a nurse training

course either in form of a special course or in form of further training. In the ambulant care the caregivers are more self-concentrated than in a hospital as colleagues or a doctor in duty are not at their beck and call at every time; therefore in this working field a special education and a good quality of work is needed. To make the grade and to reach those goals some special personal and functional modes are needed as well as interpersonal skills.

Professional competence is, for example, current knowledge of different disease patterns, knowledge of adequate care action, knowledge of adequate action in case of an accident, knowledge and execution of bedding techniques, giving the correct doses of medicine, knowledge of the effectiveness of medicine, correct application of drip-feeding, correct application of hygienic directives, knowledge in the documentation of care, knowledge in compiling a care plan, knowledge in the insurance of care, and knowledge of regulatory affairs.

Interpersonal skills include, for example, the ability to communicate with patients, the ability to communicate with the patient's relatives, maintaining respect for the patient's privacy, and the ability to cooperate with other carers.

A person taking care of a relative needs advice and instruction to minimise the risk of physical or mental problems and to ensure good quality care. In Germany, the number of institutions and care providers offering courses and guidance free of charge for caring relatives is constantly increasing. These courses cover such topics as modes of mobilisation or bedding, spine-friendly lifting (for example, from hospital bed to wheelchair), diet, devices and rehabilitation measures, insurance of care and judicial questions. Besides the agency of these relevant topics the attendants get the possibility of get to now animations for their home situation, to communicate about their care situations and to inform on discharge supplies. The supply of these free courses for relatives and honorary caregivers is fixed by the German law within §45, SGB XI of the public healthcare.

KEY CONCEPTS:

Paid Training; Practice, Theory and Soft Skills; Extra Training for Homecarers; Free Courses for Relatives.

ENGLAND (UK)

One of the most important aspects of improving quality of service is supporting the caregivers with suitable skills competences and training activities; for this reason the renewing of the care system foresees that training minimal standards are to change soon. The workforce will face great challenges over the coming years: more people will need care and caregivers may need different skills to support more and more personalised services. The Department of Health recently published a strategy on the future of the care and support workforce (see p. 9 “Putting People First”).

The most important provider for the establishment of training and qualification standards in the UK is the licensed by the government "Skill for Care and Development" (SfC&D), an alliance of six organisations,[51] collaborating on national and regional levels both with social care employers as well as training providers. The institution ensures a national framework for one million social care staff in England, providing over £25 million in funding to support improved training and qualifications for managers[52] and staff. SfC&D also created an overview of what the priorities are, used extensively at national and regional level to aid their own planning and their agreements with delivery partners. Priority 1: Leadership, management and human resource planning. Aim: To improve the quality, effectiveness and efficiency of managers, human resource practitioners and leaders at all levels within the adult social care sector in order to meet the needs of the people who use services, and carers; Priority 2: Ensuring good employability and progression skills. Aim: To improve retention and increase recruitment across the adult social care sector, to deliver personalised care in a diversity of settings; Priority 3: Developing the skills of the social care workforce of the future. Aim: To use workforce intelligence, skills development and support systems to train and develop a diverse workforce to meet the needs of people who use services, and carers; Priority 4: Developing new types of working. Aim: To develop a workforce that is flexible, can work across services and support self care and personalised services; and Priority 5: Improving the skills and enhancing the role of commissioners. Aim: To develop skills and knowledge of commissioners of care services and workforce development to ensure the quality of service.

Additionally, an agreement, the Sector Skills Agreement (SSA), between employers, providers and funders of learning provision, the Government and the Sector Skills Council,[53] maps out which skills employers need their workforce to have and how these skills will be developed. Through five stages, the SSA has the aim to influence the supply of relevant training and to develop appropriate skills for caregivers. In brief, the stages are: (1) Assessing current and future skills needs of the workforce; (2) Identifying and assessing current training and development provision; (3) Analysing gaps and engaging employers, workers, people who use services, and carers in market testing options for change, solutions and priorities; (4) Developing agreements between the sector skills council, employers and other partners; and (5) Developing an action plan.

The SSA outlines also some generic skills, currently identified as requirements: literacy, language and numeracy (i.e. skills for life); skills which prepare new entrants for the workforce; core skills (i.e. moving and handling, medication and food hygiene, etc.); communication and interpersonal skills (i.e. managing multidisciplinary and cross-

[51] Care Council for Wales, Children's Workforce Development Council, General Social Care Council, Northern Ireland Social Care Council, Scottish Social Services Council, and Skills for Care.

[52] Also the qualification for managers in the care system is based on a national framework (National Qualification Frameworks).

[53] Skill for Care and Development is the Sector Skill Council for social care.

agency teams, adopting flexible approaches, etc.); information and communication technology skills (i.e. making use of assistive technology, ICT applications for e-learning); skills to deliver a more preventative approach of service delivery (i.e. helping people living independently); skills which help develop a critical approach to reflective practice (i.e. learning from current best practice[54]); leadership and management skills; commissioning and procurement skills (i.e. identification of the right skills for the workforce); skills for people who use services, and carers; skills for life needs in social care; and skills in commissioning workforce development.

Among all these skills and competences, practical knowledge and experience related to care assistance are of extreme importance, as well as good use of English and soft skills such as personality and attitude.

By suppliers, newly appointed workers delivering personal care who do not already hold a relevant care qualification are required to demonstrate their competence and register for the relevant National Vocational Qualification[55] (NVQ) in care award within the first six months of employment and complete the full award within three years. Moreover, since 2008, the national minimum standards have defined higher criteria related to the required qualification of their staff.[56] These targets are reviewed every two years. It is expected that authorities will improve massively, so that 50% of the workers are working towards a qualification if they are not already in possession of one.

Unqualified staffs, employed for less than two years at the commencement of the application of the standards, are phased into the relevant NVQ in care over the following two years and complete the award within three years. On the other hand, most social care jobs do not require prerequisite qualifications or training before starting.[57] When people begin working in social care they will be given introductory training which takes place in the first twelve weeks of their new job, using national standards adapted for where they work, in order to get basic knowledge and skills; their manager leads most of the training (also external trainers may be involved in specialist areas). This training ensures that people know how to do their job properly and safely. Introductory training gives them professional recognition and then they may work towards the relevant NVQ.

The NVQ in Health and Social Care foresees three levels[58] of qualification: Level 2 aims at those who support and assist individuals with their physical or emotional care, daily living needs or maintaining their independence. It is extremely relevant for homecare assistants, community support assistants, healthcare assistants, and residential or day service assistants; Level 3 aims at individuals who often work without direct supervision or on their own, perhaps in a user's own home; Level 4 aims at

54 National Occupational Standards describe best practice by bringing together skills, knowledge and values.
55 In particularly, the NVQ in Health and Social Care and the NVQ in Leadership and Management for Care Services.
56 Also the managerial staff undertakes periodic management training.
57 The only precondition is to have no criminal record.
58 There is also a Level 1, which is considered a foundation qualification. All the care staffs have to attain Level 2.

people in supervisory or management roles. These qualifications are work-based awards and learners' skills and knowledge are assessed in the workplace whilst they are working directly with individuals and colleagues. They must be working in a real health or social care setting on a full- or part-time basis and in paid or voluntary work. If learners require any additional training prior to assessment, this can be based in or out of the workplace or by distance or e-learning.

Changes in training and qualification: NVQs are to be replaced by the Qualifications and Credit Framework (QFC), which are compatible with (but not replaced by) the European Qualifications Framework for mobility and cross-referencing of training standards. Units are being developed at different levels; learners can undertake units to reflect their role, certain aspects of which may be diverse through rules of combination. The QFC enables smaller steps of learning and allows learners to build up qualifications bit by bit, helping learners to achieve skills and qualifications that meet the industry's needs. Additionally, it enables work-based training to be recognised and formally accredited – rather than only official ones. A further change, not related with the QFC, is the creation of a new diploma curriculum (called Society Health and Development Diploma) targeting 14- to 19-year-old pupils. The aim is to encourage more people to continue learning and gain qualifications in the sector of care assistance.

KEY CONCEPTS:

Priorities of SfC&D; SSA (necessary skills for carers); Importance of Soft Skills; Training During the Job; Qualification "Bit by Bit"; E-Learning for Carers; Qualifications and Credit Framework (QFC).

HUNGARY

The necessary education and professional levels are defined in national acts of law which distinguish between home nursing (competent professional homecare assistance) and home help (competent domestic help and social care) qualifications. In order to practise homecare assistance, it is necessary to have a general nursing qualification.

In the home nursing sector, a level of further education must be achieved (Bachelor and Master level). Elsewhere in domestic care, only a basic level of education is required; this is composed of a two-year training programme (in professional secondary schools). The difference is based on the fact that in domestic care the nurse/helper/nursing assistant provides, as previously stated, basic help for the beneficiary (i.e. hygiene needs, feeding, moving, clothing, housecleaning, shopping, ironing, etc.); in home care the nurse executes professional nursing tasks.

Every Hungarian health worker, when qualified, receives a basic licence from the

Health Ministry Office (HMO). During the next five years, they have to collect 100 credit points; after reporting the successful acquisition of these points to the HMO, they receive a licence of practice. Fifteen points are awarded per working year, a certificate is given by the workplace, and these points are awarded for work experience. The remaining points have to be collected through theoretical training, e.g. conferences, giving presentations at conferences, or participation in theoretical training. Upon completion these trainings, the organiser awards a certificate, which have to be renewed every five years.

Nursing training to teach new methods of documentation, for example, used to be organised by the Public Health Institute. In addition, nursing schools used to organise refresher trainings on new methods, from the communication, from the new nursing-implementation. Also, pharmaceutical companies used to organise training sessions to inform about the latest development in medical products. Generally, it is possible to say that publically funded companies pay for the obligatory education of their workforce, while private companies rarely pay education costs.

KEY CONCEPTS:

University Curriculum (home nursing); VQT (home help); Recertification (credits in the workplace); Public Companies, Nursing Schools and Pharmaceutical Companies Provide Training (private care suppliers rarely).

SLOVENIA

The framework for the definition of the minimum standards related to the necessary qualification as well as the principles of the service is defined in the SAA in compliance with the Rules on Standards (see p. 11 for the definition). The types and degrees of educational programmes which provide the appropriate qualification for social care services are determined by the Social Chamber. In Slovenia, there are 21 different institutions, collected in an annex carrying out training in the social care sector which is used as preparation in the process of obtaining a national vocational qualification. Domestic social care is provided by qualified professionals, which means, according to the SAA, workers who have completed a degree of further education for social work have completed the traineeships and have passed a professional examination in the field of social welfare.[59] On the other hand, direct execution of social service at the beneficiary's home is performed by a qualified assistant who, according to the SAA, has finished at least the secondary vocational or secondary professional school for social work or care and has attended a training course. This foresees 120 hours in pedagogic seminars, including theoretical and practical parts, as well as practical training. The candidate should be at least 25 years old and should have at least five years of professional or non-professional (i.e. work experience obtained through

[59] Related to persons who have a degree in: psychology, pedagogy, administration, law, sociology, work therapy or theology; who have one year of work experience in social welfare, have completed traineeships and have passed the professional examination of the Social Security Agreement.

healthcare assistance for relatives, neighbours, etc.) experience in the field of care. Under the management of a qualified professional, service in the beneficiary's home may also be performed by laypeople who have basic education and have completed an additional training course on social work within a verified programme, according to the Rules on Standards. The SAA also defines the necessary qualifications for the management and coordination of the service.

KEY CONCEPTS:

University Curriculum (domestic social care workers); VQT + Training Course (social servicing workers); Qualification for Service Management.

SUMMERY CHARTS

Tab. 6 Form of qualification related to social workers/assistant

	IT	DE	HU	ES	UK	SLO
With university degree	X		X			
With secondary education		X		X	X	X
With qualification		X	X	X	X	X

Tab. 7 Form of qualification related to social-health workers

	IT	DE	HU	ES	UK	SLO
With university degree			X	X	X	
With secondary education	X	X		X	X	X
With qualification		X				

CONCLUSION

In order to provide some points of observation for the ProDomo partners (but also for other stakeholders) related to the next phases (valorisation and testing of one or more parts of the research), we list some aspects which may be interesting and innovative starting points for further consideration. These aspects are taken both from the model of Parma as well as from the reports on the other partner countries, according to the philosophy of exchanging ideas, the basis for the Leonardo da Vinci – Transfer of Innovation Projects.

a) The process of accreditation foresees collaboration between the Municipality of Parma, the (private) care assistance suppliers and the beneficiaries themselves. The assistance service is a process that tends, together with maintaining a high level of quality and at the same time fixed costs of the service, also a direct participation of the clients (or their family) for the definition of the service's content.

b) The Municipality of Parma creates a register (i.e. a public list of professionals) that will serve as a guarantee (under the supervision of the Municipality itself) of the qualifications and level of competence of the independent caregivers. Additionally, the Municipality will offer the possibility for the workforce to fulfil the necessary prerequisites (i.e. competences, soft skills, etc.) through vocational training courses.

c) The Municipality of Parma will briefly define the cost of the services, control the quality of the suppliers as well as the qualification of their staff and supervise the vocational training course mentioned in Point (b).

d) In Spain, Germany, UK, Hungary and Slovenia, the Social Security System or Acts (in the case of Slovenia) are nationally valid and foresee an intense interaction among the various actors (i.e. national and local governments, municipalities, care facilities, etc.) related to the care service. Quoting from the English report, the care service should be “co-produced, co-developed, co-evaluated”.

e) In the countries mentioned in Point (d), all the suppliers who organise and carry out care assistance have to be accredited in order to practise the assistance service (non-accredited bodies can practise, but any kind of allowance given by the government cannot be used by such providers).

f) Generally speaking, in all the partner countries, there is the tendency to outsource the care service, moving the competence of the care assistance to institutions closer to the end users. In Germany, for example, the municipalities have the duty to coordinate all offers of care and help targeting the elderly living in their area (a sort of front-desk).

g) The care system in England is strongly oriented towards a higher personalisation of the service, giving beneficiaries (or their relatives) a very

active role in the definition of the service: “thinking about the public services and social care in an entirely different way – starting from the person rather from the service”. The Individual Budget (IB) is one way of improving the personalisation of the service: the beneficiary has more autonomy in deciding on what kind of service (i.e. local authority adult social care, disabled facilities, housing-related support, independent living assistance) they are going to use their credit (i.e. budget given by the Government). In order to guarantee constant supervision of the care service, the care staff and the best procedures of personalisation, the National Minimum Standards and the Care Quality Commission have been established.

h) In Hungary, there is a very strong cooperation between nurses (mostly health assistance) and social workers (mostly social assistance). But in Hungary and also in Germany, the homecare staff are trained to combine the two areas of intervention (medical and social) within a single body.

a) In Hungary, care workers have to update and re-qualify every five years. The re-qualification is measured with credits which are composed of a theoretical part (i.e. training courses, taking part in seminars, etc.) and a practical part. The credits related to this last part are accumulated by normal work in the workplace.

a) In Germany, the presence of a consistent number of foreign carers (some qualified some not) has produced the launch of various private agencies specialised in qualified caregivers from Eastern Europe (mostly Poland, Slovakia, Slovenia and Hungary), guaranteeing their competence, qualifications and skills (also soft skills, incl. language skills).

i) In Spain and Slovenia, carers who obtained their competence by work experience only could only work on the black market because of a lack in official qualification. The Governments of the two countries foresee to acknowledge this work experience as “working credits”, allowing these people to obtain a final qualification and practise their job freely. As for example in Spain through the skills previously accumulated the caregivers, after being tested by a Ministry Commission (Education and Labour), receive the necessary qualification to practise the job.

j) Related to the growing phenomenon of carers coming from abroad and the related problem of acknowledgement of their qualification, in the UK a framework will be created, called Qualifications and Credit Framework (QCF), which shall support and facilitate the care workforce mobility within Europe. The QCF is based on a system which recognises also small steps in learning in order to personalise the learning path and allow the worker build up their qualifications bit by bit (which facilitates working and learning).

k) Regarding the training of carers, in Germany, the law regulates that the

health insurance bodies have to organise courses and orientation seminars free of charge for relatives caring for their family members. The topics of these courses are mainly: mobilisation or bedding, spine-friendly lifting, diet, devices and rehabilitation measures, insurance of care and judicial questions.