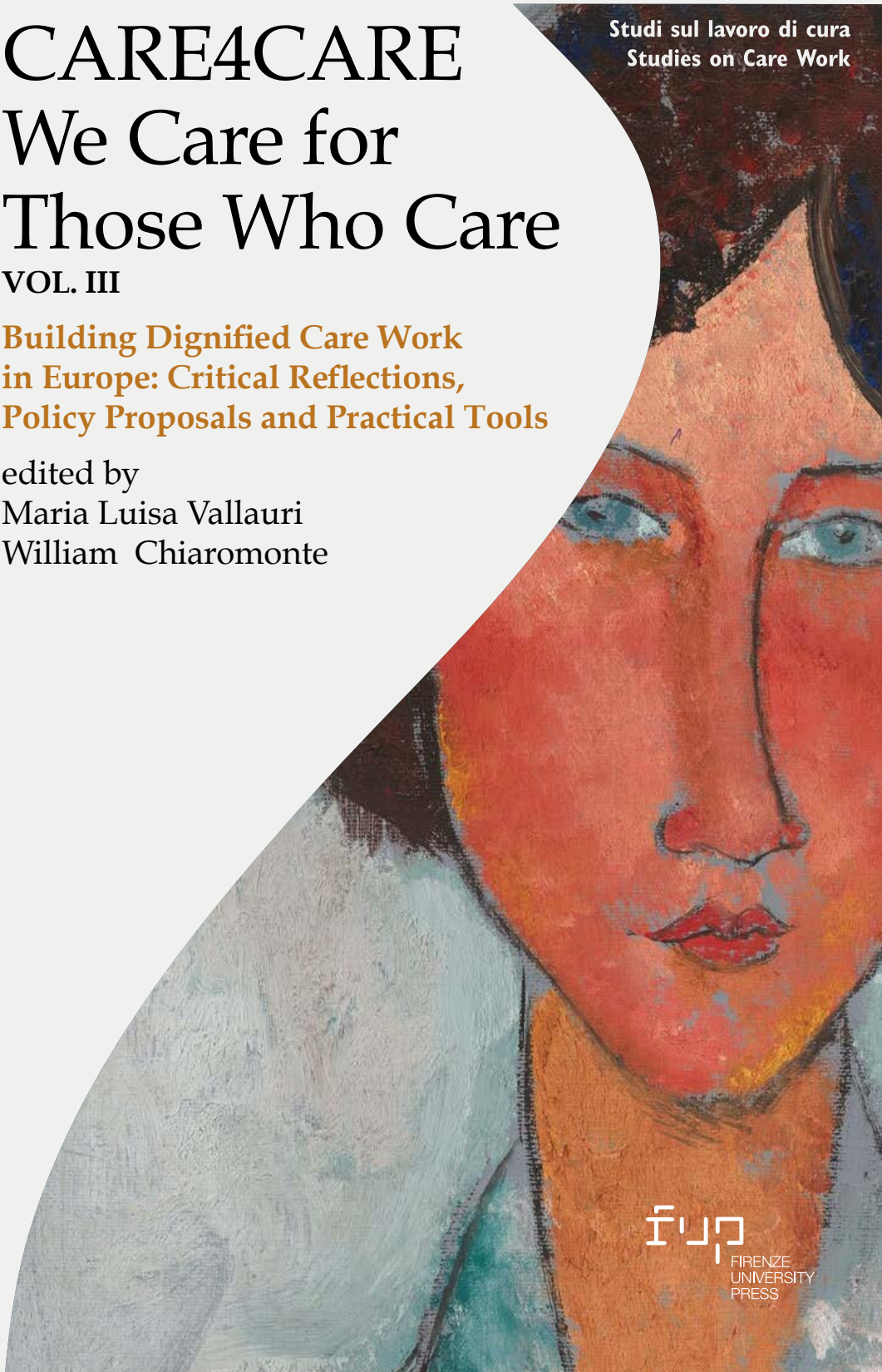
# CARE4CARE
# We Care for Those Who Care

**VOL. III**

## Building Dignified Care Work in Europe: Critical Reflections, Policy Proposals and Practical Tools

edited by
Maria Luisa Vallauri
William Chiaromonte

Studi sul lavoro di cura
Studies on Care Work



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# Introduction

Maria Luisa Vallauri

## 1. A Starting Point: Who Care for Those Who Care?

Since the Communication to the European Parliament, the Council and the European Economic and Social Committee of 20 November 2017 containing the EU Action Plan 2017-2019, the European Commission included the care work sector among those sectors "key to the future of European society and economy".

The COVID-19 pandemic has made even more clear the centrality of care work in modern societies but it also made more visible many critical issues affecting the working conditions of care workers, such as: the lack of adequate economic resources, the workforce shortage, the pressure put on care workers, the risks for their well-being, the underfinancing of social care as a consequence of the reorganisation and partial retrenchment of the welfare state involving also privatisation and commodification of public services, the weaker bargaining power in these sectors than in many male-dominated sectors, the undervaluation of female-dominated jobs, the prevalence of undeclared work in domestic care work, patterns of discrimination in the sector on grounds of gender and nationality (and the intersectionality between these two factors).

Therefore, in her State of the Union address on 15 September 2021, President of the European Commission Ursula von der Leyen announced a European Care Strategy, pointing out, among the others, the need for decent working conditions for all workers in the care sector. One year later the European Care Strategy was presented by the European Commission to ensure quality, affordable and accessible care services across the European Union and improve the

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situation for both care receivers and the people caring for them, professionally or informally.

All this brought a question to our minds: who cares for those who care?

The willingness to care for those who care was the starting point of the CARE4CARE project funded by the Horizon Europe program under GA. n. 101094603 for a three-year lifespan, the results of which are collected in the three volumes that inaugurate the series "Studi sul lavoro di cura - Studies on Care Work".

## 2. Objectives and Goals of the Project

Care workers are mainly women and migrants, which makes the care sector an interesting field to verify the dynamics of segregation and exclusion that affect the labour market. At the same time, it is a challenging testing ground, which allows to design and verify new measures to counteract discrimination and promote social inclusion.

The CARE4CARE project investigated in a comparative and multidisciplinary perspective the working conditions of care workers and their perception of the working environment and dynamics in six EU Member States (France, Germany, Italy, Poland, Spain and Sweden) in order to develop suitable tools to improve job quality and counteract discrimination in the sector, such as: elaborating policy strategies to tackle the undervaluation of care work, with particular attention to the key role that trade unions, employers' associations as well as equality and monitoring bodies can play both at national and EU level; designing training programs to empower trade unions, families' and employers' associations to improve job quality in the sector; setting up of a network on care work, which will implement a web platform accessible to care workers, in order to improve their rights' awareness.

More precisely, the project aimed at highlighting the risks and conditions of vulnerability of the target, with a specific focus on discrimination and socio-economic undervaluation.

The ambition was, then, to create a model of analysis and regulation of the care sector that can be replicated in other European countries and can bring out new relevant strategies for intervention in order to elaborate legislative and policy proposals at the national and the EU level.

Lastly, the project aimed at giving voice to care workers and to their representatives in the design and delivery of policies and measures that affect their lives. To this end, it seemed necessary to raise awareness and consciousness among care workers and trade unions by making rights clear and usable for workers and enhancing collective bargaining strategies.

Target of the project were workers employed in the public and private sector, caring for people with disabilities, the elderly and sick people: home caregivers, basic healthcare workers, healthcare professionals with at most a Bachelor's degree, such as nurses. Particular attention was also paid to undeclared work in the sector.

### 3. The Consortium

The CARE4CARE Consortium spanned the European Union from north to south and from east to west and comprises ten partners.

The Consortium has been led by a team of experts in labour law from the Department of Legal Sciences of the University of Florence (Italy). In addition to the University of Florence, six other Universities were involved: Lunds Universitet (Sweden), Universidad de Girona (Spain), Universidad de Sevilla (Spain), Europa - Universität Viadrina (Germany), Uniwersytet Rzeszowski (Poland), Université de Bordeaux - Centre National de la Recherche Scientifique (France).

Tuscan Organisation of Universities and Research 4 Europe - Tour4UE (Belgium) oversaw communication and dissemination with great expertise.

Two associations from civil society, European Federation for Family Employment & Home Care and European Federation for Services to Individuals, acted as a bridge with stakeholders at European level.

The Consortium could also rely on the support of the European Trade Union Institute (ETUI).

### 4. The Outputs of the Project

The outputs of this research project were twofold: research outputs and societal outputs.

Regarding the research outputs, firstly, the research provided a comparative analysis of the working conditions in the care sector; secondly, the research assessed the direct perception of working conditions and well-being at work, as well as awareness of rights; thirdly, the project investigated strategies and techniques of regulation of working conditions in the sector.

Regarding the societal outputs, the first outcome was represented by the drafting of the CARE4CARE Policy paper that includes: general policy objectives, possible measures in national laws, possible measures for national social partners and institutions, possible measures in European law and for European social partners and institutions.

The second outcome of CARE4CARE was the design and delivery of training programmes to empower trade unions, employers and the representatives of families' associations who will be the target group of the training. The aim is to improve knowledge and skills to recognize vulnerabilities of care workers in order to improve job quality and counteract discriminations in the care sector.

The third outcome of CARE4CARE consists in the realisation of a web platform optimised for smartphones and tablets that is structured to provide user-friendly information on relevant national legislation to improve care worker's awareness of rights.

All partners have been heavily involved in the implementation of both research and societal outputs and in the communication and dissemination of the results, in order to maximize the impact of the project on the scientific community and civil society.

## 5. The Methodology

The main methodology adopted was legal research in a comparative and EU perspective.

A comparative analysis of legal aspects, labour market conditions and industrial relations aspects on job quality and working conditions for care workers was conducted, in order to get an assessment of the sector in the six EU Member States involved in the project and characterised by different models of welfare state.

A psycho-social survey was also conducted through focus groups, questionnaires and audits to outline a picture of the quality of work and awareness of workers' rights.

Both qualitative and quantitative data were collected to shed light on psychosocial working conditions that can affect care workers' well-being across the six EU member states involved in the research. Specific attention was given to how structural variables—such as demographic variables, work-related variables, psychological and interpersonal variables—are related to care workers' mental health and well-being both in private and public sectors.

## 6. Presentation of the Publication

The three volumes that inaugurate the series "Studi sul lavoro di cura - Studies on care work" bring together the results of the research conducted between 2023 and 2025 by the Consortium that I had the great privilege of coordinating.

Volume I: *Care Work and Working Conditions: National Legal Frameworks and Comparative Insights*—brings together national reports drawn up by esteemed labour law scholars from the Universities of Bordeaux, Florence, Frankfurt (Oder), Girona, Lund and Rzeszowski . The reports outline the regulatory framework applicable to care professionals, both from a legal and collective bargaining perspective in the six countries involved in the project. University of Lund, leader of Work package 2, prepared the comparative report that formed the basis for the development of intervention strategies to improve working conditions in the sector.

Volume II: *Discriminations in the Care Sector: National Legal Frameworks and Comparative Insights*—collects reports on the mapping of discrimination based on gender and nationality in the sector elaborated through the study of case law, national reports and statistics in the six countries. The comparative report drafted by University of Girona, leader of Work package 3, summarises the national overview to identify similarities and differences in order to develop strategies to counteract discriminations.

Volume III: *Building Dignified Care Work in Europe: Critical Reflections, Political and Social Tools*—brings together critical contributions on the issues raised by the research, written by scholars who, with different sensibilities and points of view, contributed to the realisation of the project. The legal analysis is accompanied by a psychosocial reflection developed by researchers of the University of Seville, leader of Work package 4, who conducted an investigation on working

conditions and the perception of rights in the sector. The volume also includes the keynote lecture given by Professor Silvia Borelli during the project kick-off meeting held in Florence on 16th–17th March 2023.

The Policy Paper drafted by the German team of Europa - Universität Viadrina Frankfurt (Oder), leader of Work package 5, on the basis of the overall research findings, is included in the appendix to the third volume, together with the Training model for trade unions developed by the Polish team of the University of Rzeszowski, leader of Work package 6, and the description of the Web platform built by the Italian team of the University of Florence, leader of Work Package 7.

The success of this project is due to the great communication effort made by Tour4UE, which is not reflected in the volumes but was essential in bringing our research to the attention of European institutions and of National and European stakeholders.

Equally important was the contribution of EFFE and EFSI as bridges with civil society, representing the sector's needs to researchers and thus enabling the design of targeted and more effective intervention policies.

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I would like this to be a never-ending story.

My heart is full of gratitude to all my colleagues and now friends of the Consortium who contributed with their tireless work and great expertise to achieving the results we had set: Aude Boisseuil, Andrea Cano Redondo, William Chiaromonte, Marta Ciabatti, Simona Costa, Isabelle Daugareilh, Aurelie Decker, Francisco Josè Medina Diaz, Giulia Frosecchi, Thomas Hector, Andrea Iossa,

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PART 1

# Critical Reflections on Care Work in Europe

CHAPTER 1

# Care Work, Care of Work. Reasons and Aims of the CARE4CARE – We Care for Those Who Care Project

Maria Luisa Vallauri

> By nature men are neither sovereigns, nor courtiers, nor rich: all are born naked and poor, all subject to the miseries of life, to bitterness, to evils, to needs, to pains of every kind: all, finally, are destined to die (Rousseau 1997, 292).

> There is no possible human life without attention to every individual. [...] A care society would be a decent society [...] where one would take care of those who take care of others (Molinier 2013 o 2019, 36 and 42).

## 1. Introduction

> For nights on end [during the pandemic], we all stood at our windows and doors to applaud critical workers. We felt how much we relied on all those women and men who work for lower wages, fewer protections and less security. The applause may have faded away, but the strength of feeling cannot. [...] We will come forward with a new European care strategy to support men and women in finding the best care and the best life balance for them (Von der Leyen 2021).

As Ursula von der Leyen spoke these words in her annual State of the Union address on 15 September 2021—while the world was still engulfed by the COVID-19 pandemic—the idea of the CARE4CARE – We Care for Those Who Care Project, began to take shape, with the aim of exploring a sector of work—personal care—identified by the European Commission itself as one of the key sectors for the future of European society and economy.

The starting point of the research was the observation that the sector has everywhere suffered (and continues to suffer) from staff shortages, and rests almost entirely on the shoulders of women and migrants (often migrant women) who work in exchange for low pay, weak protections, and a low level of security.

The research intends to enhance the value of the work carried out and to offer a reflection on the regulation of paid care work—a topic still insufficiently

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explored and only apparently marginal, since it concerns the fate of a group of workers performing essential jobs for the wellbeing of our societies, which are rapidly ageing and therefore increasingly in need of care.

## 2. The Reasons for the CARE4CARE Project

The first root of the project idea lies in a reflection on the value of care and care work in people's lives and in contemporary societies. This reflection starts from the observation that the human condition is, first and foremost, one of vulnerability and need for the attention and care of others. Attention, as the lofty spirit of Simone Weil taught us, "is the rarest and purest form of generosity"; recognition of the other in their essential personhood depends on it, and through it passes the care that heals—first of all—the wound left by indifference.[1]

The COVID-19 pandemic imposed a radical and widespread experience of our vulnerability and gave new visibility to philosophical and sociological thought developed around this trait of our condition,[2] while at the same time fostering reflection on the essential nature of care and caring as a path to individual and collective wellbeing.[3]

Thus the seeds planted by philosophical studies theorising an ethics of care—as a foundation for an equitable and sustainable model of governance—began to sprout:[4] an ethics that generally rejects the "individualist paradigm on which not only neoliberalism is based, but also modern and contemporary contractualism", a paradigm that removes vulnerability and interdependence from the political horizon, neutralising them through protective norms that presuppose an autonomous subject, an "entrepreneur of the self" (Re 2019, 183 ff.; 2020, 102).

From the perspective of care ethics, vulnerability becomes the very foundation of coexistence and interdependence (being-with, inter-being) among persons becomes a condition for equality. Ethical action, therefore, is expressed in responsibility for the other and is generated by awareness of the other's fragility and vulnerability, their ontological weakness, their co-essence—i.e., their

[1] Weil and Bousquet 1994, 13–4. For a reflection on this aspect of Weil's thought see Greco 2023.

[2] On vulnerability as an essential human condition see Nussbaum 2003; Fineman 2008 and 2010; Butler 2009; Cavarero 2013; Bernardini et al. 2018; Giolo and Pastore 2018; Re 2019; Giolo 2020; Re 2020. See recently Mèlich 2024. Initial reflections emerged in the 1980s: Goodin, 1985 underscores the relational dimension of vulnerability, as also emphasised by Held 1987; Tronto 1993.

[3] The topic is also addressed in the arts, for example in Marco Balzano's fine book *Quando tornerò* (Turin: Einaudi, 2001), in the documentary *Care Seekers* by director Teresa Sala, or in Ken Loach's film *Sorry We Missed You*, which intertwines the stories of a delivery rider and a live-in care worker. Cavarero defines literature as the oldest gesture of care, insofar as it gives voice to stories of care that would otherwise remain invisible (Cavarero 1997).

[4] Moreover, albeit through quite different theoretical constructions, as explained in Brotto's reconstruction (2013).

dependence on the other. "In this sense, caring for others is not only a possible ideal of existence, but a necessity of being".[5]

On these assumptions is built a theory that overcomes the heteronormativity of the paradigm of rights and justice constructed on a model of an independent, impartial, and falsely abstract individual—because in reality modelled on the white male subject—arriving instead at a model that values the particularity of each person in their concreteness, requiring public authorities to design interventions and measures capable of addressing, case by case, diverse needs.[6] The subject of law is redefined—situated, vulnerable, and non-autonomous—and so is the role of the State, called upon to dismantle systems of power and privilege within particular relationships in order to achieve substantive equality.

There are also proposals that emphasize the complementarity of the two ethics—justice and care—arguing that both are necessary to address different problems and challenges: the former to ensure social equity in terms of equal rights, equal opportunities, and impartial judgment; the latter to acknowledge vulnerability and interdependence, and to value the affective and emotional dimensions that motivate action.[7]

The antidote to vulnerability, as Weil intuited, is care (Cavarero 2013), which becomes the core of coexistence and the basis of social bonds and should therefore be at the centre of political discourse—or, following the most advanced proposal, become the very heart of democracy.[8] We must speak in the conditional, because the model of care—by calling into question the paradigm of the independent and strong human being on which the capitalist system rests—has remained at the margins of public discourse.

[5] See the reflections by Mortari (2015, here at 122), who adds that recognising vulnerability alone is not sufficient to assume ethical action, since sensitivity is also required—namely, entering into contact through empathy or compassion. From this follows the relevance of "passions" in the theorisation of an ethics of care in Elena Pulcini's work (Pulcini, 2009; 2020), and earlier still in that of Hans Jonas, who acknowledges the value of the feeling of love in the assumption of responsibility, referring, however, to a feeling generated by a "sensitive reason" capable of grasping the evidence (of the other's weakness) (Jonas 1979, 163).

[6] See in this regard Tronto 1993; Fineman 2008; 2010; and Butler 2020. As Sandra Laugier notes, "ethical thinking about care is not always or only argumentative in nature; it often takes the form of a narrative in which concrete details and particulars become perceptible within the contexts of people's lives" (Laugier 2010, 67). For a narrative approach to the topic, see Hayes 2017.

[7] See in this regard Gilligan (1982) and, once again, Pulcini's thought as brought to completion in her final monograph, concluded shortly before her premature death (Pulcini 2020). On this issue, see also the critical and systematic reflection on the aforementioned theses by Re 2020, who underscores their importance in allowing "unexpected subjects" to emerge onto the scene—subjects left invisible by the order of neoliberal discourse.

[8] Tronto 2013. According to the author, democracy should consist in caring together: care practices as democratic practices capable of involving both care recipients and care providers in the design and implementation of policies, in the recognition and fair distribution of care tasks, and in a paradigm for conflict resolution and the management of power relations.

This reflection is strongly gendered, first of all because of the model of social division of labour that still characterises contemporary society and remains patriarchal in origin, continuing to allocate care work—both unpaid and paid—to women.[9]

Yet

> in today's world, care is exercised within an explosive social relationship, or at least a tense one, among women who do not occupy the same social positions: mistresses or subordinates, qualified or not, citizens or undocumented, etc. (Molinier 2013).

Financial capitalism has institutionalised the division between production and reproduction on the basis of gender; moreover, it locates reproductive work among the obstacles to progress and individual success, making its removal from women's path of self-affirmation and liberation appear necessary.

This tendency, combined with the contraction of public service provision, has produced the "outsourcing" and "commodification" of care, which ends up being "contracted out" to other women—often migrants from poor regions of the world—also seeking liberation (this time from need), and also forced to rely on others' care for their own children. The result is the construction of global care chains based not on solidarity, but on domination.[10]

The analytical perspective is therefore also that of intersectional feminism, which addresses relationships (also) among women themselves and, with that, the fabric of society as a whole, starting from the observation that there is no natural solidarity among women and no convergence of interests within the "class" of women.[11]

In the background of the research also runs the dialectic among feminisms, which approach care in different ways.

This reflection—here only sketched—has the merit of politicising care and, for our purposes, of drawing attention to care work and to the value attributed to it, both economically and in terms of social recognition.

Two theoretical aspects emerge that are important from a labour-law perspective: the definition of what counts as "work", and the social division of labour. Reflecting on when and in what terms care activity "became" work, and

[9] Molinier 2013; Honneth 2023, at 177 ff. See also Fraser's concise yet incisive reconstruction (2016) of the care system in the evolution of the capitalist model of modern and contemporary societies. The author reflects on the consequences of separating social reproduction from economic production. From the paradoxical denial of value to social reproduction—essential to economic production—there arises the "social contradiction" intrinsic to the structure of capitalist society, which in turn generates social crisis. See also Fraser 2013.

[10] See again Fraser 2016. See also Molinier 2013; Sciurba 2015; Hayes 2017; Borelli 2020, which refers to the international debate on the issue (in particular at nos. 87 and 101). See also Arruzza, Bhattacharya, and Fraser 2019, esp. at 24 ff.

[11] See Rottemberg 2018 and again Arruzza, Bhattacharya and Fraser 2019.

on how the distribution of that work within society is addressed, is decisive for reasoning about its value.

Both aspects are addressed in a recent contribution by Axel Honneth (2023), in which—synthesising his thought (see also Honneth 2020) to support the thesis that dignified working conditions are necessary to guarantee democratic citizenship[12]—he uses care work as a paradigm of socially essential activity, historically undervalued and assigned to women even after entering the market of professions in its various forms.

Honneth reconstructs what "work" means in philosophical reflection from Locke to Marx, showing how "service" tasks emerged "from the long shadow of the dominant concept of work"—understood as an activity that transforms and produces a marketable good—only thanks to Max Weber's sociology, which made publicly visible "administrative" work, both public and private.[13]

Weber's theory, according to Honneth, is important for extending the idea of "work", but still insufficient to include services provided inside homes and in health and social care institutions, as well as those performed in education and other person-centred services, since their social relevance is not brought into focus and they continue to be taken "for granted".[14]

The marginalisation of these activities disproportionately affects women, to whom they are assigned in a clearly predominant way even once they become visible.[15]

A first recognition of the value of care professions occurred alongside the wars of the early twentieth century, when thousands of nurses—mostly volunteers—demonstrated the indispensability of assistance work by saving many wounded soldiers' lives.[16] This led to the public formalisation of the nursing profession with the Royal Decree of 15 August 1925, from which followed the opening of schools preparing people for the profession and issuing a qualifying diploma (Pescarolo 2019, 182 ff.).

But the nursing profession was "tailored" to women. Doctors themselves highlighted the gender issue: they stressed men's supposed unsuitability to care for the sick due to an innate indiscipline and lack of nurturing disposition, while

[12] A thesis likewise advanced by Mari (2019), and articulated in particular in the concluding part of the volume.

[13] On Weber's idea of work—also with regard to bibliographic references—see D'Andrea 2024, who clearly highlights how central to the definition of what counts as work is the "intended meaning of the actor", that is, the working subject's intention to derive some utility from the activity performed, its instrumental character in relation to individual expectations, predominantly—but not exclusively—those of economic subsistence.

[14] The failure to recognise this work also characterises Hannah Arendt's thought, as she does not take it into account in her 1958 essay *The Human Condition*, while at the same time acknowledging that family life is "the centre of the most rigid inequality".

[15] A line of reflection already developed in Fraser and Honneth 2003.

[16] See also the book ed. by Vanni and Monaco Gorni 2019.

recognising in women a natural propensity to care, stemming from their ability to procreate and disposing them to order, obedience, generosity, and attentiveness.[17]

In this profession, as in teaching, maternal symbolism thus plays a fundamental role in determining women's segregation into certain jobs. And because these jobs are seen as the projection of an innate femininity—something one does not learn—they are perceived as lacking an economically recognisable professional value and therefore remain devalued and undervalued.

Low recognition also extends to the moment when these activities enter the labour market and become "jobs" according to the canon of classical political economy, which distinguishes work from non-work based on the presence of a quantitatively identifiable market demand. Since these are not manufacturing activities but services, they are considered less demanding than factory work (performed by men) and therefore of little economic relevance (Scott 1991).

A decisive impulse toward recognising the value of care work came from feminist movements, especially Marxist feminism (Dalla Costa and James 1972; Vogel 1983; Davis 2018) and feminist theorists of social reproduction (Bhattacharya 2017; Jaffe 2020), who denounced the "banalisation" of discourse on care and the rhetoric of motherhood and good feelings that wrapped it in history, reproducing essentialist gender stereotypes (Giolo 2020; Fazio 2024).

In this sense, Silvia Federici's 1970s campaign in the United States for recognising the value of domestic work was particularly significant. That claim aimed to denounce and counter a patriarchal social division of labour that assigns domestic tasks to women without recognising their value for the reproduction of capitalism.[18] For our purposes, it also challenged the classical political-economy assumption recalled above—according to which only what is demanded on the market counts as work—contested the centrality of productive labour and of the worker subject, and promoted the idea that work also includes activities aimed at fulfilling others' individual purposes, including the need for care (Federici 1976).

The outcome of this reflection is a redefinition of what "work" is and an extension of the idea of work to every activity with a cross-cutting value for society, including tasks that preserve life and guarantee the wellbeing of society as a whole.[19]

[17] The construction of femininity and its discrimination has its roots in ancient Greece and is concisely reconstructed in Cantarella 2019. See also Campese and Gastaldi 1977.

[18] With regard to the social division of labour, in a recent contribution Honneth emphasises that, in order to be acceptable, it should be based on individuals' freedom of choice. Instead, it continues to be shaped by several factors: economic inequality, which leads the poorest to accept any job under any conditions; stereotypes concerning personal abilities and inclinations, which result in certain jobs being assigned to particular groups; and unconscious self-selection, whereby social expectations shape individuals' employment choices (Honneth 2023)

[19] This is also the conclusion reached by Del Punta 2021. A different issue concerns the definition of work that is relevant for the purposes of labour law, namely which criterion should be applied in order to bring a "job" within the scope of regulatory discipline. Del Punta identifies the expansion of the notion of work as a challenge for labour law, which is called upon to revise its traditional canons in order to find new forms of protection. According to Novella

However, even once care activities are promoted to "work"—indeed necessary work—they remain marked by "naturalness" and therefore destined for limited legal and economic recognition, whether offered and paid by the State or inserted into the market and offered and paid by private actors.

As this latter possibility becomes increasingly widespread due to the contraction of public spending even on services relating to social wellbeing—driving privatisation processes—further issues arise that can only be mentioned here.

A first issue, well-argued by Molinier, concerns the risk arising from excessive fragmentation (or specialisation) of assistance activities, both for the quality of care and for recognition of the value of this work. Fragmenting care activity—overly rigidly distinguishing tasks—strips the work of its nature, whereas effective care requires elasticity. When assisting a person, one cannot be forced to stop at the threshold of an assigned competence; crossing boundaries must be possible so as not to paralyse activity and interrupt the flow of caring, which cannot be divided. This aspect of care work—Molinier explains through various examples—is essential and, like the protected goods themselves, priceless. It cannot be catalogued, fitted into rigid hierarchical schemes, or classified; it cuts across all professional competences and is necessary for care to truly be care. If the value of this trait of care work must be recognised, it is urgent to develop new evaluation criteria.

A second issue concerns the risk—recently highlighted by Piketty and Sandel—that the "commodification" of these services leads to a "corruption of the meaning of goods and social practices".[20] If, for our purposes, health and personal wellbeing are invaluable goods (both individually and collectively), the definition of the value of activities aimed at satisfying them—and the conditions under which they are provided—cannot be entrusted to profit-market logics. They must receive direct consideration by public authorities—the expression of collective will—who should take responsibility for this process when distributing public resources.

Against the background of these reflections, the CARE4CARE Project was conceived and built.

## 3. Object, Aims and Resources of the Research

The object of the research is the working conditions of care-sector workers whose professional profiles require, at most, a three-year bachelor's degree and who provide assistance to persons in need in six EU countries.

(2022, 17), the criterion for distinguishing what counts as work for the purposes of applying labour protections lies in the presence of a principal, a client, or an employer who benefits from the performance, regardless of the nature of the relationship. See also Molinier (2013).

[20] Cf. Piketty and Sandel (2025, 32). See also *The Care Manifesto* by The Care Collective (2020), which denounces the incompatibility of care with market logics, citing as an example what occurred during the COVID-19 pandemic with regard to the production and commercialisation of medical devices in the United States and Great Britain.

With reference to Italy, the research considered four professional profiles: nurses, social-health operators, social-assistance operators, and personal assistants working either in the care recipient's home or in health facilities or residential/non-residential care structures, both public and private.

The research did not concern informal care work provided free of charge by family members or volunteers—work that nonetheless deserves attention, since it represents a significant share of essential work for the wellbeing of people and societies.[21]

The care economy, global care chains, and the conditions of care-sector workers are widely present in international social-science debate[22] and have been regulated by the ILO. They have been less explored nationally, including comparatively.[23] Yet empirically, some critical trends common to the six countries involved emerge, making this a promising research field and providing the starting point for the project.

To begin with, the number of people needing care and assistance is increasing everywhere, also due to population ageing.[24] The need for staff therefore grows in a sector already marked by significant and worrying labour shortages.

Equally widespread is the trend toward contraction of public spending (including) for socio-health services. On the one hand, this aggravates staff shortages and, in cascade, worsens working conditions due to overload. On the other hand, decreased public service provision has driven expansion of a private "care market", creating an urgent need for regulation to counter new forms of exploitation (cf. already Hermann and Flecker 2012).

In Italy, in particular, the progressive contraction of public spending on personal care services fits into the broader trend of containing public welfare spending initiated in the 1980s and intensified after the 2007–2008 financial crisis and the 2020 pandemic crisis. The combination of reduced public spending and increased demand for care services has driven the rapid development of an increasingly structured "do-it-yourself welfare" model (Borelli 2020), in which a broad network of care-work intermediation platforms also plays a significant role—often relying on insecure and poorly paid labour (Trojanski 2000; Lenaerts et al. 2024).

Countries also address the care-sector crisis by resorting to global labour chains that pull migrant workers into a mostly informal and insecure market (Pavlou 2021). In many countries, if family caregivers are excluded, the supply of care work—especially within private homes—is dominated by migrants.[25]

[21] According to the survey conducted by ISTAT in 2018, family caregivers numbered just over seven million, predominantly women, in the 45–64 age group (ISTAT 2018). On this issue, see also the report drawn up by CNEL in October 2024 (CNEL 2024).

[22] See, for example, Pavlou 2023; Blackett 2019; Fudge 2016; Mantouvalou 2015, 329.

[23] An exception is the study by Borelli 2020 and the volume edited by Casano 2022.

[24] Suffice it to say that, according to a recent ISTAT survey, Italy is among the countries with the highest life expectancy, which has reached an average of 83.4 years (ISTAT, 2024).

[25] Ambrosini 2013. Eurofound 2020; SPC and DG EMPL 2021, 74.

But unlike migration in other economic sectors, migration for care purposes—as recalled—is strongly feminised, making the sector a significant arena for observing and studying not only multiple discrimination but also intersectional discrimination, addressed for the first time by Directive 2023/970/EU.[26]

The massive presence of women is not limited to migrant labour: it characterises the entire sector. All six countries are marked by a clear predominance of women in care work—on average more than 75% of the sector's workforce.[27] Even culturally and economically advanced countries such as Sweden and Germany are not exempt, showing how deeply rooted gender segregation is. In Sweden, for example, women represent about 90% of nursing staff and about 70% of those providing home care. In Germany, 80% of care workers are women; in early childhood care women are 95%; in care for the elderly, the ill and persons with disabilities, the share is lower but still much higher than men's; in outpatient services women are just under 88%, and in hospital care 85%.

Italy also follows this trend, and the COVID-19 pandemic only confirmed it, since in the emergency women were involved disproportionately in care and assistance activities (unpaid, in the case of family care) (see the study by Del Boca et al. 2021).

Alongside feminisation runs another cross-country trend: despite nuances and despite the impact of this work on individual and collective wellbeing, the low social and economic valuation of care work persists over time, for the historical-cultural reasons outlined above. In recent years there has been a movement to valorise care professions—for example, the *Care.Macht.Mehr* manifesto first published in Germany in 2013, or *The Care Manifesto* published by The Care Collective in 2020—but collective imagination still sees this work as "taken for granted", as if it required no professional knowledge and competences measurable by market parameters. In particular, the capacity to look after and care for people (not *to cure* but *to take care*) is seen as innate in those expected to provide it—first and foremost women—so it is deemed neither subject to nor worthy of economic recognition.

Devaluation is also fuelled, in almost all six countries, by a "familistic" welfare model, which places on the family (especially women) the duty to meet the care needs of children, persons with disabilities and older people, and therefore sees paid care work as merely substituting for an activity that should be provided free of charge.

Sweden is an exception, where the welfare state provides such a level of public services for childcare, health, older people and persons with disabilities that un-

[26] These migratory processes also produce significant consequences for the countries of origin of these workers, which are depleted of care personnel and end up experiencing the same difficulties as Western countries related to the shortage of qualified and available staff. This phenomenon—known as the so-called care drain—is highlighted in the EMPL and FEMM Report Towards a Common European Action on Care (A9-0189/2022) (cf. European Parliament et al. 2022).

[27] Cf. the final reports of the project available in Volume I and II.

paid care work—though present—can be returned to the sphere of free choice to care for reasons of affection or solidarity.

State assumption of person-centred services thus counters inequalities: generally, because it enables all citizens to access care services regardless of means, in a redistributive logic based on progressive taxation; and in gender terms, because freeing women from care burdens ensures both full participation in the labour market and the possibility of caring for family members freely,[28] removing work-life balance from the dynamics of the individual employment contract.

As for the working conditions of healthcare and care workers, critical issues typically include: generally low wage levels; psychosocial risks (work overload, violence and psychological/physical harassment) leading to stress and burnout; physical health risks leading to injuries and occupational diseases; horizontal and vertical segregation with direct and indirect discrimination; unstable jobs due to frequent use of non-standard contracts (temporary work, part-time, platform work); weak recognition of competences and low investment in professional qualification, affecting career opportunities. In particular, the entry of care work into the market of professions has produced the fragmentation process mentioned above, with significant consequences for care quality, risking dehumanisation and losing sight of the person receiving assistance (see again Molinier 2013).

Even more delicate is the condition of those providing home care, live-in or live-out. In all countries studied, work performed in the private home is subject to exceptional regulation because the employer—the family—has peculiar characteristics. Legal protections are generally weaker, collective bargaining is less developed and coverage lower, even though ILO Convention No. 189/2011 has been ratified at least by Italy, Germany and Sweden.

Home care workers are almost entirely women and migrants from Eastern Europe and third countries; irregular work and work via private agencies are widespread. Working conditions are particularly precarious, wages low, and psychosocial and physical health risks very high—especially physical and mental fatigue, harassment, lack of respect for working-time limits, and frequent confusion between work time and free/rest time.

European and international institutions stress that ensuring good-quality working conditions is necessary for good-quality care services. The ILO, for example, stated in 2018 that "poor job quality for care workers leads to poor quality care work". The European Care Strategy proceeds in the same direction, as discussed below.

A crucial aspect of job quality is the physical and mental wellbeing of care workers. Many empirical studies confirm that working conditions affect workers' physical and psychological health and wellbeing. In describing quality of life for care workers, social recognition (for building a solid professional identity), organisational characteristics (e.g., shifts), and the nature of care work (e.g., task

[28] See again the thesis already mentioned by Honneth 2023.

definitions and the competences needed) have been identified as key factors for caregiver wellbeing. It has also been established that care workers are exposed to many stressors due to heavy workloads, long shifts and high pace, exposure to traumatic events, poor support and social recognition, and perceived insecurity due to widespread precariousness.

Against this background, the project investigated—comparatively and multidisciplinary (legal and psychosocial)—working conditions and workers' perceptions of workplace environment and dynamics in the six EU Member States (France, Germany, Italy, Poland, Spain and Sweden) involved in the project, aiming to develop appropriate tools to improve job quality and counter discrimination in the sector.

In particular, the research pursued three objectives designed to have concrete social impacts:

1) Drafting a political strategy proposal to submit to EU institutions to remedy undervaluation, improve conditions and counter discrimination.
2) Designing and piloting a training pathway model for trade unions, family associations and employer associations to transfer knowledge acquired through research, making collective bargaining more effective.
3) Creating an easily accessible IT platform for workers, presenting and explaining core rights translated into all languages, to improve awareness of rights and the perceived value of work.

The project thus combines two university missions: basic research and engagement with society.

The aims influenced the consortium composition: ten partners representing six EU countries with different welfare models and labour-regulation systems: two Mediterranean countries (Spain, Italy), two central European countries (France, Germany), one northern country (Sweden), and one eastern country (Poland).

Predominantly labour-law expertise from the Universities of Girona, Lund, Bordeaux, Frankfurt (Oder), Rzeszów and Florence is enriched by a social-psychology research group from the University of Seville, responsible for the work-wellbeing investigation.

Also important is the participation of two interest-representation organisations within the sector (EFFE – European Federation for family employment and home care; EFSI – European Federation for Services to Individuals), which served as a bridge to civil society both in information gathering and—especially—in dissemination.

Equally essential was the contribution of a Brussels-based organisation specialised in communication and dissemination (TOUR4EU – Tuscan Organisation of Universities and Research for Europe Group), capable of effective dialogue with EU institutions, particularly for transferring regulatory proposals collected in a Policy Paper.

Support from ETUI (European Trade Union Institute) should also be noted, as it followed the project from the start and involved consortium members in scientific initiatives.

## 4. Care Work Within European Social Policies…

In its Communication to the European Parliament, the Council and the European Economic and Social Committee of 20 November 2017 containing the 2017–2019 EU Action Plan, the care-work sector was included among the sectors "key for the future of European society and economy".

The COVID-19 pandemic made the centrality of care work even more evident, but also made visible many critical issues regarding workers' conditions: scarcity of economic resources, labour shortages, pressure on workers, risks to wellbeing, underfunding of social care as a consequence of reorganisation and partial downsizing of the welfare state—bringing privatisation and commodification of public services—weaker bargaining power compared with many male-dominated sectors, undervaluation similar to other predominantly female jobs, widespread undeclared work among home carers, and discrimination risks based on gender and nationality (and their intersection).

For this reason, in her 15 September 2021 State of the Union address, Commission President Ursula von der Leyen announced a European care strategy, highlighting—among other things—the need to ensure dignified working conditions for all workers engaged in personal care activities.

The *European Care Strategy* document was adopted on 7 September 2022, when the CARE4CARE Project had already been approved, confirming EU institutional interest.

The Strategy is an articulated document in which the Commission set out intervention lines to strengthen EU social policies concerning personal care, highlighting the link—relevant to our purposes and already captured by the theoretical reflection quoted above—between service quality and the quality of working conditions.

The document addresses all actors involved: recipients (children, older people, persons with disabilities) and providers (formal and informal caregivers), and adopts a gender perspective based on two observations: the shortage of care services, still largely compensated by women and thus excluding or penalising them in the labour market; and the feminisation of the care sector, which offers precarious and low-paid jobs.

Accordingly, the Commission promotes: expansion of care services—among other things—freeing women from unpaid informal care; improvement of working conditions to assign proper value and recognition to essential work and make the sector more attractive, including to men.

It identifies routes to reach these goals: strengthening social dialogue at EU and national levels (so far weakened due to low representation, itself linked to high irregular work and many migrant workers); improving skills and reskilling; transparency and predictability of working conditions; strengthening health and safety measures for care work.

A few months later, the Council adopted the announced Recommendation on access to high-quality, affordable long-term care, again stressing the need to ensure quality employment and fair working conditions for long-term care

workers. It again emphasises social dialogue, higher health and safety standards, and effective measures. Particular attention is paid to home care providers, live-in and live-out, who receive a first definition and formal recognition in this Recommendation.

These commitments were confirmed more recently in the *La Hulpe Declaration on the Future of the European Pillar of Social Rights* (16 April 2024), where EU institutions, Member States and European social partners—against the backdrop of global crises linked to climate change and ecological disruption, and ongoing wars (especially Russia–Ukraine)—reaffirm commitments to social and economic progress, equal opportunities, quality jobs and fair conditions, poverty and inequality reduction, and a just climate transition. Given ageing populations, special emphasis is placed on care, underlining the need for effective prevention strategies and access to adequate, fair, and economically sustainable care. For our purposes, it reiterates the need to improve working conditions and vocational training, again highlighting the strategic role of social dialogue and collective bargaining.

### 5. …and the Research Contribution to Improving Working Conditions

In this framework, as result of national analyses and comparative research on the condition of care work in the six countries (now compiled in Volumes I and II) and of related critical reflections (now collected in this Volume), the Consortium reached some conclusions in terms of policy proposals at EU level to improve working conditions.

These conclusions have been translated in a Policy Paper fully available in the second part of this Volume.

The legal and psychosocial study identified two main areas of criticality around which public debate concentrates in the six countries and on which proposals were built: poverty of working conditions (pay, health and safety, stability, and effective enjoyment of rights), and labour shortages with low sector attractiveness. These two aspects are clearly linked in a vicious circle and thus require integrated strategies.

The Policy paper is therefore structured around three main areas.

The first one aims at defining general political objectives to improve job quality and social inclusion of vulnerable groups, based on a synthesis of critical issues and on the conviction that job quality and care quality are interrelated.

The second part outlines measures at national level, stressing the need to strengthen social protection systems, increase public investment in care services, ensure fair minimum wages, establish pathways for developing and recognising qualifications, and strengthen collective bargaining and its effectiveness.

The last part drafts actions for social partners and EU institutions, starting from promoting sectoral social dialogue, defining framework agreements, incentivising exchange of good practices, and coordinating responses to sector challenges.

In sum, the policy document promotes recognising the value and dignity of care work within social dialogue and collective bargaining—for example by

valuing knowledge and competences (including emotional skills) and teamwork capacity. It supports improving working conditions—for example by recognising work-related stress among psychosocial risks referenced in the 2004 framework agreement, and by strengthening the right to rest through measures enabling home carers to "disconnect" without leaving care recipients without necessary support. It also aims to counter exploitation and irregularity among live-in carers by proposing a presumption of subordination and transparency rules to prevent and sanction non-compliance.

Regarding migrants, the document proposes facilitating mobility between countries, extending the scope of the Blue Card Directive, easing transitions between employers and coordination of multiple employers, strengthening the role of the European Labour Authority (ELA) in care, countering discrimination by including care workers in the Commission's new anti-racism strategy for equality for 2025, and promoting ratification of the 1990 UN Migrant Worker Convention by all Member States.

Regarding women workers, it calls for a clearer and more effective anti-discrimination strategy within the next Gender Equality Strategy: on one side, more effective action against the social division of labour that still assigns unpaid care to women and against stereotypes excluding men from these jobs; on the other, stronger state intervention in service provision, including introducing quality targets set by the ELA, making funding conditional on achieving them.

Another significant outcome of the project is the design of a model of training programme aimed at strengthening trade unions, family representative associations, and employers in the sector, with the objective of providing them with a more in-depth understanding of the care sector. This knowledge is intended to support the development of competencies to identify the vulnerabilities of care workers, improve job quality, and counteract discrimination within the care sector.

The training programme specifically seeks to: increase awareness within national trade unions and employers' organisations of the realities of care work and the importance of trade union engagement in this sector; promote an understanding of the multiple vulnerabilities experienced by care workers, with a view to supporting unionisation and improving collective bargaining coverage; develop practical skills—particularly negotiation and conflict resolution skills—among representatives of trade unions and employers' organisations operating in sectors where care work is prevalent; and strengthen the capacity to prevent and resolve interpersonal conflicts, both within institutional care settings and in the context of family-based care arrangements.

The training programme was conceived and subsequently piloted with the main stakeholders in the sector in mind, in particular trade unions and employers' organisations. However, non-governmental organisations (NGOs) and other entities involved in the protection of care workers and in the development of a sustainable care sector were also included within its scope, in light of the potential contribution they can make to improving conditions in the care sector.

The programme was developed taking into account feedback gathered from a sample of stakeholders who had been involved across the six participating countries from the early stages of the research. The contributions received were numerous and played a decisive role in improving the programme. Moreover, this process facilitated the creation of a highly relevant network of relationships, essential for ensuring the effectiveness of the project's outcomes and for designing the continuation of the research.

The training curriculum is structured in the form of mini-modules. The first part applies to all participating countries and ensures uniformity and coherence of approach. The second part, by contrast, is tailored to specific national training needs, as identified by the research units over the course of the project. Each project partner conducted a contextual analysis through stakeholder interviews, surveys, and expert consultations, thereby developing a country-specific component of the training programme to complement the common core.

The result is a transferable model of research and training that can be adopted in other countries interested in initiating a process of investigation and improvement of working conditions in the care sector.

A further objective pursued by the Consortium, which also represents a strategic response to the vulnerability of the sector, is to enhance workers' awareness of the value of their work and of their rights.

The web platform is designed to provide, in a clear and accessible manner and translated into the main languages of migrant communities, key information on employment conditions across the six countries involved, increasing awareness, empowerment and protection against exploitation of care workers.

The platform brings together the main labour law provisions derived from legislation and collective bargaining agreements, accompanied by explanatory notes that clarify the complexity of the respective legal systems and offer guidance to workers, including references and links to access support services, in particular through social partners—namely trade unions, employers' organisations, and family representative associations—which act as primary interlocutors and provided a highly significant contribution to the implementation of the project, engaging to a far greater extent than initially anticipated.

In light of these results, it appears that the project has successfully combined legal and psychosocial research with the development of intervention strategies targeting civil society, capable of fostering change towards improved working conditions.

This represents a non-trivial outcome, made possible by the Consortium's strong and shared commitment to addressing the urgent need to restore dignity and value to care work on which we depend and without which we would betray our shared humanity.

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CHAPTER 2

# Global Care Chains and the Legal/Social Rights of Migrant Workers: an Interdisciplinary Inquiry into Discrimination, Industrial Relations, and Transnational Welfare Regimes

Agata Ludera-Ruszel, Hubert Kotarski

## 1. Introduction

In the 21st century, care work has emerged as one of the most significant and yet cryptic forms of labor. Even though it is essential for economies, households and welfare systems, care work remains largely neglected in terms of legal recognition and social protection. The term "global care chains", coined by sociologist Arlie Hochschild in the early 2000s, captures this tension through the description of international flows of care—predominantly performed by women—that link households, economies and welfare systems around different countries (Hochschild 2000, 130–46). What was once conceived of as private acts of caregiving or household work are now intertwined with a global economy that is shaped by inequalities, gendered roles and diverse rights to citizenship. In a world where globalisation is also increasingly "feminised", the care economy symbolises the tension between the commodification of care and genuinely loving concern, juxtaposing (wo)man-made labour and market transactions. It is profoundly personal and powerfully economic (Williams 2021, 142). The expansion of global care chains results from both structural changes in the international division of labor and demographic shifts in the Global North. At the same time, birth rates are falling, populations are aging and welfare services have been cut, generating a growing demand for paid care work—including in Europe, East Asia and the Gulf (Daly and Lewis 2000:.281–298). In the meantime, economic ine-

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qualities and the limited job opportunities available in much of the Global South and Eastern Europe have generated a huge supply of migrant labor—primarily female—to remain sufficiently cheap (as well as flexible) for border-crossing to provide these equally vital yet undervalued services. This transnational movement, it turns out, has not only displaced labor; we are actually witnessing the re-arrangement of the topology of global social reproduction (Parreñas 2015, 12–9). In families in countries including Poland, the Philippines and Ukraine, remittances sent by caregivers who are mothers or daughters working in places like Germany, Italy, Spain or the Middle East often constitute a key source of income. They are also seen by remittance-analysis in counteracting the shortcomings of weak public welfare systems on both the sending and receiving ends of remittance flows (Yeates 2009, 40–59). The "care deficit" of the Global North is correspondingly inversely related to its "care drain" from the Global South and East, resulting in what researchers have termed transnational asymmetries of reproduction: while wealthy states displace care's costs, societies from which migrants depart absorb accompanying social costs (Williams 2010). In this nexus gender continues to be the primary organizing principle. Feminist scholars have shown that care work, although essential to the maintenance of societies, is systematically devalued due to its association with femininity and affective labor (Federici 2012),35. These hierarchies are also played out on a transnational level by the global care chain, in which women from poorer parts of the world supply intimate labour for households in richer states. These arrangements replicate the past feminization and racialization of domestic work. One of the hallmarks of the global care economy is intermediaries, including agencies that recruit workers, posting companies and transnational subcontractors. These intermediaries serve to broker between household demand for care on the one hand and migrant need for work on the other, but they also are instrumental in reproducing legal fragmentation (Blackett 2019, 49). By building complex chains of contract, intermediaries dilute accountability and obfuscate the employment relationship. So thousands of Polish or Romanian women are being offered jobs as live-in carers in Germany, Austria or Switzerland, for example - often through an agency (Radziwinowiczówna 2019, 89). The workers involved are typically categorized as self-employed by the agencies, which charge them for placement and transport, among other costs. This construction, despite fulfilling the formal criteria of EU law, effectively shifts social contributions onto the workers (EPSU 2021, 21). In fact, many can't afford comprehensive insurance, meaning they may be one illness away from poverty. In the Middle East likewise, employment agencies exploit regulatory breaches. Working under the kafala system, these agencies are middlemen for employers and migrants—frequently charging exorbitant fees, or even confiscating passports. While there has been some recent reform in places such as Qatar and Saudi Arabia, the implementation of that reform is uneven and workers remain highly dependent on their sponsors. These cases illustrate how intermediaries can support and profit from the legal fragmentation of such systems. They take advantage of jurisdictional gaps to avoid costs, and still manufacture consent (Fudge and Strauss 2014, 115). Be-

cause responsibility is dispersed among several agents—households, agencies, sending and receiving countries—no single entity can be held fully responsible for workers' rights. The concept of fragmentation is a system of governance in its own right, not just dragging behind globalization. As David M. Trubek and Alvaro Santos proposed, the displacement of "command-and-control" regulation in favor of "governance through flexibility" speaks to deeper neoliberal transitions in thinking about law (Trubek and Santos 2006, 23). In care work, flexibility is enshrined on a structural level, through atypical forms of employment and the privatization of risk. The operation of this governance model is based on three interlocked principles. The first is juridical differentiation: "A state can continue to manage labor migration even while it does not officially liberalize it by creating category types of work, such as domestic worker, or self-employed caregiver, posted worker" (Blackett 2019, 81–82). Second, there is responsibilization: in this strategy the risk is transferred to workers themselves who are supposed to be responsible for their own well-being by purchasing private insurance or through remittances (Rose 2019, 153). Finally, there is selective enforcement: authorities are more concerned with migration management than labor protection and this effectively renders social rights second class in comparison to border policies (Anderson 2010, 18). What results is a patchy and asymmetric system balancing conflicting objectives of policy as between making care affordable to citizens, maintaining control over migration and flexibilising the labour market (Fudge 2013, 98). For the receiving countries fragmentation decreases financial costs, for the sending countries, it produces remittance inflows that prop up economies at home (Piper 2008, 1290). To workers, it results in chronic insecurity and dependency. Below the structural shifts are people's real lives. Ample evidence shows that the well-being of migrant caregivers is negatively affected by fragmented rights (Lutz 2011, 113–18).

In the absence of labor law enforcement, this class of labourers are typically worked long and hard hours, offered no compensation for overtime or rest (ILO 2010, 32). The absence of health insurance prevents them from reproducing medical assistance, and they are left unprotected in old age (EPSU 2021b, 34). This emotional toll is compounded by the loneliness that accompanies live-in work and separation from their families (Parreñas 2015, 56–9). All of these developments mean a serious erosion of the guiding principles of labor law: equality, dignity and social justice (Arthurs 2011, 30–2). If rights are mediated by citizenship or type of employment, then the promise of universal protection becomes an empty one. And fragmentation is not just a technical matter of legal proof but also involves "substantive moral and political questions" (Fraser 2016, 115). It calls into question the coherence of welfare states and the legitimacy of legal systems that claim to recognize human rights, particularly when they exclude those practicing such rights. We need to appreciate the fragmentation of labor rights and welfare entitlements within transnational care markets as a systemic inequality rather than an isolated technical problem (Williams 2021, 105). It reproduces hierarchies of value between productive and reproductive labour, citizens and migrants, formal and informal economies. It shows

the political and spatial boundaries of social solidarity in a world of global interconnection. In the EU, these hierarchies manifest themselves in discriminatory treatment of mobile workers from more recent member states vs those of older ones. In the South, they take the form of making use of migrant workers to whom rights are denied, who become part of production (of reproductive labour) running their lives for them (Blackett 2019, 102–5). When we consider both of these situations, care work is really a litmus test for how comprehensive our social citizenship is and how agile our labour laws can be. The challenge of fragmentation is more than one of technical co-ordination; it requires a fundamental re-assessment of the operating principles informing our labour and welfare systems (Fudge and Owens 2006, 19). If care is fundamental to human life and social reproduction, those who provide it must be recognized as rights-bearing workers, not as a special exception to the law. The discussion earlier of social fragmentation, noted how care markets straddle a legal grey area and are marked by moral inconsistency.

The article aims to investigate the gap between the high ideals of labour rights and social rights, on the one hand, and the realisation for migrant care workers who are part of global care chains, on the other. Despite national and international laws which promote equality, decent work and social protection, the experiences of these workers frequently tell a different story: one of systematic exclusion. The piece explores these disparities by focusing on how they arise from the complex crosshatch of different regulations—labor law, migration law, welfare policy—that are designed to look as if they have nothing in common and on the gendered and racialized biases that feed them. It also seeks to identify how both the precariousness and discrimination can be transmitted across borders. The structure of the article itself reflects the epistemic strategy pursued by the article: from conceptual framing, through legal analysis and comparative empirics to normative reconstruction. The comparative component is pivotal. Each corridor—whether it is: a) Poland-Germany, b) Philippines-Middle East or c) Romanian-Ukraine and Italy-Spain—exhibits specific patterns of labour mobility, welfare systems and industrial relations. Taken together, they illuminate the diverse landscape of care-migration governance globally and a common trajectory of fragmentation across borders. The comparative dimension also enable the contribution to follow a scale of fragmentation from more regulated (EU) to less regulated (Middle East) and semi-regulated (Southern Europe). In this way, it positions the discourse of migrant carers within a worldwide typology of transnational welfare regimes.

## 2. Conceptual Framework: Global Care Chains and Social Reproduction

It becomes clear just how care work is organized globally, and you see that economic globalization, changes in gender roles and welfare states are all tied together. It's a reflection of how reproductive labor, which has long been considered private and not for sale, is increasingly being treated as just another commodity to be traded across borders. We can make sense of this broader trend

using the notion of the global care chain (GCC), suggested by Arlie Russell Hochschild in the late 1990s as an influential framework for understanding this phenomenon (Hochschild 2000, 131). This perspective connects individual migration narratives to wider changes in labour markets and social policies, and it reveals how richer countries come to rely on women from poorer regions of the world to plug their care deficit as demand is met with supply (Lutz 2004, 89–104).

The concept of global care chains came out of feminist discussions on globalization and international migration. The term was coined by Arlie Hochschild to describe "a chain of personal links between people around the world in which the care of one depends on a larger circle of care at a great distance" (Hohschold 2000, 131). This concept highlights a dimension of global capitalism that is central yet so often hidden: the movement across borders of emotional and reproductive labour. Drawing on Hochschild, Rhacel Salazar Parreñas (2015) proposed the concept of the international division of reproductive labor to underline the hierarchies among women based on diverse nationalities, races and classes implicated through networks of care (13). Since then, the notion has been extended and refined by later studies. Nicola Yeates situated global care chains in the broader political economy of care, concentrating on institutions, states and international organizations rather than just individual migrant stories (Yeates 2009, 25). Yeates located care as a dynamic of globalization: he demonstrated how the global circulation of carers sustains rich nations' welfare systems while worsening dependence in countries from which people move. This analysis was further mobilized for labour law in the work of Eileen Boris and Jennifer N. Fish, who show how transnational chains of care governance reproduce inequalities through a networked with partly gendered legal regimes (Boris de Graw 2015, 94–6). Theoretical underpinning for this work is drawn from feminist political economy. Nancy Fraser elaborately argued that the "crisis of care" points to a fundamental contradiction inherent in modern capitalism—the deepening commodification of social reproduction stands in tension with the moral and practical limits of privatized responsibility (Fraser 2016, 99–117). So too feminists like Silvia Federici and other scholars of reproductive labor have highlighted how the unpaid or underpaid care work women do—in the home, community and on a global supply chain scale—amounts to an invisible subsidy for capital accumulation (Federici 2012, 35).

Together, these essays position care not as a marginal or "domestic" concern but as a structural feature of global political economy. Care chains are not accidental to globalization; they are an essential part of it. This is a global care chain, through which reproductive labor is redistributed cross-nationally in the form of emotional, physical and domestic services that flow from one household/plurality to another (Yeates 2009, 35). These chains often link (up) women across borders in structures of hierarchy: a woman from the Global South or Eastern Europe might take care of a family in the Global North or Western Europe while delegating her own caring responsibilities to another woman at home; dispositive passes fungible on sea, sky and land in ostentatious grasp for chameleonic

commodity" (Parreñas 2015, 17). Not only does this process move around reproductive labour internationally, it also valorises the expectation that women are the prime caretakers.

Care chains exist as part of the larger spectrum of social reproduction—activities that maintain and reproduce life, such as raising children, caring for elderly members, providing emotional support or whatever transforms our personal space into a home (Bhattacharya 2017, 3). "Social" reproduction has both a material and a symbolic aspect: it refers to the daily and generational production of labour power, but also of social relations (Luxton 2006, 37). These labours were invisible in classical political economy, as they existed outside of waged labour, but without them productive labour could not be (Vogel 1983, 142). Hence, feminist scholars have argued for the re-centring of reproduction as a category of analysis.

Global care chains illustrate the transnationalization of social reproduction that, in the past, had been largely contained within the family or country (Williams 2021, 158). The privatization of welfare services in the Global North, as well as demographic ageing and women's labour-market participation, creates demand for cheap care labour. At the same time, economic precariousness and few job opportunities in the Global South encourage women to migrate. This flow of care work becomes a drain (like "brain drain") responsible for the deprivation of local communities capacity to reproduce life (Yeates 2009, 42).

This transnational re-allocation of care generates transnational opposites: wealthy countries dump the burdens of social reproduction on poorer ones and thereby mirror global hierarchies of wealth, gender, and race (Parreñas 2002, 39–54). As Yeates contends, the global care economy is "a system of social reproduction whose uneven geography is constituted by power asymmetries between North and South, men and women, citizens and migrants" (Yeates 2009, 89). These opportunities are not just economic, but legal and moral. Migrant care workers routinely occupy sites of incomplete incorporation: incorporated into the host economy but excluded from full social citizenship (Vosko 2010, 11–3).

The care chain analogy is more than just a tale of exploitation. And as Parreñas adduces, it also relates to agency, emotions and negotiation: migrant women aren't just victims at the mercy of some abstract force; but more so active agents that employ migration in order to support their family and find their own identity (Parreñas 2002, 21). But the extent to which they can act is constrained by structural forces that transform care into a commodity and racialize the workers who provide it.

A key characteristic of global care chains is the feminization of migration. While in the past, international migration used to be mainly male and for employment in construction or agriculture and manufacturing, today women make up roughly half of all global migrants, even exceeding 50% gender shares on some corridors (UN 2020, 8). A large part of this feminized migration is dedicated to care work and domestic labor. The feminization of migration is not just a demographic shift; it reflects changing labor market requirements and shifting gender roles. Restructuring welfare states, under the heavy influence of neoliberal

austerity regimes, has created a "care deficit" in industrialized countries (Daly and Lewis 2000, 284). As increasing numbers of middle-class women enter the labor force, demand for domestic help increases. But instead of men picking up more unpaid caring roles, families frequently rely on migrant women to help (Williams 2010, 2–6). This context creates what Helma Lutz has called the "globalization of intimate life", not only meaning that women have services and love begin to crisscross boundaries, but carer able to be bought (Lutz 2011, 3–4). "This womanly character has consequences for the position of (the poorest) women in society… this 'natural femininity' renders women from some regions more suitable for… low-status and low-paid jobs" (Lutz 2011, 15). In addition, race and nationality intersect with gender in the formations of hierarchies: Filipino, Ukrainian or Ethiopian woman are regarded differently within different labour markets according to prejudiced expectations about their reliability, obedience and emotional warmth (Palenga-Möllenbeck and Lutz 2011, 4–6).

These hierarchies are graduated levels of precarity. Feminised Migration Feminised migration is usually on temporary contracts, not in formal employment and heavily dependent upon employers or intermediaries Fudge 2013, 96). A large percentage of care givers fall outside the mandate of national labour legislation; and are frequently not permitted to join trade unions (ILO 2010, 4). Their legal relationships—whether they are live-in domestic workers, self-employed caregivers, or irregular migrants—significantly shape their vulnerability to exploitation.

But precarity is not only one of legality or economy; it has emotional and spatial aspects too. [ Page 96 ] Live-in Caregivers often experience both isolation and privacy invasion, and are emotionally drained" (Lutz 2011, 114). Labour in the intimacy of the private household generally involves essential confusion between work and welfare, professional task on one side limited relationship on the other (Parreñas 2002, 66). Migrant caregivers form close connections with those they care for, but they also struggle with longing and loss—homesickness and separation from their own kin.

This emotional labor also brings out the bitter irony of global care chains: they are sustained by human affection, yet they transform that affection into a commodity. Love and care, as Hochschild observed "formerly exchanged within families are now being traded in the new international division of labour" (Hochschild 2000, 133). Here the emotional and affective side of care is production inherent in its value -in other words, it is both that which makes car e valuable and devalued (because it supposedly "comes naturally" from women's hearts), as well as not a worthwhile actual wage or even legal figure:1075 because it comes naturally (Anderson 2010, 133 ).

The double-edged nature of care as both a private and public good accounts for its Janus-headed legal and institutional position. Care, on the one hand, is of fundamental importance for societies to reproduce and economies to function; and yet, it tends to be "privatised" (within families and markets) (Esping-Anderson 13). This ambivalence is written into law: care workers often occupy a grey area between work and kin, professionalism and domestic life. From an

economic perspective care is generating positive externalities whereby societies gain when the old, young and those with disabilities are well cared for (Daly and Lewis 2000, 288). But since the positive effects of these choices are enjoyed by society as a whole, and costs are borne individually, markets both underprovide and underpay care. Historically, welfare states tried to redress this failure through public provision or subsidisation, but under neoliberal retrenchment the burden has increasingly been re-privatised along households and migrants workers (Williams 2021, 161). Legally, the work of care challenges the traditional model of employment around which labour law was constructed (Arthurs 2011). Labour codes are built on the model of a male, factory or office worker "breadwinner", not an in-home migrant woman attending to an elderly person (Blackett 2019, 72). Domestic and care work has therefore historically been left out of legal safeguards which include the minimum wage, protection against excessive working time and collective bargaining (Fudge and Owens 2006, 14). Where they have been added, protections are frequently compromised by a range of exemptions acknowledging the "special nature" of domestic work (Blackett 2019, 80). International instruments, such as the ILO Domestic Workers Convention no. 189 (2011), have recently begun to challenge this idea that domestic work is in some way less important by affirming once and for all that "domestic work is work" (ILO 2011). The truth is that ratification and implementation are fairly limited but enforcement of such standards remains problematic, particularly because the workplace is considered private (HRW 2008). In numerous areas, labor inspectors are barred from private homes as a result of which the distinction between family and employment borders on the legally and morally incomprehensible. Indeed, this confusion is further complicated by the fact that care work entails both emotional and economic dimensions (Lutz 2011, 108–10). It's hard to regulate emotion and it's hard for legal systems that are dealing in law-and-order points to measure emotional labor inequity, or differentiate between real love and coercion. But, as Adelle Blackett analyses, the problematic is how to bring together the intimate and relational with the universal of labour law (Blackett 2019, 85). With too much formalization—the potential for care to become simply "contractual"—competing with not enough regulation and the absence of protections for workers (Boris and Fish 2015, 112).

To be sure, some thinkers have urged that the law should re-imagine care as a public good and a social right beyond of the rigid confines of employment (Folbre 64). That would involve treating care as basic social infrastructure, like education or health care, publicly financed and regulated. Alternatively, some advocate the development of "transnational welfare regimes" securing "the portability of social rights for migrant carers" (Yeates 2009, 201). Both models seek to destabilise the false dichotomy between personal caring and professional labour.

Above all, at the end of the day, care's ambiguous legal status is so interesting because it sheds light on some deeper social contradictions concerning value and dependence. We inhabit a world of self-realization and efficacy, yet little appreciation is given to the co-dependence that enables these values (Fraser 2016,

115). Migrant carers are right at the centre of these contradictions: they belong to a largely hidden backbone of global social reproduction.

The concept of global care chains and social reproduction lets us see that care work isn't a sideshow; it's central to understanding the complexities of globalization, migration and inequality. It connects the quotidian with what is personal and private in households to larger or structural dynamics in the world economy. Feminist theorists as diverse as Hochschild, Yeates and Parreñas have argued that the mobility of care labour across national boundaries not only bolsters but also undermines certain modalities of contemporary capitalism.

By linking emotional labor to the larger process of accumulation of wealth and welfare cutbacks, the GCC framework is also valuable in terms of considering care as a public responsibility that merits legal recognition. If care remains confined to the household and handed over as a commodity under unpredictable conditions, ideals of equality and social citizenship will remain illusory. Nonetheless, in what follows I aim to push this thought further, and consider more carefully how it might help us reconceive labor laws (and related industrial relations and welfare policies) so as better to align the intrinsic worth of care with the rights of those who do it.

## 3. Legal and Institutional Contexts

The labour law and social law of care work is a classic liminal one. International and European norms have gradually recognised these as economic and social activity, but domestic systems persist in treating care as a residual or special category. This part gives an account of the international and EU legal framework on care work, describes mismatch national labour codes deviations, analyses the concept of "legal invisibility" and assesses what welfare regimes and the portability of social security rights imply for migrant caregiver.

The juridical classification of domestic and care work as "work" is recent. International labor standards over the history have however focused mostly on industrial or male-heavy professions and largely ignored reproductive labour. The adoption of the ILO Domestic Workers Convention, no. 189 (2011) and Recommendation no. 201 was a significant development. For the first time, the International Labour Organization acknowledged in unmistakable terms that domestic workers are entitled to the same basic rights as all other workers: decent wages, reasonable work hours, safe working conditions, social security and freedom of association.

Ratification and implementation have been under way, but there's still no harmonization between countries. Only some forty countries had actually ratified the Convention even by 2025 and in most instances, compliance tends to be partial (ILO 2015). There are continuing enforcement problems, largely because care work is so frequently done in the unofficial or private economy; labor inspectorates have little power to control what goes on inside people's homes. Then the notion of "progressive realization" contained in the language of the Convention's Article furthers a great amount of discretion, leaving domestic workers suspended in a realm with partial protection (Blackett 2019, 75–7).

At the EU level care work is addressed indirectly rather than directly, through a number of instruments. The European Pillar of Social Rights (2017) provides for "equal opportunities", secure and adaptable employment" and access to social protection" for all workers, including the self-employed (European Commission 2017, 5–18). Principle 18 foregrounds the need for "affordable long-term care services of good quality", but it does not extend to the labor rights of the caregivers. Although the European Union's Directives on Transparent and Predictable Working Conditions (2019/1152) and Work-Life Balance (2019/1158) offer protection—rights to informed work, parental leave as well as non-discrimination—how these translate in practice can vary greatly from one EU Member State to another. The regulations on worker posting and self-employment within the EU are of particular importance to migrant caregivers. Provider of Services Directive Members' research service Page 3 The Posting of Workers Directive Despite being posted, employees remain under the law of their home Member State.

The rules of posting workers and self-employment in the EU are especially relevant for migrant carers. Statement of the previous legal situation The Directive 96/71/EC on the posting of workers (transposed into Belgian law by way of a Royal Decree, implemented to Article II.2–19 par. 1 of the Social Penal Code) provides that employees posted to another Member State whilst performing work there for a certain period continue to be covered by social legislation in force in their home country. Within the sphere of care work, "posting" workers from Eastern to Western Europe—through which intermediaries proliferate and a regulatory grey area is created 15—has been made possible under this framework. By contrast, under the EU Treaties self-employed persons are guaranteed freedom to set up in business and provide services. This is what enables agencies to call caregivers "independent contractors", even while there's a real sense of subordination in the work.

Both of those substitutes—in turn themselves resulting in what scholars would call jurisdictional evasion. This is what happens when employers and intermediaries artfully select legal forms to reduce costs and circumvent the protections provided by host states (Fudge 2014; 2009–2010). The result is a patchy system that divides between the national and migrant care workers, driving apart EU social citizenship (Davy 2013, 632).

Legal constructions of domestic labour domestically and throughout Europe (and beyond) differ widely in how they categorise care work and regulation. In Germany and Austria the care of home-bound employed by migrant third country nationals is predominantly organised as so-called commercial-law based self-employment, not under labour law (Palenga-Möllenbeck and Lutz 2016, 68). They are not covered by collective bargaining and by most social insurance programs. 3 It is interesting to note that the domestics work is recognised in Italy and Spain in the labour law, exactly under specific regulation with less stringent standards for working: time, break periodisation and dismissal (Bonizzoni 2020, 119–33). In the Philippines, care migration is consolidated by the labor export policy and securitized by standardized contracts approved by the Philip-

pine Overseas Employment Administration (POEA). But the level of contract enforcement in third states actually depends on the agreements reached with those host nations (Rodriguez 2010, 46).

The essential comparative disjuncture is between the personal character of care work and the industrial structure of labour law. Labour codes presuppose the wage-labour as being done in a public workplace, and it is observed by a known employer. Domestic and care work, on the other hand, takes place in private homes and is typically intermediated through agencies, with blurred lines between intimate relationships and employment (Anderson 2000, 19). Consequently, a lot of national laws are silent on care work, or create special rules (which are frequently rationalized in terms of privacy and trust). Recent national reforms in countries such as Spain (Royal Decree 2022/1521) have sought to integrate domestic workers into the mainstream social security systems at large, signalling a gradual trend of moving towards compliance with ILO provisions. Yet, the continued availability of these nested categories— including live-in vs live-out, direct hiring versus agency, national and migrant status—undermines a realignment with equality in law. [St14] Legal invisibility has been an important intensification point for domestic and care work in socio-legal research (Blackett 2019, 80). It refers to the legal mechanisms where law makes some labours invisible as well as partially visible. Invisibilization happens in a variety of ways: a) categorical exclusion, or simply leaving domestic work out of labour codes; b) normative exceptionalism, which is the regulation of domestic work under diluted or "special" regimes; and c) practical non-enforcement whereby rights on paper are nowhere to be found when it comes to reality(Boris and Fish 2015, 101).

Legal nonexistence is both a cause and an effect of care devaluation. The intimate environment in which domestic work takes place blurs the division between productive and reproductive labour, which may be invoked by employers and policymakers to explain why standards should be lowered because of "family-like relations" (Anderson 2000, 21). This sentiment is echoed by feminist legal scholars like Adelle Blackett who claim that this exceptionalism reinforces gender- and racialized hierarchies, as women—particularly migrant women—are relegated to an unregulated emotional labour sphere (Blackett 2019, 82).

Furthermore, invisibility is not limited to statutory words but also includes administrative and judicial practices. Labour inspections seldom enter private homes, and few cases go to court because workers are "tied" through their residence permits and there is a sense of shame around domestic work. This has the effect of undermining the protective function of the law where vulnerability is greatest. Fudge refers to this state as "precarious legality": rights in name only, but not delivered through structure (Fudge 2013, 96).

Labour rights themselves will not ensure dignity to care workers unless there is access to social protection. Regrettably, however, social rights remain firmly rooted within national territorial borders based on citizenship or residence (Esping-Andersen 1990, 12). This presents problems for migrant care providers who have frequently worked and circulate across (sub)national boundaries

finding themselves excluded from a means of social insurance contributions, pensions, and health coverage.

In the European Union, social security systems are coordinated by Regulation (EC) No 883/2004. Remember, while you're working on your responses, that the language really is important; don't make up a whole new one. It allows periods to be aggregated and vitiation of benefits between Member States. The latter is on the condition that employment relationships are legally established, with precise records regarding contributions and—what is less common in a fragmented care sector (European Commission 2020, 19)—institutions. Self-employed and informal caregivers are entirely excluded from the coordination system.

Social-security agreements In bilateral social-security agreements between EU and non-EU countries (such as the Philippines, certain Middle Eastern countries), a restricted degree of portability is offered. Domestic workers in the Gulf are frequently excluded from social-insurance based schemes because of national laws (HRW 2008, 6). Where coverage is available, the complex bureaucracy and absence of clear information can make it hard for people to file claims. The consequence is what Nicola Yeates labels the "transnational welfare gap"—carers underpin the destination country's welfare with little or no entitlement themselves (Yeates, 2009, 92).

The welfare regime structure also influences the demand for migrant care. In familialist regimes like those found in Southern Europe, low public provision forces households to take up the slack with increased reliance on informal markets (Saraceno 1998, 165–82). In liberal states such as the UK, privatisation was followed by creeping dependency on low-paid migrant labour through formalised agencies. In social-democratic nations like those in Scandinavia, government is more effective at providing a safety net, though inequality still looms. Women migrants, for example, commonly occupy the bottom of the care hierarchy (Williams 2021, 171). This is not confined to any specific form of government, and the absence of transnational portability leaves many in precarity and furthers the gap between those who are cared for and those who provide care.

The legal and institutional fabric concerning care work continues to be highly fragmented on different scales—international, regional and national. It's a problem that recent legislation has attempted to address. Although ILO Convention No 189 and EU initiatives are steps in the right direction, gaps in implementation, jurisdictional slips and funnelled welfare remain. Domestic and migrant caregivers still inhabit a terrain of legal invisibility, in the interstices between private love and public duty.

These divides need to be divided itself; it demands a reconceptualization of labour law's conceptual geography, and of welfare law's territorial imperative. To recognize care as essential work demands not only that employment rights be extended, but also that social security be transnationally portable. Until legal regimes align domestic and international realms of care, the workers on whom the welfare of the world's social reproduction depend on will be left outside the most generous offers of social membership.

## 4. Comparative Case Studies: Transnational Corridors

And the way that care work is organized in every corner of the world is not identical. It actually reflects the special cocktail of laws, welfare systems, migration policies and gender ideology. Through the juxtaposition of three cross-border corridors, i.e., Poland to Germany, the Philippines to the Middle East and Romania-Ukraine to Italy-Spain, we can see that structural inequalities are institutionalized in different legal-social structures. Each of these cases represents a different model of transnational labour governance: intra-European mobility, contract migration with sponsorship, and household employment in the informal sector. These cases offer some insight into what happens when the international and national, law and quotidian lives of migrant caregivers intersect.

This Poland-Germany corridor is really illustrative of the difficulties involved in European integration. Since the enlargement of the European Union in 2004, labour and services mobility has generated high East-West migration, particularly in the care domain (European Commission 2020, 18). Today, tens of thousands of Polish women are working in Germany at nursing homes, where round-the-clock care is needed and the labour market demand is forgiving toward short-term employment (GERMAN – Schenk 2005: Lutz et Palenga-Möllenbeck 2016, 65–90).

### 4.1 Regulatory Triad: Posting, Self Employment and Agency Intermediation

It's also a complex legal terrain to travel when it comes to cross-border care—there are worker postings, self-employment and agency work all in the mix. Under Posting of Workers Directive (96/71/EC revised in 2018) Polish staffing firms can send temps to Germany without breaking contract under the Polish law. This arrangement not only facilitates lower social-security contributions and wages in Poland, it also places these undertakings at a competitive advantage, though at the expense of formalizing a regulatory loophole (Fudge 2014, 410).

In Poland those making the arrangements are often *jednoosobowa działalność gospodarcza* i.e. "self-employed". But the conditions in which they work are nearly identical to traditional workers. Polish agencies are often hired by German households, which subcontract the work to women who by law are technically self-employed. This three-way setup also makes it difficult to assign blame and creates an opaque relationship of employment, which weakens the enforcement of German labor protections such as their Minimum Wage Act and working-time regulations.

The boundary between lawful posting and pseudo-self-employment is deliberately nebulous. Transnational care markets are capitalizing on jurisdictional evasion that is benefiting from the tension between EU freedoms and national labour standards. Labour inspections are frustrated by the challenge in determining which law applies, and enforcement is problematic because the workplace is a private place.

### 4.2 Dismembered Insurance and Coordinating Welfare

Posted and mobile workers are theoretically able to keep or transfer their insurance rights across borders under EU Regulation 883/2004 on social security coordination. But this system assumes steady jobs and provable contribution histories. De facto quasi self-employed carers contribute only marginally to part of the Polish social insurance and both do not have a pension or health coverage in any of the two countries (European Labour Authority 2023). The effect is a "social security limbo", in which transnational workers support two welfare systems yet are integrated fully into neither.

### 4.3 Industrial Relations and the Boundaries of Collective Representation

The decentralized, atomizing nature of home-based care is the enemy of collective organization. The traditional trade unions in Germany, for instance ver. di, traditionally targeted at institutional care rather than private households. Only the past few years have seen initiatives such as Faire Mobilität (Fair Mobility), and the FairCare Alliance start providing carers' mobile legal counselling and advocacy. The division of employment status into self-employed, posted and informal work make it difficult to extend union coverage or bargain collectively.

Polish trade unions, on the other hand, have very little to do with emigrant workers—who they consider as not being part of their domestic labour constituency. As a result, transnational carers slip through the mesh of industrial relations on either side of the frontier. The Poland-Germany scenario exemplifies the "Europe paradox", the combination of legal mobility and social stratification in an allegedly united labour market (Davy 2013, 632).

The Philippine state continues to promote labor export as one of the cornerstones of its national program of development. This "state as broker of global care labor"—a notion Robyn Rodriguez uses to describe it—emphasizes the state's role in brokering out this exchange of workers (Rodriguez 2010, 46).

### 4.4 State-Controlled Migration and Contractual Governance

Magdaraog (et al. 569) describe it as both a facilitator of labor export and regulator in the recruitment, deployment and welfare of overseas Filipino workers (OFWs)". The POEA is responsible for processing the applications of job seekers while OWWA deals with mandatory insurance coverage before OFWs leave for abroad. They utilise standard employment contracts that specify wages, working hours and conditions for repatriation, which aid in ensuring state control (POEA 2023). Preferably, these contracts will internalize existing global labor standards into the 2-way agreements between PH and host countries such as Saudi Arabia, Kuwait and Qatar.

This system, based as it is on contracts, represents a kind of state-managed precarity: the regime reduces some vulnerabilities through pre-departure training and welfare funds but also sanctions mass expropriation for export in place

of domestic employment policy. Despite its small size as a population, remittances play a massive role in the Philippine economy and amount to nearly 10% of the nation's GDP. This also draws attention to the continued political and economic dependence on overseas laborers (Philippine Statistics Authority 2024).

### 4.5 Sponsorship Systems and Lega/Dualism

In countries where there are migrant workers, such as the Gulf Cooperation Council (GCC) states, domestic workers come under Kafala, or sponsorship systems. These systems tie their legal residence and job to their employer (HRW 2008, 6). Due to this system, workers do not have the ability to change jobs or leave the country without their sponsor's permission. It results in a two-tier legal system: independent contractual agreements and global norms give hope for basic rights, while domestic immigration law fosters a web of dependency and control (Amnesty International 2022, 11).

While there have been some recent reform within Qatar and Saudi Arabia to relax certain restrictions, the implementation of these changes is often anything but consistent; many employers continue to confiscate passports and restrict freedom of movement - practices that human rights organizations have decried as modern-day slavery (ILO 2022, 8). Lack of mechanisms through which workers can raise issues, and the private nature of domestic work only helps to perpetuate a culture of impunity.

### 4.6 Human Rights Dimensions and the Political Economy of Remittances

It is tension between rights talk and economic reliance, which shapes this corridor. The reality is that of the government's *ajlput* representation of overseas Filipinos, who it calls "heroes of the nation" (*bagong bayani*) and roundly praises for the dollars they send back to their relatives home, without inconvenient discussion of how so many got into vulnerable situations in the first place (Rodriguez 2010, 83). Meanwhile, the countries that host these workers rely on sponsorship systems in order to transfer the social support responsibility directly to the migrants being excluded from welfare schemes.

There are some inroads in human rights advocacy through international non-governmental organizations, church groups, and groups from the Filipino diaspora. For example, they have signed model contracts that guarantee workers a day off per week and minimum-wage pay (ILO and OWWA 2021). But, as these victories show, this progress exists alongside persistent structural inequality. As Adelle Blackett notes, contractualization without citizenship replicates colonial hierarchies in the name of legal modernization (Blackett 2019, 87).

Here then, the Philippines-Middle East corridor is illustrative of international labour law's capability to counter state sovereignty and gendered migration and global remittance dependency. It underscores how legal dualism—in the form of contractual protection versus sponsorship domination—underpins a transnational system of care extraction.

The third stretch-the connection from Eastern Europe to Southern Europe-is a hybrid system which is officially neither fish nor fowl. Italy and Spain depend on migrant women to plug service gabs generated by familialis welfare and ageing.

### 4.7 Informalization and Cyclical Regularization

Care work in Southern Europe is frequently characterised by a high level of informality. Most of the migrants arrive on tourist or illegal visas and begin to work without formal contracts (Bonizzoni 2020, 120). To counteract this, it has sometimes been the practice of some governments to initiate regularization campaigns (sanatoria) whereby temporary residence and work permits are issued to those that can prove employment. The 2020 regularization in Italy legalized almost 200,000 domestic workers, most of them from Eastern Europe (Italian Ministry of Interior 2020).

Notwithstanding this policy, informality remains as regularization is conditional on job sponsorship and fees (Lutz and Palenga-Möllenbeck 2016, 87). The cycle of these drives creates a revolving door of legality, with employees vibrating in and out. And there continue to be gaps in coverage as well as enforcement under Spain's 2022 reform incorporating domestic workers into the broader social-security system.

### 4.8 Migrant Organizations and New Solidarities

Where there is not strong union representation, the void has been partially filled by migrant-led organizations and NGOs. Organizations like SEDOAC in Spain and Casa delle Donne di Milano in Italy are doing important work bringing legal advice, food, care and protest to the streets, demanding that care work be deemed essential labor. These networks often work transnationally, connecting with counterparts in sending nations like Ukraine or Moldova to exchange information and coordinate advocacy.

All of these, such as weedy localists with a transnational conscience represent what I call a "grassroots transnationalism" rooted not in collective bargaining as organizations per se but in care, and mutual aid (Piper 2003, 357–75). They contest the assumption that migrant carers are simply passive recipients of policy, but rather emphasize them as active political agents who transform local and transnational labour relations.

### 4.9 Gendered and Racialized Hierarchies

The intersection of gender, race and nationality shapes access to labour and treatment within the household. Those who are most sought after including Eastern European women, namely Romanians and Ukrainians at the expense of migrants originating from Africa or Asia due to some racialized perceptions, which prioritize cultural proximity and feeling of "European-ness" (Lutz 2011, 5). However, there is a downside to this presumption of control: it often entails

long working-hours, social isolation and not enough financial compensation (see also Palenga-Möllenbeck and Lutz 2011, 6).

The *badante* ("live-in carer") has emerged as a defining social figure for Italians, symbolising both dependence and marginalization (Williams 2021, 170). These are workers who perform a vital function in the lives of middle-class families when it comes to achieving work-life balance, and they're literally invisible in our country (Williams 2021, 170).

The corridors are three interrelated but distinct modalities of transnational care governance:

Table 1. Three transnational care corridors: regulatory models, primary mechanisms of fragmentation, and dominant employment forms.

| Corridor | Regulatory Model | Primary Mechanism of Fragmentation | Dominant Employment Form |
|---|---|---|---|
| Poland-Germany | Intra-EU mobility | Posting/self-employment ambiguity | Pseudo-self-employed or posted worker |
| Philippines-Middle East | Contract migration under kafala | Sponsorship dependency and dualism | Live-in domestic worker under contract |
| Romania/ Ukraine-Italy/Spain | Informalized market with periodic regularization | Administrative temporariness | Irregular or semi-regular carer |

But despite their differences, all three regimes share certain structural features: they privatize social reproduction, externalize welfare costs onto others, and devalue (usually gendered) care work. In every case relying on how legal and institutional fragmentation reinstate new hierarchies of inclusion and exclusion in a global labor market.

Poland-Germany offers a case of fragmentation within a supranational legal order; the Philippines-Middle East configures fragmentation between formal contracts and sovereign immigration control; and, our Romania/Ukraine-Italy/Spain exemplifies fragmentation through informality and selective regularization. These are not aberrations from globalization but its rule-bound logics.

The comparative view emphasized a key truth that needs recognition: legal formality does not ensure equality. Under the aegis of EU directives, bilateral accords or even unwritten agreement (a reference here to informal day labor), care work continues to be precarious, and its value remains unrecognized by the very systems that prove dependant on it.

## 5. Cross-Comparative Analysis

The three transnational care corridors—Poland-Germany, the Philippines-Middle East, Romania-Ukraine to Italy-Spain—thus not only speak of a rich diversity but also about common structural patterns that underpin global care systems. Despite the variations between these corridors with respect to their le-

gal regimes, welfare states and migration histories, what all three reveal is how global capital's reliance on gendered social reproduction results in a "legal fracture" and experiences of institutionalized insecurity. This chapter draws together the key commonalities and differences across these regions, focusing on structural discrimination within their legal orders as well as industrial relations and advocacy beyond national borders by NGOs and at transnational level which have been reconstituting labor solidarity.

## 5.1 Comparative Synthesis: Commonalities and Divergences

### 5.1.1 Shared Structural Logics

Conceptually, all three corridors are constituted by a shared dependence on the care labour of migrant women in order to underpin an ageing or restructured welfare state. And in the European, Middle Eastern and Southern European conjunctures, one equivalent is performing; what is being externalised onto transnationally mobile feminised racialized labour (Williams 2021, 171). The macroeconomic logic of cost containment meets the moral economy of care, to create what Helma Lutz refers to as "intimate labour regimes of global capitalism" (Lutz 2011, 4).

Across all cases, three intersecting structural features emerge: "Privatization of care provision. Whether through domestic labour, agency arrangements or sponsorship systems, the sphere of care remains 'private', individualized and very poorly regulated" (Yeates 2009, 92).

Legal exceptionalism. Domestic and care work retains a unique legal status, characterized by its exclusion from normal labour law, porous employment perimeters (69 Ibid., 73 70 What Counts as Work?, Gornick et al.) and minimal protection in enforcement (Blackett 2019, 71).

Migrant dependency. Care workers' rights are linked with specific employers or intermediaries through immigration or residence permits, bilateral contracts and posting, which reduce autonomy and collective representation (Fudge 2013, 96).

These shared themes point to a transnational pattern: care work is constituted as intrinsic to social reproduction but not inscribed within the full entitlements of social citizenship. As Judy Fudge suggests, "fragmentation is not the product of accident but a constitutive element in the current global labour regime" (Fudge 2013, 214; also 410).

### 5.1.2 Regional Divergences

While there are some commonalities, each corridor has its own way of governing reflecting its particular institutional logic.

- The Polish-German model is not set with EU law where the freedom of movement for people and integration of markets are complementing each other under membership, which have been accompanied by various national rules. That makes for a bit of a patchwork and underscores the continued tug-of-war between economic freedoms and social protections.

- The Philippines-Middle East model demonstrates what we refer to as contractualized sovereignty: countries that send workers regulate migration by way of standardized contracts, while receiving countries retain control through sponsorship laws (Ibid.). This creates a dual system in which workers are overregulated and under protected.
- The Romania-Ukraine and Italy-Spain model shows a composite pattern of familialist informalization, with most care delivered within households and occasional government action through amnesties and partial inclusion into schemes for social security (Saraceno 1998, 165–82).

What these distinctions suggest are divergent means by which certain care work is commodified, though all to the same effect of a feminized precariat at the bottom rung of global social hierarchies.

### 5.2 Structural Discrimination and Juridical Diversity

#### 5.2.1 Gendered and Racialized Work Stratification

Right from the onset, gender constitutes the axis of labour differentiation. Care work has been socially constructed as "women's work", and rendered legitimate through discourses of women's altruism and maternal instinct (Palenga-Möllenbeck and Lutz 2011, 352). These gendered logics are racialized in particular ways: Eastern European women are constructed as "culturally proximate" and therefore more suitable for intimate labour in Western Europe, while Asian and African women working as maids or cleaners in the Gulf states are hierarchically organised according to their nationality and race (HRW 2008, 5).

This racial stratification is built up through recruitment procedures, visa types and wage disparities. Filipina domestic migrants, for example, receive higher salaries than their Ethiopian and Indonesian counterparts as a result of stereotypes about discipline and English ability (HRW 2008, 5). Conversely, for example, Polish or Ukrainian carers in Germany and Italy might be privileged over non-EU migrants as a matter of practice, but their whiteness does not automatically translate into legal equality. 13 As Ewa Palenga-Möllenbeck notes, "migrant women are either indispensable or disposable —privileged in proximity; precarious in rights" (Bonizzon 2020, 120).

#### 5.2.2 Fragmentation of Labour Rights

"Fragmentation" in a sense of splintering d certain legal phenomenon appear in three related ways:

This fragmentation arises when multiple young legal orders—respondent, state, and bilateral laws—do not appear to have any coherent architecture. Look at the Posting of Workers Directive, which is based on market freedoms more than it does on social protections. This creates the potential for employers to take advantage of variances in legal systems (Palenga-Möllenbeck and Lutz 2011, 7).

Fragmentation of normative affects, coming from differentiated sets of legal categories—of employee, self-employed and domestic worker—which take the care workers out from full labour standards. In Italy and Spain, domestic work is regulated by "special regimes", with weaker rights.

The mechanisms of accountability are weakened by institutional fragmentation, which arises when enforcement agents—labor inspectorates, welfare agencies and migration authorities operate in de-coupled fashion from each other (ILO 2010, 30).

The combined effect is to produce a ranked system in which different categories of workers are granted different tiers of rights, according to their immigration status, sex as well as the character of spaces in which they work (frequently privatized). The home as a site of care and employment, meanwhile, presents a "legal blind spot" that effectively screens inequality from view (Blackett 2019, 80).

#### 5.2.3 Welfare Regimes and Non-Portability

The welfare rights are also fragmented. In every corridor social security systems are territorially-bound and benefits such as pensions and health care are not portable (Esping-Anderse 1990, 15). The migrant carers frequently pay into social insurance of the host country and yet again have no claim to benefits when they return or move on within/ retrogress between Member States. The EU's coordination rules cover only "genuine" employees, and do not extend to those who are pseudo self-employed or irregular migrants (European Commission 2020, 19). In an already informally suited labor market like the one in the Gulf or Southern Europe, contributions are not made often enough to provide serious long-term social protection and it feels just a bit more like a fantasy.

Non-portability of benefits thus entrenches transnational dependency: carers underpin the welfare systems of the North and more affluent countries, without gaining an entitlement to support themselves (Yeates 2009, 103). Consequently, the feminization of migration is an exact parallel to a feminization of welfare poverty (Daly and Lewis 2000, 283–300 ).

### 5.3 Industrial Relations and New Forms of Collective Action

#### 5.3.1 The Boundaries of Conventional Industrial Relations

The need to extend that to include the care workers for whom it provides work will be further considered below. What all this demonstrates is that traditional systems of industrial relations, conceived as solidly based on collective bargaining between employers and unions within particular national economies, are poorly placed to represent effectively transnational care workers (Arthurs 2011, 20). In domestic care, membership in the unions is modest because of the scattered and transitory nature of the work itself and the informal character of many household employment relationships.

In Germany and Austria, a role distinction between paid care in the home as taking place in private households, with public guardianship for it considered outside their area of responsibility by conventional unions at first was evident (Lutz and Palenga-Möllenbeck 2016, 70). In the Middle East, many trade unions are legally restricted, or they simply do not have migrant domestic workers in their membership (Amnesty International 2022, 11). In the case of Italy and Spain, there are domestic workers' union structures that find it difficult to reach collective agreements due to the dispersed and home-based character of their labor (Bonizzoni 2020, 128).

The division in industrial relations mirrors the preceding discussion on legal invisibility. When service workers do not readily have access to a collective voice, they tend to rely on "intermediaries—NGO's, religious groups or internet networks - to mediate in disputes and provide for legal assistance"(Piper 2003, 362).

### 5.3.2 Transnational Organizing and Hybrid Modes of Representation

In recent years we have witnessed some promising new forms of collective action, ones that transgress national boundaries (Fish 2017, 5). Projects such as the Migrant Rights Network Europe and the Global Domestic Workers Alliance (GDWA) plus the International Domestic Workers Federation (IDWF) dwarf a range of struggle from the grass roots across these lands. They are also working very closely together on advocacy, policy lobbying and capacity building (IDWF 2023).

These movements are two-tiered—they engage in grassroots strategies to establish themselves and win labor rights, they then link up in transnational networks to influence international standards (Piper 2003, 369). A case in point is the IDWF, has played an important role in pushing for C189 and continue to engage with it through shadow reporting process and peer-to-peer learning across domestic worker's trade unions (IDWF 2023). On the European front, organizations such as FairWork and Faire Mobilität are pseudo-syndical intermediaries that provide assistance (counselling, legal support and public lobbying) for mobile care workers (Faire Mobilität 2024). In Italy and Spain, there are informal unions known as SEDOAC and Collettiva delle Badanti who negotiate with local municipalities in their regions to access services and achieve recognition. These hybrids challenge our understanding of the division between labor and civil society activism, becoming pregnant with what Jennifer Fish calls "care-based unionism" (Fish 2017, 31).

### 5.3.3 Digital and Diasporic Mobilization

Digital communication has really done a lot to foster community across borders by enabling workers dispersed around the globe to share their stories and mobilize campaigns. In the Gulf, for example, Filipino domestic workers are using social media to raise awareness among their counterparts of the abuse they face and as means by which to organise protests that will attract both action from networks in home communities NGOs far afield (Rodriguez 2010, 90). In Germany and Italy for example Eastern European care workers are mo-

bilized in virtual communities of mutual help and advocacy (Lutz 2011, 117). These "networked publics" replace the missing collectivities of workplace and contest the isolation that comes with live-in care.

## 5.4 NGOs, TANs and Intermediary Regimes

### 5.4.1 NGOs as Legal Intermediaries

This goes hand in hand with a crucial mediating position of NGOs in the governance of transnational care work (Piper 2008, 366). Without effective state enforcement, NGOs serve as a shadow infrastructure for protecting rights—initiating litigation and offering legal aid, shelter, training and policy advocacy. In Germany, the Faire Mobilität project collaborates with trade unions in enabling assistance for Eastern European carers (Faire Mobilität 2023, 9). In the Philippines, Migrant Forum Asia and Centre for Migrant Advocacy are doing policy dialogue and legal counselling with returnees (Migrant Forum Asia 2022). Feminist NGOs and church-based groups have operated by default as welfare brokers for irregular workers in Italy and Spain.

Such organizations are as Nicola Piper describes them, "intermediary regimes. They are hybrid governance arrangements that span state and market (Piper 2015, 14). Translating global norms into local terms, they also facilitate transnational accountability, connecting local level grievances to international advocacy fora.

### 5.4.2 The Transnational Advocacy and Policy Diffusion

Transnational advocacy networks TANs operate by diffusing norms, setting agendas and shaming. An excellent example is the mobilization for ILO Convention No 189, which demonstrates how domestic-worker organizations, feminist academics and global non-governmental organisations worked relentlessly to transform domestic work as a private matter into an acknowledged part of international law (Blackett 2019, 80). And these networks are still alive today, monitoring how the Convention is being implemented, producing shadow reports and pressing governments to ratify and enforce.

The fight for the social rights of carers The role that NGOs and other European institutions have taken have also pushed a collaboration in favour of migrant carers calling their responsibility national governments to resolve issues surrounding workers' and social protections (Yeates 2009, 96–8). But when the involvement of NGOs is institutionalized, there may be a depoliticization: once included in consultative settings, advocacy groups lose their radical edge and are disempowered as service providers instead of agents of structural change (Alvarez 1999, 181–209).

### 5.4.3 Intermediate Governance and Responsibility Redefinitions

Intermediary regimes are challenging the understanding we have of how labor is governed. Thus, care-work is no longer subject to direct state oversight

but is instead regulated via what appears as networks of delegated authority in which there are regulatory roles for NGOs, transnational networks and agencies (Piper 2003, 357–75).

That change will have a lot of different results. On the one hand, it may create protection mechanisms that are more adaptable and responsive; on the other hand it also provides states with an opportunity to abdicate their responsibilities with respect to the rights of migrant workers.

The moral economy of care is also mediated by intermediaries. Faith-based charities tend to emphasize the need for compassion and sacrifice while feminist NGOS have concentrated their attention on rights and equality (Boris and Fish 2015, 105). This mix of stories serves to emphasize the mixed berries nature of global care governance—a palatable blend of welfare, market and mission driven forces.

### 5.4.4 Toward Transnational Solidarity

This is not to say that the emergence of NGOs and advocacy networks suggests even a nascent transnational public sphere oriented around care (Williams 2021, 175). Shaping initiatives such as #MyFairHome and Decent Work for Domestic Workers create the conditions in which activists can challenge care as a human right rather than an issue of personal responsibility (ILO 2016). Such movements are only touching the tip of what Nancy Fraser calls a "transnational social citizenship" based on principles of recognition, redistribution and representation beyond nation-states (Fraser 2016, 19–20). From this comparative analysis of the three corridors we conclude that global care governance is characterized by a blend of diversity and some common ground. Disparities in legislation, welfare and migration regimes often obscure something more fundamental; namely the progressive feminization of transnational labour, the privatisation of social reproduction and the question of legal exceptionalism. The changing modes of industrial relations and advocacy among NGOs, migrant groups, and transnational networks in cross-border collaboration offered a tantalizing foreshadowing on alternative governance. But these initiatives are frequently hamstrung by power differentials and absence of enforceable transnational labor laws. The true hurdle, after all, is turning moral recognition into legal rights: moving from humanitarian sentiment to legal entitlement. This comparative lens not only draws attention to differences in policy, but also the global architecture of inequality that sustains what comes to be termed "the care economy". It is for this cluster of scholars, policymakers and activists to work on making the disaggregated ecology look more like a base from which to launch transnational campaigns for justice.

## 6. Normative and Policy Implications

The above comparison establishes that care work is one of the most paradigmatic instances of inequality in the global labour market. It's indispensable to

a sound economy and social fabric, but often fades into the background—from legal and policy neglect to a sheer lack of social recognition. (f) Consideration is given to the following chapter's argument that the legal and policy structures regulating global care work require re-examination. It goes into four interrelated areas: (1) how current labor and social law systems (don't) work, (2) the significance of acknowledging care as indispensable work, (3) ideas for harmonizing laws and ratifying ILO Convention no. 189; and (4) prospects for transnational welfare arrangements to guarantee rights can be transferred. "Tilting" covers these topics through a mix of legal and sociological lenses -- focusing on the conflict between what we would like to have happen and what is possible with our current institutions.

## 6.1 Towards the Re-evaluation of the Compatibility of Labour and Social Law Existing Frameworks

### 6.1.1 Fragmented Foundations

Labor and social law architecture had its foundation on the Fordist ideal of a stabilized full-time male breadwinner producing in factories (Arthurs 2011, 19–24). This model overlooks the realities of care economies as we experience them today, which are defined by feminised, informal and transnational labour. As Judy Fudge makes the critical point, there is a "mismatch between the normative bases of labour law and the empirical reality of global labour markets" (Fudge 2014, 404–11). Most national labor codes tend to either exclude domestic and care workers from the scope of their application, or subject them to a special set of rules that undermine the minimum protections such as working time limits, freedom of association, collective bargaining and social insurance (see Blackett 2019, 72–83). In the EU, the legal protections are fragmented over different directives in relation to working conditions, posting and self-employment. Because these are mandates about movement and flexibility, they frequently omit their object: the rights of care workers. Further, social law is largely dealt with on a national level which restricts the rights of carers who move across borders (Davy 2013, 631–44). (It is not only technical but structural limitations that plague these frameworks; indeed, they are the result of a long standing de valuation of re productive labour as "nonproductive" or "private") (Fraser 2016, 99–117). "the household remains an exclusion frontier where morality and the economic care are conjoined so as to (re-)demarcate the borders of labour law" (Blackett 2019, 75–7).

### 6.1.2 Discrepancies in Implementation and Enforcement

And even when legal benchmarks are in place, enforcement is weak. Labour inspectorates rarely visit private households; complaints procedures are not available to undocumented and dependent workers, and judicial redress is slow and expensive (ILO 2010, 30–3). The discrepancy between formal rights and

their practical enforcement produces a condition of precarious legality, in which workers may be formally recognized by law yet remain materially vulnerable in practice (Fudge 2013, 95–119).

When global care work is at play, the issue of accountability becomes that much more complicated. You may have workers being hired in one country, working in another and being paid by an employer based elsewhere. This fragmented state of jurisdictions makes labor standards and social insurance applicability difficult to enforce (Fudge and Owens 2006, 1–21). The Poland-Germany corridor constitutes one of the best examples of this kind due to regulatory vacuum, where the former and the latter control enough spaces for movers to shift among them without taking full responsibility. Similar patterns are found in the Philippines-Middle East corridor, where access to bilateral agreements rubs against constraining immigration regimes such as kafala (HRW 2008, 1–10). To address these limitations in enforcement intermediary responsibility schemes are recommended, which place intermediaries, agencies and end-users of care services on "joint monitoring" (Fudge and Struss 2014, 115–32). But the political will to make such systems a reality remains small, because states and employers both enjoy the advantages of great regulatory confusion.

## 6.2 The Importance of Recognizing Care as Work That Matters

### 6.2.1 Recognition of Pandemic as Cause to Legal Metamorphosis

The coronavirus pandemic really put a spotlight on how essential care work is. Governments around the world began to hail nurses, caregivers and domestic workers as "essential" for ensuring that society continued to function (ILO 2020). But that recognition often didn't result in any actual changes. Yet care-workers continued to face low pay, long hours and precarious legal status (ILO 2011, 15–22).

We need to redefine what we mean by "essential work". It should also not just be a question of moral, it should be the strong basis for labor law and social policy. As we come to understand care as foundational, we should see it as core public infrastructure rather than simply private provision (UNRISD 2016, 43–9). For Nancy Fraser, society has long imagined care as a "free gift of nature", obscuring the way in which it is fundamental to how our economy functions (Fraser 100–4). A welfare state that is sustainable has to rethink care and incorporate it into the definition of productive labour, protect it in juridical frameworks and embed it within law of social citizenship.

### 6.2.2 Beyond the Gendered and Familialist Paradigms

Recognition also demands that we critique and disrupt the patriarchal, family-based assumptions underlying our care systems. The genderefication of care work, particularly involving migrant women exposes continuing cultural storytelling that links womanhood with caring and burdens individual families with dependency (Parreñas 2015, 12–22). By treating care as a collective

social responsibility, governments can put the emphasis on public institutions instead of individual households.

Making more services free to the public, formalizing job relationships and ensuring that all are paid fairly form part of this transformation. If Nordic countries would be examples due to their public services and strong unions, even their migrant women are generally standing at the bottom rung of institutional hierarchy (Williams 2021, 163–72). So recognition is really important, but we need more than inclusion—we need the kind of recognition that tackles racial and class-based hierarchies in care economies.

#### 6.2.3 Importance of the Emotional and Relational Aspects to Work

It comes from the private nature of care work, and its emotional components. The emotional work entailed—such as understanding, having patience, and paying attention—is hard to quantify, so it's underestimated in compensation schemes (Hochschild 1983). The recognition of care in law must include these relational aspects without objectifying them as a commodity form. The ILO's decent-work approach has much to offer in this respect as it seeks connections of economic rights with dignity and respect (ILO 2010, 4–6). For us to achieve real support, we require a more profound ethical transformation in which care is at the center of our human relationships and our struggle for social justice.

### 6.3 Proposals For Complementary Legislation And Ratification Of ILO Convention no. 189

#### 6.3.1 Inherent Potential of and Constraints to ILO Convention no. 189

Adoption of the ILO Domestic Workers Convention (no. 189) in 2011 represents a significant advance in international Labour law. The Convention upholds the rights of domestic workers to fair pay, reasonable work hours, social protection and freedom to join associations. However, for 2025, less than forty countries have ratified it in reality and its application is extremely restricted (ILO 2025). Numerous states are wary of ratifying the pact for fear that they will be saddled with more responsibilities to regulate private households or that it could hamper the flexibility of labor markets.

The Convention's greatest significance is not so much in its legal constraints as in its normative impact.' It transforms domestic work into legitimate work as any other (Blackett 2019, 80–90). When countries sign on, they signal their commitment to work for equality. For the European Union, if members ratify it in parallel, it could ensure that common minimum standards are respected and give a new lease of life to the European Pillar of Social Rights. For nations such as the Philippines, ratification of the treaty not only represents an externalization of their own agency, especially within bilateral diplomacy (Rodriguez 2010, 45–55).

### 6.3.2 Toward Harmonized Standards

Law harmonization is a sophisticated work and it should be addressed through different measures including international, regional and national. Internationally, universal ratification of ILO Convention no. 189 must be secured and it should be fully integrated at the domestic level. At the regional level, the EU could develop a directive on domestic and care work that would provide an opportunity to consolidate existing norms concerning working conditions, equality and social protection (European Commission 2020, 18–22). So an instrument like that could require member states to regulate domestic work in general labour law, to include it under the social insurance umbrella and to protect carers' rights who are mobile.

At the national level there is a need for them to modernize labor codes, to eliminate special or exceptional regimes that maintain inequality (ILO 2013). This includes the guarantee that all workers have access to a minimum wage, overtime pay, a decent meal break or rest periods; and the right to bargain collectively. We also need ways to enforce that go beyond the workplace, by thinking of creative inspection methods that are respectful of privacy but make sure people are observing the rules—feeling comfortable reporting anonymously, going to mediation services, knowing that at some point somebody could come and inspect (ILO 2016a).

### 6.3.3 Upgrading Enforcement with Transnational Collaboration

Harmonization should also extend to cross-border enforcement. We need to establish bilateral and multilateral agreements that put in place systems of joint inspection, sharing of data and portability of benefits. The European Labour Authority (ELA) could be given an enlarged role to better coordinate action in the care sector. In the global South, meanwhile ASEAN and the GCC at regional level could operate on creating binding provisions around ILO standards (ASEAN 2017). It is also important to include civil society— e.g. trade unions and migrant organizations—in these mechanisms to ensure accountability and legitimacy (Piper 2003, 357–75).

## 6.4 Towards Transnational Welfare Regimes for the Mobility of Rights

### 6.4.1 Arguing for Transnational Social Citizenship

Globalizing care requires a coterminous globalization of welfare governance. The current systems however link social rights with territorial citizenship or residence, thus, excluding those workers who themselves keep in place transnational circuits of welfare (Williams 2021, 170–76). Social citizenship must be dereferentialised from nationality to include everybody who contributes to the social product' (Davy 2013, 640).

Think of a welfare system that transcends borders, acknowledging the value people produce regardless of where they happen to live. Such a scheme would

see benefits, such as pensions, health insurance and parental leave made portable (ILO 2018 ). The European Union has achieved somewhat with its coordination regulations (883/2004), but these are designed only for formally employed laborers (European Commission 2020, 19–21). Making benefits available to the self-employed, posted workers and irregular carers would mean rethinking the very basis of how welfare contributions function.

Consider a system financed from both national contributions and shared solidarity funds (what we have with the European Social Fund). Instead of being associated with a specific workplace, individuals should have portable personal welfare accounts, easily carried across regions (ILO 2018, 21–7). Utilizing digitised records and bio-metric identification, it is very easy to track these accounts which would solve the double taxation issue.

### 6.4.2 Governance at Multiple Levels and Common Responsibility

Cross-Border Welfare States need to be co-ordinated in several layers of governance. In order for organizations like the ILO, WHO and IOM-in collaboration with regional groups, such as the EU, ASEAN and GCC to "work together" regarding standardized frameworks for contributions, verification and distribution of benefits (ILO 2021a) are:. With bilateral agreements it is okay to promote mutually beneficial exchange, with global compacts minimum expectations for everyone involved are on the table.

A second note is on the politics of shared responsibility—receiver states, sender states and intermediaries need to share in funding social insurance schemes (Fudge and Strauss 2014, 120–26). Take the Philippines-Middle East corridor, as an example; it could become a pilot experiment for tri-partite funds co-managed by governments, employers and migrant representatives. In Europe, bilateral funds between Poland and Germany could address holes in social-security coordination for posted and self-employed carers (European Labour Authority 2024, 32C36).

### 6.4.3 Ethical Grounds for Transnational Solidarity

Legal reforms alone will not result in genuine justice without a real commitment to solidarity. And when we speak about transnational welfare, we have to acknowledge that social reproduction is a global public good equalling also a local issue (UNRISD 2016, 43–9). This knowledge has pushed against the national particularist conception of welfare, the gender divided privatization of care. As Nancy Frasser and Rahel Jaeggi argue, "crises of care are crises of capitalism's moral limits" (Frasser and Jaeggi 2018, 55–60).

The reimagined transnational welfare is about a new formulation of social citizenship that is more inclusive, relational and flexible. This is moving from charity to justice, moving from "nobody cares about us" to a narrative of shared responsibility and ownness, and transforming invisibility into visibility. The point is not to create a one-size-fits-all approach, but to build a network of inter- connected welfare systems that are grounded in common values, such as

fairness and reciprocity. The consequences of global care chains are much more than just labor-market regulations. They urge us to reconsider what social citizenship, economic value and human dignity truly entail. Labor and social law frameworks that are outmoded industrial models cannot provide the kind of protection necessary for those who keep our societies running through care work. To really see care as foundational, our legal, institutional and ethical frameworks have to change. Harmony, in the form of ILO Convention no. 189 for example, provides a route, but effective protection requires coordination with more general welfare reforms assuring rights in motion. The care-freedom equation must be globalized: If people and products can travel home and abroad, so too should their best shot at justice. In the end, to measure progress we need not see how efficient global labour markets are only in how legal systems can price interdependence itself as a principle of equality. It is only when care workers, whether migrant or local, formal or informal, can take their rightful place with full labour and social rights that globalization can reach its own vaunted goal of shared prosperity.'

## 7. Conclusions

Care work, as this article has shown, is located at the intersection of law, migration and social reproduction. It is at once the infrastructure of life and the blind spot of labour and social policy. In the different transnational corridors we've examined—from Poland to Germany, the Philippines to the Middle East and Romania-Ukraine to Italy-Spain—care work is a great example of how much national frameworks are limited in our global world that we have been living. This conclusion serves to underline the broader argument that care work is a litmus test of social citizenship in the 21st century. It also offers an alternative vision of reform that is grounded in equality, representation, and dignity, indicating new directions for cutting-edge research at the forefront of international labor studies.

### 7.1 The Future of Social Citizenship as Barometer: Care Work

#### 7.1.1 From the Outskirts to the Centre of Labour Law

The image of the male industrial worker as the paradigm labour law subject was an image that had assumed dominance for most of the twentieth century: steady, fulltime and connected to a particular nation (Arthurs 2011, 19–25). But the picture is changing with "global care chains" that are showing how work belongs to a transnational, feminized and informal economy (Hochschild 2000, 130–46). So the disappearing act of care work in our laws is just a part of a much larger picture of broader changes in the world of work itself: We are moving away from mass jobs and toward more flexible, precarious and global forms of labor. Here care work serves as the "test case for whether labour law can adapt to the

challengers of globalization" (Fudge 2001, 5–28). As Fudge insists, the disintegration of labour law for work and the emergence of global production networks highlight how national legal structures cannot guarantee such universal coverage (Fudge 2014, 403–25). Similarly, as Adelle Blackett argues, the "exceptionalism of domestic work" lingers on as a gauge of one labour law's failure to bring private and public realms into alignment (Blackett 2019; see also Abenov 1998).

Care work being recognized as essential during the COVID-19 pandemic revealed a paradox: societies rely on care, but they systematically devalue those providing it (ILO 2020). This contradiction epitomizes how membership to social citizenship (understood as entitlements to social and labour rights) is only ever a conditional one premised on archaic understandings of productivity and the public value. Care work must be constructed as part of the legal and moral basis for social citizenship or welfare systems will continue to be both exclusionary and unviable (Fraser 2016, 99–117).

### 7.1.2 Transnationalization of Social Citizenship

The comparative evidence in this study indicates an imperative to reconceptualize citizenship itself. In both corridors, care workers "work transnationally" and "prop up the systems of destination countries, without reciprocating rights" (Williams 2021, 168–72). Ulrike Davy's vision of global social citizenship very much brings out the conflict between national welfare systems and that of workers across borders (Davy 2013, 631–51). Migrant domestic workers have stuck in a difficult situation: They are an essential part of several economies but often don't reap the benefits that their labor fuels. For this problem to be really treated, the transnational social citizenship has to get out of the nation-state as its main territorially oriented source of rights and entitlements (Davy 2013, 640). The transference of rights, recognition of contributions across borders and supranational enforcement are at least elements of the architecture for fairness in an integrated care economy (see ILO 2018, 12–9). Care labour is not an add-on; it is key to understanding the ways in which contemporary welfare states can reconcile human mobility with social justice.

## 7.2 Reform Prospects: Equality, Fair Representation and Dignity

### 7.2.1 Equality: Legal Convergence and the Valorization of Care

It is essential to have equal values in the care economy across different places - and that will need the homogeneity of labour and social norms between jurisdictions. The ILO. Domestic Workers Convention (no. 189) and the European Pillar of Social Rights provide important guidance on promoting converging labor standards, but the practice is still very uneven. Centrally important for international labour law is the principle off-air remuneration on the basis of equal value but this must apply to care work too, transcending it from its archaic moniker "non-productive" (ILO 2010, 5–6).

Material equality goes beyond gender-blindness: it requires a revaluation of the societal and economic importance of care. Otherwise, as feminist economists like Nancy Folbre and Silvia Federici argue, unpaid and underpaid care work is central to perpetuating capitalist growth (Folbre 1994, 27–32). Incorporating care into national accounts and wage structures is therefore not a question of charity but one of justice. Rethinking care also requires we confront our fiscal policies. That could mean things like tax credits, wage subsidies or even public money to address a deep-seated undervaluation that is built into markets (UNRISD 2016, 32–3).

### 7.2.2 Representation: Expanding Collective Voice

The second pillar is representation. And traditional industrial relations institutions, such as trade unions, collective bargaining, and WCs lose their effectiveness in representing transnational, household-based or informal workers (Fudge and Strauss 2014, 9–15). But now we are witnessing the emergence of new kinds of collective action: migrant associations, nongovernmental organizations (NGOs), and global federations such as the International Domestic Workers Federation (IDWF) are beginning to raise claims for recognition and a decent standard of work have considerably increased in recent years (IDWF 2023). This is a type of cross-border advocacy that marries grassroots organizing to transnational, and demonstrates that representation doesn't have to stop at the borders of nation-states. Legal frameworks, in turn, must adjust to these hybrid modes of organization. Freedom of association and collective bargaining rights should be extended to all domestic workers regardless of their migration status (ILO 2012, 45–6). Moreover, Member States should encourage sectoral social dialogue within care services through the involvement of trade unions, agencies and civil society organisations (European Economic and Social Committee 2022, 12–6). This would institutionalize the incipient transnational activist work through enforceable legal channels.

### 7.2.3 Human Dignity: Between Compliance and Human Rights

Finally, any reform agenda must place dignity at the core. Wages, hours and contracts, the traditional measures of labor law, barely scratch the surface about what care workers really endure. Dignity is referring to the entitlement to respect, safety, privacy and freedom from coercion or violence (ILO 2016b, 20–4). Nowhere is this more important than volunteering in people's homes, and with the sponsorship system where isolation can trigger abuse (HRW 2008, 9–13). For dignity to become a true modus vivendi we must institute rights-based approaches that intermesh labour and migration law (UN OHCHR 2011, 11–3). Domestic workers must have justice, the right to movement and without being at risk of deportation, when they assert their rights (Amnesty International 2022, 14–8). National human-rights institutions and ombudspersons can have a crucial role to play in monitoring the provision of care, an area where exploitation is rife (FRA

2021, 22–7). Dignity also demands that greater social value be attached to care work. It is therefore necessary to challenge the stereotype that care is merely an expression of women's selfless nature and to reframe it as highly skilled professional labour that makes a vital social contribution (Anderson 2000, 88–94).

## 7.3 Directions for Further Research

### 7.3.1 Empirical and Comparative Frontiers

Further empirical investigation of these microdynamics of care work across legal regimes is warranted. For example, there might be interesting ethnographic (and socio-legal) studies about how care workers negotiate multiple agencies and welfare systems. Longer-term analysis of the effects of legal fragmentation would be Such comparative longitudinal research, that followed workers' social security trajectories over borders, might well reveal insightful (Yeates 2009, 96–104). Second, comparative study could investigate experiences beyond Europe and the Middle East, such as Latin America or East Asia where care economies have ballooned under different modes of state regulation (Blackett and Trebilcock 2015, 243–51).

### 7.3.2 Intersectional and Postcolonial Perspectives

To really understand the nuances of care work, we must dig further into intersectional analysis. Gender, race, migration status and class intersect to shape the vulnerability and agency through global care chains' (Parreñas 2015, 10–8). Indeed, postcolonial perspectives draw attention to the links between former domestic servitude and contemporary migrant care work (Boris and Parreñas 2010, 6–11). As Bridget Anderson and Rhacel Parreñas have argued, the global care economy reflects colonial divisions of labor: women from the global South and East enable households in the North and West (Anderson and Parreñas 2018, 1–5). So to grasp what care work is, we have to situate it in the millennia of global inequality.

### 7.3.3 Normative and Institutional Innovation

The cutting edge of our conversations attend to new ways to govern others across borders. Researchers need to start engaging with ideas like portable welfare accounts, being able to collectively bargain across borders, global agreements on care that look something like climate accords (Fudge 2020, 203–25). Combining legal, sociological and economic analysis we can produce models of how mixed systems or transnational enforcement might conceivably operate (ILO 2021a, 59–64). Moreover, in this digital age—with new digital tools emerging such as blockchain for tracking contributions—we have the exciting potential to make social security systems increasingly portable and transparent (European Labour Authority 2024, 31–5).

### 7.3.4 A Theoretical Renewal: Reconceptualising the Subject of Labour Law

In conceptual terms, care work calls for a reinvention of labour law's original subject. It is time to depart from the traditional worker-as-producer model and instead embrace a wider understanding of the worker as a caregiver, whose work does not produce things, but rather sustain life (Blackett 2019, 170–76). The whole future of social citizenship depends on our embedding that relational aspect into our legal theories. Feminist jurisprudence and critical political economy can provide crucial support for this move, emphasising the centrality of mutuality, dependence and reciprocity in laying the groundings of rights (Frasser and Jaeggi 2018, 55–60).

Care work really brings to the fore the moral economy of globalization. It links households and nation-states, enfolding private intimacies in public good and folding production into reproduction. But workers in the industry—who are typically migrant women—often remain outside of full protections offered by law and citizenship. Their tales remind us of how brittle are the social contracts we currently have. If labor and social laws can change enough to protect care workers, then surely they can also change enough to make life worth living for all of us in a world that's becoming more insecure by the day. After all, and it's all the same to me whether you kill that weasel inside of you or kill him out on the street": ).So reforming care systems is not a small issue; it is an existential imperative. It is a test of whether our laws can maintain dignity in the face of globalization's dislocations. As we conclude our conversation, one thing is clear: Care work isn't an afterthought when it comes to the future of labor law—it's at the center. How we understand, govern and value this work will determine if global society can integrate economy and human equality. The crucial task now is to ensure that those who care for others are also cared for under the law.

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CHAPTER 3

# A Critical Reflection on the Need or Not for Immigration in the Care Sector: Mechanisms at the Disposal of the European Union

Ferran Camas Roda, Andrea Cano Redondo

## 1. Introduction

This paper aims to analyse the political and regulatory initiatives undertaken by the European Union, but also by associations, employers' associations, social agents, or entities in the care sector, with respect to the perspective to be taken with respect to immigration.

To begin with, in April 2022 the European Commission published the initiative "Legal Migration: Attracting skills and talent to the EU" (European Commission 2022). It is worth analysing the press release that accompanied the initiative promoted by the European Commission, as it clearly showed the interrelated objectives pursued by the European Government. On the one hand, the first one mentioned in the Communiqué in a way that I consider very appropriate with the measures that are intended to be activated is the one relating to "Legal migration", that is, to the promotion of it, although, once read, it would have been more appropriate to say, "Legal migration of a labour nature" or "Labour migration through legal channels". Since the set of measures that are intended to be promoted has as its basic objective the encouragement of migrants who are nationals of third countries to come to Europe to work. This is expressed in the presentation of the New Migration Package by the Vice-President for the Promotion of the European Way of Life, Margaritis Schinas, when she said that

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> with the initiatives adopted today we recognise that legal migration has a positive impact at all levels: it offers those who wish to migrate the opportunity to improve their situation, while providing host countries with more skilled workers, which, in turn, stimulates the economy for the benefit of all.

As well as the Commissioner for Home Affairs, Ylva Johansson, according to whom

> Legal migration is essential for our economic recovery, the digital and ecological transition and the creation of secure channels of access to Europe, and at the same time reduces irregular migration.

This issue relating to legal migration was already expressed in the Commission's New Pact on Migration and Asylum in 2021, but its inclusion in the Pact did not appear to be a priority or urgent, which is contradicted by what was adopted by the EU institution itself this April. This impulse is not arbitrary, but is fully justified by several factors, such as the post-pandemic situation we are experiencing and the consequences it has left in the labour market, although in my view there is an even more obvious cause: what the Commission calls Russia's war of aggression against Ukraine, which has caused the displacement of millions of people within the EU. In particular, there are 2,5 million adults, a number that, in my opinion, has led the European Commission to activate this community proposal for legal migration. In this regard, the Commission itself points out that the set of proposals also includes specific actions aimed at facilitating the insertion into the EU labour market of those fleeing the Russian invasion of Ukraine, as well as the immediate need to integrate people displaced by the war of working age into the EU labour market.

On the other hand, the second objective strictly linked to the previous one is configured by the title of the press release when adding Legal Migration, the one corresponding to "attracting skills and talent to the EU". In fact, this quotation mark fits exactly with the title of the European Commission's Communication of 27 April 2022 (European Commission 2022), which is the political document that promotes and commits the Community institution to the adoption of all the measures on migration launched by the Community institution. From a quick reading, it could be assumed that the main axis is that they seek to promote the reception of qualified migrant workers (which could be understood as those who have a higher qualification), when the truth is that, as we will see later, the Community objective is to amplify the promotion of labour migration towards low- or medium-skilled workers.

This Communication from the European Commission is divided into an Introduction, structured in two main headlines, on the one hand the political and economic arguments in favour of labour migration, on the other the explanation of the demographic context facing the European Union and the main challenges to be overcome through the promotion of legal migration, and finally the provision of three pillars that should characterise a sustainable EU policy on legal migration (as will be developed later, these 3 pillars are legislative, operational, and prospective promotion).

From the introduction, it should be noted that its first sentence is already a declaration of intent with respect to what the European Commission intends to say when it says that legal migration benefits both migrants and the countries of origin and destination (a phrase to which it will later add, that in addition to this, legal migration also leads to the objective of reducing irregular migration). In any case, according to the Commission's parameters, such legal migration is linked to the integration of the EU economy and the interdependence of the labour markets of the Member States. Therefore, a first conclusion from the first lines of the Communication is that success in promoting legal migration in labour matters depends on a connection between "the labour markets" of the EU Member States.

The Introduction contains three basic foundations for promoting legal migration in the EU. Firstly, what the Communication itself calls "the political and economic arguments in favour of labour migration" (it is therefore already clear here that legal migration must have a labour perspective). Among these arguments is the fact that, after the pandemic, it is found that although pre-pandemic employment is on the way to recovery, it is found that the shortage of labour in certain sectors is greater than before COVID-19. In fact, the Communication states that the EU labour market needs new workers, particularly in structurally weak sectors such as tourism, hospitality, temporary disability, and logistics.

The second rationale for favouring legal migration is the demographic context. The Communication says that the EU has an ageing and shrinking workforce. According to the Commission, this holding increases pressure on labour markets, undermining economic competitiveness and growth, especially in those States most exposed to demographic ageing. In addition, the EU re-emphasises something that has been made in the past: the EU must address the labour deficit in specific sectors and in certain regions, especially arising from the difference in levels of development between them, covering "all types of skill levels". In fact, it notes that EU employers face shortages in up to 28 professions employing 14% of the EU workforce in 2020. These professions include plumbers and pipefitters, nursing professionals, systems analysts, welders and oxycutters, heavy truck drivers, civil engineers, and software developers.

According to the Commission, in order to meet these growing labour market needs, linked to demographic trends and shortages, it is not enough to mobilise the national workforce or facilitate intra-EU mobility, but the EU must be more attractive to "talents from all over the world". In my view, this call for talent includes highly qualified foreign workers, whose regulatory directive has been amended in the last year, but also other types of workers with different levels of qualifications. In fact, the Communication points out that the search for greater attractiveness for migrant workers can not only derive from the objectives pursued by the amendment of the Directive on highly qualified workers, but that all those aspects that seek it "should also be strengthened for other categories of immigrants, together with measures to combat labour exploitation and discrimination".

Finally, under the title "Towards a sustainable EU policy on legal migration, based on three pillars", the Commission proposes the following:

- A legislative pillar, recasting the Long-Term Residents Directive and the Single Permit Directive, with the aim of simplifying the procedures for admitting workers of various skill levels to the EU, the intra-EU mobility of workers from non-EU countries who are already in the EU, and the improvement of their rights and their protection against labour exploitation.
- An operational pillar, which addresses the challenge of what we understand as international matching, so that the so-called talent partnerships with the main associated countries and the key characteristics of a specific action on the EU.

Talent Pool is developed-A forward-looking pillar based on three specific priorities for action that should guide EU policy on legal migration: assistance, youth, and innovation.

With regard to the legislative pillar, the European Commission is committed to amending the Directives on third-country nationals who are long-term residents, basically to support greater integration and mobility within the EU of nationals of non-EU countries who already reside and work in the EU, as well as the one on the single permit (which was done with Directive (EU) 2024/1233, of the European Parliament and of the Council of 24 April 2024 establishing a single application procedure for a single permit authorising third-country nationals to reside and work in the territory of a Member State and establishing a common set of rights for third-country workers legally resident in a Member State (recast).

In any case, with regard to the operational pillar, the Commission seeks to support a better match of the capacities and needs of the EU and associated countries (i.e., non-EU countries that may be the source of migratory movements to the EU).

Within this operational pillar, the fundamental measure is cooperation with third countries through "talent development partnerships". These partnerships should not only seek to meet labour needs in the EU but, according to the Commission, should combine direct support for mobility programmes for work or training with skills development and investment in human capital, including skills development, vocational education and training and the implementation of work-based exchange programmes. In short, "they must transform the risk of brain drain from partner countries into brain gain for all partners".

In the operational plan being outlined, the Commission points out that these partnerships should be open to all skill levels and may cover various economic sectors, such as ICT, science, engineering, health and long-term care, agriculture, transport, horticulture, food processing and tourism, construction and port works, transport, and logistics.

The Commission's Communication also sets out how it will implement these Talent Development Partnerships, through four main steps: consultation with Member States and associated countries on the launch of a specific Talent Partnership; organising meetings with interested Member States to share knowledge on their labour market needs and ongoing, and planned initiatives with the Tal-

ent Partners. The specific partner country; cooperation between the Commission services, the European External Action Service, and the EU Delegations with the relevant partner countries in order to jointly develop a dedicated talent partnership; and finally, once a general agreement has been reached on the content, design and implementation of a Talent Partnership with a specific partner country, the mobilisation of funding through a combination of various financial instruments; in particular, these instruments will be the Neighbourhood, Development and International Cooperation Instrument - Global Europe (INDI-CI-Global Europe), and the Asylum, Migration and Integration Fund (AMIF), the Member States' own funds and the private sector fund, or even the funds of partner countries, depending on the possibilities and priorities.

The Commission expressly notes that its intention, on the basis of strong and continuous cooperation on all aspects of migration management under the comprehensive approach of the New Pact on Migration and Asylum, including irregular migration, is to launch the first Talent Partnerships with North African partners, in particular Egypt, Morocco and Tunisia, for implementation by the end of 2022. From autumn 2022, in parallel with the launch of the Talent Partnerships to be launched with the above-mentioned countries, it is planned to start assessing the feasibility of launching Talent Partnerships with Pakistan, Bangladesh, Senegal and Nigeria, as one of the key components of enhanced migration management cooperation with these countries.

In addition to the above, the European Commission is proposing the creation of the first EU-wide matching platform and tool, the EU Talent Hub, to help make the EU more attractive to non-EU nationals and address the challenge of connecting EU employers with talent they cannot find in the EU labour market. This will be a pool of candidates from non-EU countries, who will be selected based on specific qualification levels, criteria, and migration requirements, following an examination of candidates' credentials. In this regard, it announces that it will launch a pilot EU Talent Fund for people fleeing the Russian war of aggression against Ukraine by the summer of 2022.

In parallel with this pilot initiative, a permanent and comprehensive EU Talent Hub will be developed for all non-EU nationals who are interested in migrating to live and work in the EU, in close consultation with the participating Member States and other stakeholders, such as employers' organisations, social partners and vocational education and training centres. The Commission says that by mid-2023, the Commission intends to formally launch the EU Talent Hub and its web portal and will propose a recommendation to create the EU Talent Bank, including a charter and a detailed roadmap for its phases of gradual development.

Finally, around the operational pillar, the Commission intends to improve the governance of labour migration at EU level. As stated in its Communication, progress in the area of labour migration and the success of the new initiatives mentioned above will depend on closer cooperation and better understanding between the migration and employment sectors. With this package, the Commission is launching a new platform that will allow for operational discussions

on practical issues of labour migration, in particular on the external dimension of migration policy, labour shortages and issues related to labour market processes.

Finally, in relation to the foresight pillar, the Commission considers that it is possible to focus forward-looking policies around three areas of action: care, youth, and innovation. These three areas correspond to three important policy priorities, those of attracting low- and moderate-skilled workers from non-EU countries, in sectors where there are significant shortages and labour needs, for example, long-term care; creating more opportunities for young people inside and outside the EU; and to promote innovation and entrepreneurship in the EU and invest in the EU's technological sovereignty.

A specific reference is made in the Commission's communication to attracting long-term care workers from non-EU countries. This specificity is justified by the Commission in adopting a gradual approach to legal labour migration: in this respect, the Commission opposes focusing first on a sector in which it is clearly beneficial to act at EU level: long-term care. In fact, the Commission is based on the fact that in the long-term care sector, up to 7 million jobs are expected to emerge between now and 2030 for associated health professionals and personal carers, which will only be partially covered by the EU labour market.

Directly with regard to this sector, the European Commission says that it will study how to better attract the "low- and medium-skilled workers" that the EU labour market needs. In this context, the Commission appeals to the aforementioned Talent Associations, which must be addressed to all levels of qualification, including those of low and medium qualification.

The Commission adds that it will launch a mapping of the conditions and rights of admission of long-term carers from non-EU countries in the Member States, as well as the needs in this regard, in order to study the added value and feasibility of developing a legal admission regime at EU level to attract these workers.

Along with the above, the European Commission says that it will promote the mobility of young people; in this matter, it does express the need for them to be qualified, as an EU youth mobility programme could make the EU as a whole a more attractive destination. It would do this by granting qualified young people from non-EU countries the possibility of coming to the EU to reside, travel and work for a limited period of time (non-renewable).

The Commission also proposes to facilitate the admission of entrepreneurs at EU level. According to the Commission, the EU could further facilitate access for innovative entrepreneurs and start-up founders to the entire EU single market by supporting their admission and the creation of their business. These measures would help to attract the best talent and thus promote innovation and entrepreneurship in the EU. This would be in line with the Innovation Agenda for Europe and the EU's overall support for business start-ups.

In this framework, the Commission proposes to study the relevance of a new EU visa for innovative entrepreneurs, drawing inspiration from national systems, in particular from the criteria for selecting the most promising and innovative entrepreneurs. These options will be discussed in close cooperation with

Member States and stakeholder initiatives, in the framework of the European Innovation Council and the European Alliance of Emerging Nations forum.

As a conclusion to the Communication, it should be noted from the document under review that the Commission states that the perspective for the implementation of this package of measures is pragmatic and gradual towards an ambitious and sustainable EU legal migration policy, attracting the skills and talent needed to address labour shortages and respond to demographic change in Europe.

Finally, the Commission notes its objective to organise a high-level conference in the third quarter of 2022. This conference will launch the new EU platform on labour migration and pave the way for a sustainable EU legal migration policy.

In conclusion, in a Communication on Migration, specifically the one on attracting talent, the care sector is already mentioned as a sector in which it is "beneficial" to act, in particular by attracting migrant workers. This statement derives from seeing the care sector as an area where jobs will be needed. It remains to be seen if this issue has had continuity at the European level.

## 2. Initiatives and Regulations Launched by European Institutions Linking Care and Legal Migration Channels

1) On 5 July 2022, the European Parliament adopted its resolution on promoting common European action on care (European Parliament 2022). Following its title, the Resolution would seek to promote the adoption of a common European action or strategy on care for people, both thinking of people in need of this assistance and of the care staff, as well as of the entities, private or public, that provide it.

The aspect related to work in the care sector is the backbone of the entire Resolution, and therefore, of the action to be carried out in the field of care. In this context, among the Considerations of the Preamble of the resolution, those that address the issue of the work of caregivers stand out, and in addition to them, one that has caught our attention, specifically the one expressed in Recital P, which recognizes that many care and domestic workers belong to an ethnic minority or are migrants who face precarious situations and intersectional discrimination, and suffer from unlimited working hours or lack of an official employment contract, which makes them (most of them women) more vulnerable to exploitation. In fact, in the AG Recital, figures are put on these issues, noting that in 2020 migrant and mobile workers accounted for 28% of personal caregivers.

In fact, taking advantage of what has been said in the previous two, we bring up, jumping into the recitals and going to what the letter Y says, in which it states that in the Union "at least 3.1 million workers are employed without declaring themselves in personal and domestic services", which lack recognition and fundamental labour rights, such as collective bargaining, social security and social protection; Parliament adds that undeclared work leads to less protection for workers, which facilitates labour exploitation and abuse, while representing a loss

of income for Member States; and concludes by saying that the conditions of undocumented third-country nationals working in the care sector are particularly difficult in terms of their social rights and access to decent working conditions;

For its part, Recital X literally states that:

> Considering that the provision of quality care depends on the existence of a sufficiently large, well-trained, motivated and specialised workforce, on the creation of attractive and dignified working conditions through social dialogue and collective bargaining and on adequate and fair wages, as well as integrated services and adequate public funding; whereas the care sector has been facing labour shortages for some time and whereas in the years 2019 to 2020, 421 000 workers left the residential care sector; whereas quality care work is a skilled profession that requires training and experience and the demand for qualified carers will only increase in the coming years; whereas employment and continuous training in the workplace through the professionalisation of the sector can contribute to an increase in the quality of care service provision; whereas, in the context of longer care journeys and evolving practices and technologies, carers are accumulating know-how that needs to be recognised; that the Acquired Rights Directive (2001/23/EC) should apply whenever employment contracts are transferred to a purchasing caregiver.

Following these considerations in the Preamble, the resolution begins its operative part: from that part, in which we could highlight that in the section on decent working conditions for all workers in the care sector, the European Parliament lays down provisions on the need for Member States to create quality jobs in the sector (81), national legislation on digital platforms should take account of the specific nature of care work (82),the problem of undeclared work should be addressed (83),Convention 189 on decent working conditions for domestic workers should be ratified (85),Member States should take measures to protect fundamental labour rights and improve the working conditions of carers (with particular mention, among others, long working hours, inadequate remuneration (see paragraph 86), the provision of training measures for care personnel (87); Member States to enforce decent working conditions and guarantee the right to organise (89), or to recognise COVID-19 as an occupational disease in the care sector (91).

In any case, as can be seen, there is no specific reference to adopting legal measures to attract foreign personnel to this sector; the ideas put forward by the European Commission have not yet found sufficient echo in Parliament, which, in any case, emphasises the poor working conditions currently suffered by workers in the care sector.

2) Secondly, on 7 September 2022, the European Commission adopted its *Communication on the European Care Strategy* (European Commission 2022). It is also interesting to read the press release of the European Commission in which it presents this Communication under the title: "A European Care Strategy for caregivers and care recipients", in which it is advanced that the European Care Strategy launched by the Commission is accompanied by two recommenda-

tions for Member States on the revision of the Barcelona objectives in the field of early childhood education and care and access to affordable, high-quality long-term care.

In this Communication from the European Commission, the issue of the connection between care and the work of caregivers is visible in many of its proposals, although not with the burden or intensity that the European Parliament did in its Resolution of 5 July 2022, on the promotion of common European action on care. For example, the European Parliament's resolution makes important references to personnel involved in care work, while this is not the case in the Commission's communication, which, incidentally, has been the subject of criticism by the European Federation for Services to Individuals (EFSI)), which adopted a resolution on 7 September 2022 stating that although the European Parliament recognised the primary role of personal and home services, this sector is not mentioned once in the strategy; and added that despite the fact that a large majority of Europeans express their desire to age at home and the fundamental role of the sector in ensuring continuity of care during the COVID-19 pandemic has been recognized, personal and home services were absent from the Strategy. EFSI's statement goes on to say that personal services, as defined by the European Commission in 2012, comprise a wide range of activities that contribute to the well-being of individuals, their families and work-life balance. Also referred to as domestic work on the international scene, personal and household services take place in people's private homes and include both direct and indirect care provided by a professional. It is therefore important to remember that home care and domestic help services are one and the same thing and should be considered as such in the European Care Strategy. Echoing what the International Labour Organization maintains, workers in home care services are an integral part of the care sector, since "care provision includes not only personal care, but also indirect non-relational care work". Although the European Parliament called on the European Commission

> to address difficult working and employment conditions in the European care strategy [...], and to lay the foundations for the recognition, regulation and professionalisation of personal and domestic services, it has been completely side-lined in the strategy.

From a reading of the Commission's communication, the main ideas that can be drawn from its content is that care services are not affordable or accessible and are not available to many people, which in turn has an impact on women (as the main caregivers) taking long-term family leave, reduce their working hours and retire prematurely from the labour market. In fact, the Commission notes that greater investment in such care services would help more women to enter the labour market.

On this basis, the European Commission intends with its communication to establish an agenda to "improve the situation of both those who provide care and those who receive it". In this regard, it calls for strengthening access to accessible, affordable and quality care services, and for improving working conditions

and the reconciliation of family and professional life of caregivers. The two main proposals that result from this are a proposal for a Council Recommendation: the one on the revision of the Barcelona objectives on early childhood education and care services, and the one on access to affordable and quality long-term care.

Thus, with regard to early childhood care and education, the Commission proposes that the Council review the Barcelona objectives, various invitations are made to Member States regarding early childhood education and care services until 2030, including the need to improve the working conditions of workers engaged in early childhood education and care services and the adoption of measures to improve the reconciliation of family and professional life and reduce the gender gap in care. About long-term care, the European Commission and the Commission are submitting to the Council a proposal for a Recommendation, inviting Member States to take measures to address common challenges in the field of long-term care, and among others stressing the need to improve working conditions and opportunities for professional development and retraining in the care sector, while emphasizing the valuable contribution of lay caregivers and their need for support.

Of particular interest in this regard is section 3 of the Communication, entitled "Making the care sector more resilient and balanced between women and men", which is subdivided into two sub-sections, one on improving working conditions in the care sector, and the other on a better balance between work and care responsibilities. A key to the content of both subsections is the recognition by the European Commission that the care sector has great potential to create more jobs, driven especially by the ageing of the population, and it is in this context that the Commission points out that in order to maintain long-term care coverage at the current level, by 2050 "more than 1.6 million caregivers would be needed"; however, the European Commission recognises that labour shortages in the EU are becoming increasingly important, also for the post-pandemic labour market recovery, a problem to which the Commission provides a solution, in particular, legal migration can be a key factor in remedying labour shortages.

Therefore, here there is a specific recognition in terms of care that legal migration can be a key factor in remedying labour shortages, thus following the line followed by the European Commission in April 2022 with its initiative "Legal Migration: Attracting skills and talent to the EU".

In addition, in relation to immigrants, the Commission's Communication addresses this issue to advance that these can be a key solution to address labour shortages, but also points them out when dealing with domestic workers, as many of whom are women and often of migrant origin and are subject to some of the most precarious working conditions imposed on long-term carers. According to the Commission "they usually do not declare their work or are bogus self-employed, earn extremely low wages, and are sometimes denied basic labour rights, such as rest periods and adequate pay". On this point, he recalls that ILO Convention 189 provides standards for decent working conditions, including for domestic workers, but its ratification is delayed, as only eight EU Member States have ratified it.

For the Commission, there is a need for a comprehensive review of the implementation gaps in the EU legal framework in relation to working conditions in the long-term care sector and recalls the importance of Convention 190 and Recommendation 206 as an international framework for preventing, remedying, and eliminating violence and harassment in the world of work. In this area, the Commission urges Member States (9)

> to address gaps in the application of EU labour law and the acquis on working conditions in the care sector, and to ratify and implement ILO Convention 189 on Domestic Workers. It also urges Member States to take measures to formalise and regulate the specific situation of domestic workers and live-in carers.

They also called on them to address workplace harassment and violence related to violence and harassment in the care sector and to adopt the Council Decision authorising Member States to ratify ILO Convention 190 on the Elimination of Violence and Harassment in the World of Work.

3) Following the Commission Communication, the next European document of interest is the Recommendation of the European Council of the European Union of 8 December 2022 on access to affordable high-quality long-term care (Council of the European Union 2022). Within this Recommendation, it is of interest to focus on the aspects most linked to the people who care for them, especially the working caregivers.

Regarding the Council Recommendation on access to affordable high-quality long-term care, the first thing to note is what is meant by "long-term care", and secondly the specific object of the Recommendation. Subsequently, we will review the operative content of the Recommendation, restricting my gaze, as I have said before, to the references that the European Council makes to caregivers rather than to those in need of care. In other words, we are going to focus on the aspects that the Recommendation incorporates relating to the working conditions of caregivers.

Thus, it should be noted at the outset that, according to the Recommendation, and for the purposes of the Recommendation alone, "long-term care" is

> a range of services and assistance for persons who, because of their frailty, disability, or illness, mental or physical, for a long period of time, are dependent on support to carry out activities of daily living or need certain permanent nursing care. Activities of daily living for which support is needed may be self-care activities that a person must carry out on a daily basis, namely activities of daily living such as bathing, dressing, feeding, getting in and out of bed, sitting in and out of a chair, moving around, using the toilet and controlling urinary and bowel functions or may be related to independent living, namely, instrumental activities of daily life such as preparing meals, managing money, buying food or personal items, performing light or heavy household chores and using the telephone.

The key to the definition lies in the need for care by a person on a permanent basis. In addition, the definition has a broad vision of the subjects who care and the character with which they do so, since by not making any type of restriction,

it would be understood to include both caregivers with training and those who do not have training for it, both those who obtain remuneration and those who do not. or both those that are in the family environment of the person receiving care, and those referred by public or private providers of care services. In any case, what the Recommendation does do is to establish for when it is convenient in its articles what is meant by "professional long-term care" and "non-professional care". The former is provided by "professional long-term care workers", which according to the definition given may take the form of home care, community-based care, or residential care. The definition links professional care to the character of worker of the person who performs it.

The Recommendation differentiates between professional and non-professional long-term care, establishing that it is understood as care provided by a non-professional caregiver, i.e., "a person in the social environment from whom care is needed, in particular the partner, a child, a parent or another person, who is not employed as a professional long-term care worker". The Recommendation will apply to these non-professional caregivers, although comparing what is said in the Recitals or Preamble of the Recommendation, with respect to the subsequent content of recommendations, there is a deficit of the latter with respect to this group: in fact, the preamble of the Recommendation speaks of the feminization of this group, whereas their care provision can adversely affect the physical and mental health and well-being of caregivers and constitutes a major barrier to employment, especially for women; whereas this has a direct impact on their current earnings and affects their old-age benefits due to the reduction in the accumulation of pension entitlements; that they need a good work-life balance and a better balance between work and care obligations; that they do not enjoy adequate social protection and do not receive sufficient direct or indirect support for their welfare activities, including financial support; or that require support for the validation of their capacities to adequately transition to other professional care activities.

Of all these considerations, the Recommendation includes in its Article 9 that the Member States establish clear procedures to identify non-professional carers and support them in their care activities. It calls for their cooperation with long-term care workers to be facilitated; their access to the necessary training is supported and they are helped to combine work responsibilities with care responsibilities; and provide them with access to social protection or adequate financial support, while ensuring that such support measures do not deter them from participating in the labour market. These are very generic recommendations, in which the importance of training, helping them to combine their care tasks with their work and providing them with access to social protection or adequate financial support stands out, without specifying what type of social protection or economic support (without mentioning, therefore, the retirement pensions mentioned in the recitals).

The Recommendation states in its first Chapter, on Objective and scope, that it "aims to improve access to affordable high-quality long-term care for all people who need it". In this regard, the Recommendation focuses on Member States providing long-term care with a high quality, which should involve the

providers of such services and the people who provide them, and also that they should be affordable for those who wish to receive them. In fact, the Recommendation addresses, as stated in Article 2 of the Recommendation, all persons in need of long-term care and all professional and informal carers, as well as applies to long-term care provided in all care settings.

The Recommendation is divided into the following chapters: Adequacy, Availability and Quality on the one hand; Caregivers, on the other; and finally, Ordinance, monitoring and reporting. The Recommendation incorporates an Annex on Principles of Quality in Long-Term Care, to which Member States should refer in order to comply with certain aspects of the previous chapters.

Starting with the Chapter on Adequacy, Availability and Quality of Long-Term Care, the recommendations contained in it focus on promoting certain measures to States with respect to the people receiving care; also, with respect to the services offered as care, as well as mechanisms aimed at long-term care providers. In this framework, the Recommendation contains quality principles, applicable to all long-term care providers and in all care settings. In this sense, due to its labour content, two principles must be mentioned that have to do with "labour" and "Facilities". With regard to the former, the considerations of the recommendation point out that access, affordability and quality are the main challenges in the field of long-term care and that having an adequate workforce is essential to meet the growing demand for high-quality services, while "highlighting that informal care often entails a number of costs that are overlooked". The Recommendation would thus aim to promote professional care rather than non-professional care, whose "costs" (perhaps, those referred to above in its recitals) are invisible or are not sufficiently addressed.

With regard to the Workforce in the care sector, it is said that "long-term care is provided by trained and competent workers with a decent wage and fair working conditions", also that adequate worker ratios are established and respected that reflect the number and needs of people receiving long-term care and the different care contexts; that workers' rights, confidentiality, professional ethics and professional autonomy are respected; that caregivers be protected against abuse, harassment and any form of violence, and it adds that "all long-term care workers have continuous learning opportunities at their disposal".

With regard to migrant workers, the Recommendation calls for addressing the challenges of vulnerable groups of workers, such as domestic long-term care workers, live-in care workers and "migrant care-providing workers", including through effective regulation and professionalization of such care work.

Another recommendation addressed to Member States is to work together where appropriate, with social partners, long-term care providers and other stakeholders, to promote the professionalisation of care and to address skills needs and shortages of long-term care workers, including, inter alia, "establishing ways for undeclared long-term care workers to regularize their employment situation; and exploring possible legal migration pathways for long-term care workers".

The European Council thus follows the Commission's trend of enabling legal migration pathways in the specific area of the long-term care sector, although it

also calls for the regularisation of the employment status of workers employed in these services.

In any case, these political initiatives laid the foundations for the adoption by European associations and entities to advance the need for migrant workers in the care sector, which are significantly reflected in 2024 as will be seen below.

4) Finally, we come to the Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on *Labour and Skills Shortages in the EU: An Action Plan,* of 20 March 2024 (European Commission 2024).

According to this Communication, the proposed Action Plan covers several areas which are: 1) To contribute to the activation of under-represented people in the labour market. 2) To provide aid aimed at skills, training, and education. 3) Improve working conditions. 4) Improve mobility of workers and learners within the EU that is tailored to their needs. 5) Attract talent from outside the EU.

Therefore, one of the areas of the Action Plan is "Attracting talent from outside the EU". The origin of this objective is to be found in the European Commission's initiative to make a proposal for an EU talent pool to be negotiated with the European Parliament and the Council. It is entitled "Proposal for a Regulation of the European Parliament and of the Council establishing an EU Talent Pool" (European Commission 2023).

The proposal begins by stating that legal migration is an essential part of the global approach to migration established in the Pact on Migration and Asylum; for the European Commission, effective legal pathways can help reduce irregular migration and fill gaps in our labour market. It goes on to say that while Member States retain the right to determine the volumes of admission of people from third countries to work, the EU's common migration policy should reflect the integration of the EU economy and the interdependence of Member States' labour markets. That is why, as the New Deal underlines, EU policies should promote a level playing field between national labour markets as destinations for migration. They must also help Member States to use their EU membership as an asset to attract talent.

In this framework, the Proposal for the talent pool promoted by the document would aim to partially address the aforementioned challenges by making it easier to obtain a job offer, which is an essential prerequisite for receiving a visa or a work-related residence permit. In addition, it would provide clearer and more transparent information on immigration, employment, and recognition of qualifications rules in the Member States, thus facilitating access to immigration and recognition procedures.

Finally, by providing a tool for placements in the context of a different measure driven by the 2020 New Pact, Talent Partnerships, it will also contribute to improving labour migration cooperation with third countries, while taking into account the labour market concerns and needs of third countries. These Talent Partnerships are launched with specific partner countries to boost international mobility and capacity building in a mutually beneficial way, as part of a comprehensive approach to migration management. In this regard, the proposed EU

Talent Pool would support the implementation of talent partnerships by providing a tool for the effective placement of job seekers from partner countries participating in these partnerships.

In any case, according to the Proposal, the aim would be to create an EU Talent Platform or Talent Bank aimed at facilitating international recruitment and providing opportunities for jobseekers from third countries who are interested and have the necessary qualifications to work in deficit occupations at EU level. In any case, this platform would be open to job seekers with low, medium, and high qualifications. In addition, the Commission also supports Member States' efforts to provide and improve legal and safe pathways to the EU for people in need of international protection around the world.

According to that proposal, the online platform would support the matching of job vacancies from employers established in the Union with the profiles of third-country jobseekers residing outside the EU. In any case, it would be a voluntary tool for the Member States concerned.

The Proposal under discussion contains its introductory part, with the grounds justifying the proposal, and then a Chapter I (General Provisions), II (EU Talent Pool - IT Platform), III (Governance), IV (Register of third-country jobseekers and participation of employers in the EU Talent Pool), V (Information Provisions, support services and expedited immigration procedures), and VI (Final Provisions).

It should be said at the outset that the legal basis for EU action in this area is Article 79(2)(a) TFEU. This provision empowers the European Parliament and the Council, acting under the ordinary legislative procedure, to adopt measures in the field of conditions of entry and residence of third-country nationals. As the EU Talent Pool aims to facilitate the recruitment of third-country nationals residing abroad who wish to work in the EU, and since finding a job and obtaining a job offer is a precondition for third-country nationals to acquire the right of entry and residence in a Member State in accordance with the EU migration legal framework, EU, the action of the EU legislator that makes it easier for a third-country national to receive a job offer from an employer in a Member State, allows third-country nationals to fulfil this condition. The European Commission therefore justifies that the planned action of the EU legislature falls within the scope of the conditions of entry and residence of third-country nationals.

From the recitals of the Proposal, we are left with several ideas (Camas Roda, F. 2023):

(a) Reiterating the above, the Union and the Member States are facing labour shortages in a wide range of sectors and professions, including those related to the green and digital transitions. In fact, the proposal specifies that the shortage of labour in the sectors of construction, health, hospitality, transport, information and communication technologies and science, technology, engineering and mathematics comes from a long time ago and has been aggravated by the COVID-19 pandemic and the acceleration of the ecological and digital transitions. Labour shortages are expected to persist and may worsen in the light of demographic challenges.

(b) In order to facilitate international recruitment and provide opportunities for third-country nationals to work in deficit occupations across the EU, an EU talent pool should be established in the form of a Union-wide platform to collect and support the matching between the profiles of registered third-country jobseekers residing outside the Union and the job vacancies of employers established in the participating Member States.

(c) The Talent Pool should contribute to the objective of discouraging irregular migration, including by facilitating access to existing legal pathways. Jobseekers from third countries who are the subject of a judicial or administrative decision refusing entry or stay in a Member State or an entry ban in accordance with Directive 2008/115/EC of the European Parliament and of the Council should not be able to register their profiles on the EU Talent Pool's IT platform, given that they will not be allowed to enter and remain in the Union. To that end, jobseekers from third countries should be required to declare that they are not currently subject to a refusal of entry or stay in a Member State or a ban on entry into the territory of the Union before registering their profiles in the EU Talent Pool. Information should also be provided on the consequences of making a false statement in this regard.

(d) As the Preamble goes on to say, the principles of the European Pillar of Social Rights should apply to all activities carried out in the context of the EU Talent Fund, in particular with regard to the right to fair and equitable treatment in terms of working conditions, minimum wage, access to social protection, training, and protection of young people at work. In accordance with these principles, the EU Talent Reserve must ensure quality employment.

Article 1 then provides that the regulation to be adopted establishes an EU talent pool available to all Member States to facilitate the recruitment of third-country jobseekers residing outside the Union. According to Article 2 thereof, it would apply to third-country jobseekers residing outside the Union and to employers established in the participating Member States. Article 3 states that any Member State may decide, at any time, to participate in the EU Talent Pool.

For its part, Article 5 of the proposal creates the EU "Talent Pool" computer platform to facilitate the recruitment of jobseekers from third countries.

Finally, I consider it of interest to point out that Article 11 includes the Registration and access of job seekers from third countries. In this regard, it is regulated that job seekers from third countries will be able to create their profiles through the Europass profile creator to register on the EU talent pool's IT platform. In this regard, the proposed regulation ratifies that access to the registration of a profile on the EU talent pool IT platform will be limited to persons who expressly declare that they are not subject to a judicial or administrative decision refusing entry or stay in a Member State in accordance with its national law or to a ban on entry into the territory of the Union in accordance with Directive 2008/115/EC. It is also noted that the profiles of third-country jobseekers registered in the EU talent pool will be visible to employers participating in the EU talent pool. On the other hand, it is regulated that job seekers from third countries registered on the EU Talent Fund's computer platform will be able to search for job offers.

This proposal became a regulation in 2026, following the adoption of the Regulation (EU) 2026/1047 of the European Parliament and of the Council of 29 April 2026 establishing an EU Talent Pool, which, broadly speaking, retains the comments made, whilst including in the Annex to the Regulation a list of occupations facing labour shortages, notably one relating to the need for care staff in institutions.

On this basis, the Commission Communication on *Labour and Skills Shortages in the EU: An Action Plan* of 20 March 2024 is an initiative to promote employment accessibility for third-country nationals through legal channels and their recognition of skills, while ensuring fair and equal working conditions for both migrant and non-migrant workers**.**

The Commission recognises that in addition to harnessing the talent available within the Union, "regulated mobility from third countries" also has an important role to play in addressing labour and skills shortages. In any case, the Commission warns that in addition to this adoption of "regulated" pathways, additional measures are needed, so among other things it proposes: firstly, to study how to continue supporting non-EU countries in the development of curricula and training modules, also in the framework of talent partnerships and with the help of EU funding programmes; secondly, to establish the EU Talent Pool, once adopted by the co-legislators, to facilitate the international recruitment of third-country nationals residing outside the EU; thirdly, to intensify cooperation on skills and legal pathways with non-EU partner countries, in particular by intensifying and exploring new partnerships in the field of talent as part of strategic and global cooperation in the field of migration management and other relevant cooperation initiatives; while preventing the "brain drain" and transforming it into "brain drain" in partner countries; fourthly, to intensify its col labouration with Member States and social partners on issues relating to both legal migration and employment through the Labour Migration Platform.

Finally, among other requests, the Commission urges Member States to continue to engage in talent partnerships to enhance legal migration pathways by launching new mobility programmes supported by EU funding, where appropriate, and through jointly agreed roadmaps for such partnerships, but also to systematically enforce EU and national legislation to address the labour exploitation of migrant workers and ensure equal treatment for them, in line with the Employer Sanctions Directive and the enhanced protection provided for in the Single Permit Consolidated Directive.

### 3. Declarations, Recommendations, or Initiatives of European Associations or Entities in the Care Sector

1) First of all, it is worth noting the "Five Recommendations" for a "Europe of Social Care: advancing the recognition of the personal and domestic services sector in EU policymaking" of February 2024, prepared by EFSI (European Federation for Services to Individuals) (European Federation for Services to Individuals 2024). As expressed in the document, with these recommendations EFSI seeks to raise aware-

ness of the need to improve the image and perception of the personal and domestic services sector and to promote appropriate policies in support of its development.

The 5 recommendations launched by EFSI are the following: 1) Promote the application of social and fiscal incentives. 2) Attract and retain workers in the personal and domestic service sector. 3) Address undeclared work. 4) Ensure legal competition between employment models and providers in the personal and domestic services sector, and 5) Raise awareness of the contribution of the personal and domestic services sector to work-life balance and gender equality.

In addition to these 5 recommendations, EFSI proposes 4 specific EU-wide targets to be achieved by 2030: 1) The percentage of people who are unable to access personal and household services for economic reasons needs to be reduced by 50% (it currently stands at 35.7% of people in the EU). 2) Attract at least 1,400,000 new personal or domestic service workers to address labour shortages. 3) That at least 2 million more workers in the personal and domestic services sector should have "regular" access to social protection rights and benefits. 4) That the percentage of undeclared work in the personal and domestic services sector be reduced by 50% (i.e., 1.75 million workers).

We must focus in this analysis on the second recommendation expressed, that relating to the need to attract and retain workers in the personal and domestic services sector.

The framework in which EFSI frames this recommendation is the process of demographic change that is being experienced in Europe, which will lead to an increase in the demand for employment in the personal and domestic services sector that could lead to the creation of 17.5 million jobs by 2035. although it is also stated that such growth could be more limited depending on factors such as perceptions of (poor) working conditions and other indicators of job quality, the shortage of skilled personnel and the evolution of skills needs.

As a result, EFSI proposes that the European Parliament and the European Commission take into account the specificities of the sector when regulating employment and working conditions (such as working time, sick leave, risk prevention etc.): also that personal and domestic services be recognised as qualified professional work and improve working conditions.

Of interest in EFSI's proposal are the references made to migrants. On the one hand, it talks about the need to promote better access to work permits and social rights for migrant carers, advocating for the establishment of EU-wide guidelines on migration pathways from third countries and establishing labour migration policies that provide work permits of a reasonable duration, with a limited administrative burden and the portability of social protection rights and benefits.

In addition, according to EFSI, immigrants should be guaranteed the effective right to change employers without having to face the risk of losing their permit or having to apply for a new one.

The document also expresses the proposal to adopt an EU-wide recommendation on effective and ethical recruitment practices for third-country nationals in the field of occupational safety and health, as well as to promote a level playing field in terms of the creation of legal pathways for migrant workers in

all types of occupations. instead of attracting only highly qualified and talented workers under the "Talent Package".

In our opinion, we should follow up both on the proposals that the European Commission is making for the creation of a talent platform, to attract foreign staff to Europe, for example in the care sector, and specifically if they are only aimed at highly qualified personnel, despite the fact that this sector may be understaffed. In fact, it should be considered whether with the consideration of talent, not only highly qualified personnel should have access.

EFSI also proposes to promote the recognition of the competences and qualifications of the different occupations that fall within the scope of domestic work, by promoting the adoption of a recommendation on the harmonisation of competences within and outside the EU, as well as EU-wide guidelines suggesting common definitions of domestic occupations (based on standard classification systems, for example, the criteria of ISCO, ESCO, EUROSTAT and CEDEFOP).

It is also proposed to reverse the image deficit of occupations in the personal and domestic services sector through national and European awareness campaigns.

Finally, EFSI states that attracting and retaining workers in the personal and domestic services sector means rewarding care work in a way that reflects its social and economic value, also granting them better access to childcare services and facilitating family reunification practices between domestic workers and their children to tackle the problem of "white orphans".

I consider the latter to be a very interesting issue, which seems to refer to the problems of migrant women in the care sector and their children, in order to facilitate family reunification for both (so, if I have understood it correctly, in this case, the qualification of white would perhaps be reductionist). Policies such as greater public childcare services could benefit both people who outsource care at home and workers in the domestic sector, in addition to measures for reconciling work and family that are expressed in the last recommendation.

The third recommendation refers to addressing informal or undeclared work, since, as echoed by EFSI, the personal and domestic services sector is the third with the most work of this type, after the construction sector and hotels, restaurants and catering. In fact, it is stated in the document that according to recent estimates among the 10 million domestic workers in Europe, at least 3.5 million of them are not declared.

To improve the current situation, EFSI urges EU decision-makers to adopt the following target: that the percentage of undeclared work in PHS should be reduced by 50% by 2030 (i.e., 1.75 million workers).

To this end, EFSI calls on the newly elected MEPs and the upcoming College of Commissioners to design a European policy package to specifically address undeclared work in personal and domestic services; strengthen the work of the "European Platform to Combat Undeclared Work" in the framework of the governance review of the European Labour Authority, in particular to enable the European Labour Authority to issue concrete and detailed policy guidance to Member States on the various preventive and enforcement-oriented measures

targeting the personal and household services sector, its efficiency and profitability. Finally, launch an ad hoc study to establish indicators for effective monitoring of domestic labour, including undeclared workers, in order to address the problem of underestimated numbers.

The fourth recommendation relates to ensuring fair competition between employment models and personal and domestic service providers.

It is of great interest the delimitation of the employment models made by the document in this sector, where four are located, which are, the traditional one is direct employment, in which the private household is legally the employer of the domestic worker (34% of the staff or 2.2 million are employed through this model; another of an intermediate nature, in which workers are hired by a third-party organization commissioned by customers, either private for-profit or not-for-profit; a third or provider-service delivery model, in which an employer hires and refers its workers to the homes of people in need of services, on the basis of a tripartite worker-provider-user configuration (66% of workers are hired through this model); and finally, due to specific legislation and the rise of platform work, the self-employment model.

EFSI therefore calls on the newly elected MEPs and the upcoming College of Commissioners to ensure fair competition between providers of personal and household services and models of work in this sector across Europe, including through European tax and competition rules; to adopt a human needs-based approach and to ensure the personal choice of each individual to become a private employer or to use a service provider, agency or authorised representative to assist in meeting their needs; and finally, recognition of the personal and domestic services industry as a whole and in its diversity, recognising the complementarity and coexistence of the different modes of intervention at home and improving the current statistics of each model.

Finally, the last recommendation refers to raising awareness of the contribution of personal and domestic services to the reconciliation of work and family life and to gender equality.

For EFSI, for the development of this sector the need for a better reconciliation of work and family life and the social inclusion of migrant workers, where the reconciliation of work and domestic responsibilities is a constant concern in the EU. In fact, women continue to carry out most of the informal self-produced PHC activities within the household.

EFSI therefore calls on the newly elected MEPs and the upcoming College of Commissioners to promote an accessible, high-level and affordable personal and household services sector that improves the level of work-life balance for all workers and family carers, regardless of gender, as well as their mental health, either through the implementation of the Council Recommendation on long-term care or through a recast/follow-up of the Work-Life Balance Directive.

Also, to recognise that access to personal and domestic services is key to increasing women's participation in the labour market, strengthening their mental health and promoting equal economic independence between men and women; to promote an equitable sharing of unpaid domestic and care work between men

and women; and to reduce the wage and pension gap between men and women and thus combat female poverty.

2) Following the above recommendations, it is necessary to bring up the Declaration "Joint Statement—Action to Tackle Labour and Skills Shortages—Labour and Skills Shortages in the Personal and Household Services Sector in Europe", signed in October 2024 by what we could describe as two employers' associations in the sector EFFE (European Federation for Family Employment & Homecare) and EFSI (European Federation for Services to Individuals), and two players, EFFAT (European Federation of Food, Agriculture and Tourism Trade Unions) and UNI-Europea (European Trade Union Federation) (EFFAT; EFFE; EFSI; UNI EUROPA 2024).

These social partners in the Personal and Domestic Services (PHS) sector are urging the new European Commission to prioritise the solution to the labour and skills shortages in the PHS sectors when they start their mandate later this year. To this end, they issue a Declaration that is worth taking into account to know the realities of the sector and its needs.

From the document issued, it is of interest to retain some data that are expressed on the sociological reality of services to the person and in homes. For example, that there are at least 10 million PHS workers in the European Union, of which 6.5 million are legally employed, while the remaining 3.5 million are undeclared.

Among formally employed workers, 60% (approximately 3.9 million) are employed through the service provider model, and 40% (2.6 million) are employed through the direct employment model, i.e., they are directly contracted with one or more households. In fact, according to the PHS Employment Monitor 2024 study, 96% of these workers are women (PHS Monitor 2024).

The document also notes that more than 70% of PHS workers in the 18–34 age range do not believe their jobs are sustainable until retirement age, and 60% of workers surveyed in the *PHS Employment Monitor 2024* responded that they have considered leaving PHS sectors altogether in the past 3 years. Of this group, 67.5% cite low wages as the main reason.

The Declaration notes that the limited presence of collective bargaining in PHS sectors underscores the vulnerabilities caused by deficits or gaps in economic and social protection systems. In addition, the paper notes that insufficient recognition of experience gained, and lack of adequate training programmes exacerbate the challenges faced by PHS sectors, which are too often perceived as low-skilled, reinforcing the perception that undeclared work is the norm. Finally, the cost-of-living crisis and inflationary pressures have contributed to a further increase in undeclared work, as users of personal services are found to lack the support needed to secure legal employment.

## 4. Conclusions

The care sector, and particularly the field of long-term care, is emerging as one of the sectors on which the debate on attracting migrants to work as caregivers is focusing.

This objective derives from several causes, including the global labour shortage, which according to some voices should be solved with an improvement in the working conditions of workers in the care sector. This issue has been in the background of the debate in the care sector between EU institutions, which are more inclined in some cases to solve the issue of the working conditions of care workers, which, let us remember, is widely feminised and, depending on the country, also with a high degree of migrant workers. while other institutions have turned their vision more towards attracting foreigners from their countries of origin to work in the care sector.

In our opinion, it is urgent to solve the precarious working conditions that workers in the care sector suffer in many cases, reducing the gender gap that can manifest itself in wage issues, betting on the training of workers, combating situations of harassment (especially of a sexual nature) or violence against workers, recognising the specificity of the illnesses or accidents they may suffer, or improving the system of their social protection.

In any case, the improvement of the working conditions of care workers must be a complementary measure, not a substitute, with respect to the need to establish "regulated" ways for migrants to come from their countries to work in the care sector. In other words, working conditions must be improved, especially wages, but this policy must go hand in hand with attracting people to care for others, and that attraction must be regulated.

The European Union is working on the regulation of talent booking platforms and the adoption of talent partnerships. These pathways can have significant potential to attract immigrants, either for their residence and stable work in the EU, or as a form of circular migration, i.e., to return to their countries after a period of work in Europe.

In any case, this attraction of talent must be combined with the training of these people and the obtaining of the corresponding qualifications, either in their countries of origin or on arrival in the corresponding EU Member State. The provision of training for the care of people is a transcendental issue for the improvement of the quality of life of the people cared for.

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CHAPTER 4

# Building Sustainable Institutional Care: Evidence-Based Recommendations for Healthier Work Environments

Celia Gago-Valle, Francisco J. Medina, Ines Martinez-Corts, Veronika Kuradchik-Pekarskaya, Maria D. Burguillos

## 1. Setting the Scene: Institutional Care Work in Europe

Across Europe, institutional care services—such as nursing homes, residential facilities, and hospitals—constitute one of the essential pillars of long-term care systems (OECD 2025). They provide daily support, safety, and dignity to millions of older people and individuals with disabilities who rely on professional assistance. Yet the sustainability of these systems depends on a crucial condition: ensuring healthy, safe, and decent working environments for those who provide care.

### 1.1 Challenges and Pressures on the Care Workforce

In 2023, the health and social care sector employed more than 13 million people across the European Union, representing about 8% of total employment, and over four out of five workers were women (Eurostat 2024; OECD 2023). Despite this vast workforce, the sector remains under significant strain. One in three long-term care workers reported feeling emotionally exhausted at least once a week (OECD 2023), while staff shortages and turnover rates continue to rise across Europe. According to Zapata et al. (2023), the continent will need

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4.1 million additional health and care professionals by 2030, particularly in institutional long-term care. These data highlight both the magnitude and the vulnerability of a sector central to Europe's ageing societies.

In recent years, care institutions have faced growing structural and human challenges. Population ageing, chronic staff shortages, increasing workloads, and the emotional intensity of care work have placed unprecedented pressure on care workers, affecting not only their mental and physical well-being but also the quality and continuity of care provided (Eurofound 2020; Maghsoud et al. 2022; Popucza et al. 2025). The COVID-19 pandemic made these vulnerabilities even more visible, exposing long-standing inequalities and the urgent need to strengthen the resilience and attractiveness of the care profession (WHO Regional Office for Europe 2022).

Furthermore, care workers in institutional settings are exposed to high quantitative demands, time pressure, and emotional demands. These are among the most prominent stressors in the workplace and can lead to strain, fatigue, and emotional exhaustion when they exceed workers' resources (Sonnentag et al. 2023). In care and health professions, these job demands are particularly high because employees deal with human suffering and must maintain emotional composure even under time pressure and staffing shortages (Sonnentag et al. 2023). The need to provide compassionate care under tight schedules and chronic understaffing often generates frustration, moral distress, and feelings of powerlessness (Eurofound 2020). At the same time, the emotional involvement that characterises care work leads many professionals to develop strong bonds with residents and colleagues, which, although rewarding, can blur the boundaries between professional and personal life and impede recovery outside work hours (Sonnentag et al. 2023).

Alongside these risk factors, certain protective factors can help mitigate their impact and support care workers in their everyday work. Research points to the role of factors such as autonomy, social support, and opportunities for professional development in reducing strain and fostering motivation among care staff (Sonnentag et al. 2023).

Although welfare systems and organisational structures differ across Europe, similar challenges persist throughout the long-term care workforce. Staff shortages, high workloads, and low pay remain persistent issues across countries (Eurofound 2020; OECD 2025). In Southern Europe, such as Spain, Italy, and France, care work is largely carried out by low-paid, predominantly female workers who often face long shifts, precarious contracts, and limited professional recognition (Eurofound 2020). In Central and Eastern Europe, including Poland and Germany, workforce shortages and work intensification are major concerns, frequently associated with stress, emotional strain, and turnover (Eurofound 2020; European Commission 2021). Even in Nordic countries such as Sweden, where welfare systems are more established, care workers continue to report high levels of stress, emotional exhaustion, and challenges in maintaining work-life balance (Eurofound 2020). Taken together, these findings portray a sector under constant pressure—yet one

with considerable potential for improvement and innovation (Eurofound 2020; OECD 2025).

### 1.2 Understanding Care Work and Well-being

According to the World Health Organization (2010), health is not merely the absence of disease but a state of complete physical, mental, and social well-being. Applied to the workplace, this concept implies going beyond harm prevention. A truly healthy work environment is one where employees and managers work together to remove risks and to promote conditions that allow people to thrive. Contemporary occupational health frameworks therefore view well-being as a dynamic balance between being free from distress and actively experiencing positive states.

In this sense, well-being at work encompasses both negative and positive aspects. Negative aspects include emotional exhaustion or burnout, physical fatigue, disengagement, work-life conflict, and the intention to quit, while positive aspects involve happiness, flourishing, and work-private life enrichment. Neither cancels out the other: a worker can feel proud of their contribution and still be exhausted by its demands. For this reason, both dimensions are considered together, reflecting how people actually experience their jobs.

### 1.3 Analytical Framework and Purpose of the Chapter

This chapter focused on findings of the "CARE4CARE: We Care for Those Who Care" Project (Horizon Europe), which investigates the risk and protective factors that influence the well-being of care workers across six European countries (Spain, Italy, France, Poland, Germany, and Sweden). Using a mixed-methods approach, the project explores how organisational, relational, and contextual conditions shape the everyday realities of care work in both home and institutional settings.

To understand how these factors influence the well-being of care workers, we used the Job Demands-Resources Theory (JD-R) (Demerouti and Bakker 2011) as a conceptual framework, which is widely applied in occupational health research. According to this theory, job demands—such as workload, emotional labour, and interpersonal conflict—can lead to stress and exhaustion, whereas job resources—including autonomy, social support, and recognition—can foster motivation, engagement, and resilience. By applying this framework, the CARE4CARE Project identifies the main psychosocial risk (job demands) and protective (job resources) factors shaping the well-being of care workers in institutional environments, which are explored in the following sections of this chapter.

While the previous chapter examined home-based care, the present one focuses on institutional settings, where work takes place within structured teams and formal hierarchies that introduce both risk and protective factors. In these environments, care is provided by a diverse workforce combining practical and

professional expertise. This includes *basic care workers*—staff with short-term or vocational training who deliver direct personal and practical support to care recipients, often in intermediate-level occupations—and *professional care workers*, such as nurses, social workers, occupational therapists, physiotherapists, psychologists, and other health or social care professionals who perform more complex or medically oriented tasks.

Ultimately, the aim is not only to describe the challenges of care work but also to provide actionable, evidence-based recommendations. By advancing strategies across policy, organizational, and professional levels, the chapter advocates for healthier, fairer, and more sustainable work environments—recognizing that sustainable care systems start with caring for those who provide care.

The following sections explore in depth the specific psychosocial risks and protective factors, illustrating how the balance between them shapes care workers' well-being and performance. This analytical approach not only identifies key areas for intervention but also provides the conceptual foundation for the recommendations that conclude the chapter—aimed at fostering healthier, more resilient, and sustainable care environments across Europe.

## 2. Understanding Institutional Care Work: Listening to Voices and Interpreting Evidence

### 2.1 Listening to Care Workers Across Europe: a Collaborative Approach

The CARE4CARE Project was conceived with the aim of deepening the understanding of the working realities of those employed in the care sector across Europe. While the overall study encompasses both home-based and institutional services, this chapter concentrates on the latter—specifically, the work performed within nursing homes, residential facilities, and hospitals.

To examine how working conditions influence employees' negative and positive wellbeing indicators (see Table 1), an initial cross-sectional survey was conducted to collect data on employment conditions, focusing on psychosocial risks, protective factors, and their association with physical and mental health. This was complemented by a weekly study based on repeated questionnaires administered over several consecutive weeks, allowing for the examination of short-term dynamics and the consistency of these relationships over time.

Although quantitative data are essential to identify general trends, they cannot fully capture the lived experience of care work—its emotional demands, ethical tensions, and intrinsic sense of purpose. To address this, a qualitative phase was undertaken to bring these statistics to life. Through a series of focus groups carried out in different European countries, care workers collectively reflected on the central challenges and sources of satisfaction of their profession. These discussions revealed the human meaning underlying the data, shedding light on dimensions often obscured by numerical indicators: the emotions, dilemmas, and everyday strategies that sustain care work.

Table 1 – Definitions of negative and positive well-being indicators.

| Dimension | Variable | Definition |
|---|---|---|
| Negative well-being indicators | Burnout (disengagement and exhaustion) | Job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress (Maslach et al. 2001). |
| | Physical exertion | Perceived level of physical effort required to perform job tasks (Borg 1970). |
| | Turnover intentions | Intention or desire to leave or abandon the job or profession (Price 1997). |
| | Work-Private life conflict | A form of inter-role conflict, characterised by clash between the demands of one's professional role and those of their personal or familial responsibilities (Greenhaus and Beutell 1985). |
| Positive well-being indicators | Work-Private life enrichment | A process at the work-private life intersection, in which the involvement in one role enhances the quality or performance in the other role (Greenhaus and Powell 2006). |
| | Happiness | General perceived level of personal happiness. |
| | Flourishing | The combination of subjective and psychological well-being, in which the individual is experiencing feelings of engagement, meaning, having personal resources and positive interpersonal relationships (Diener et al. 2009). |

### 2.2 Interpreting Results: Conceptual Framework

As outlined earlier, the research was informed by the Job Demands-Resources (JD-R) Theory (Demerouti and Bakker 2011), which conceives well-being as the result of a balance between risk and protective factors. While risk factors may deplete the care workers' well-being, protective factors enhance the well-being and may buffer the negative effect of risk factors on well-being.

This theory accurately reflects the daily reality of care institutions, where heavy workloads, emotional intensity, and interpersonal tensions coexist with

strong professional commitment, solidarity among colleagues, and a deep sense of personal fulfilment. By focusing on both sides of this equation —risks and protective factors—, the analysis sought to identify the elements that most strongly influence the well-being of institutional care workers in Europe.

## 3. What We Found: Risk and Protective Factors in Institutional Care Work

This section presents the main findings on the risk and protective factors that most strongly influence the well-being of care workers in institutional settings. On the risk side, workload intensity, emotional demands and hiding emotions, tasks beyond duties, intragroup conflicts, workplace incivility, and exposure to workplace violence are closely linked with worse well-being—more burnout, physical exertion, turnover intention, and work-private life conflict. On the protective side, emotional support, autonomy, possibility for development, and predictability are associated with better well-being —more happiness, flourishing, and work-private life enrichment.

### 3.1 Workload Intensity

Workload intensity is defined by two related factors: quantitative demands and work pace (Burr et al. 2019). Quantitative demands refer to the psychological demands that arise from the amount of work that must be completed within a given timeframe, while work pace reflects the speed and intensity required to perform tasks during a shift. Together, they capture the perceived effort and time pressure experienced by workers.

At the *quantitative level*, workload intensity was found to have a negative impact on the well-being of care workers in the institutional sector, with professional staff reporting the highest levels of quantitative demands. This suggests that more qualified personnel are likely to bear greater responsibilities and experience higher time pressure within institutional environments.

At the *qualitative level*, the analysis revealed that *quantitative demands* stood out as one of the most pervasive challenges in institutional care. Workers described a constant race against time, shaped by chronic staff shortages, rigid schedules, and unpredictable incidents (such as medical emergencies, falls, behavioral disturbances, unexpected staff absences, or lack of essential supplies) that multiplied their workload. Even the absence of a single colleague could disrupt the entire routine, forcing others to reorganise tasks and stretch their energy beyond reasonable limits.

This sense of overload was both physical and psychological. In Spain and Italy, care workers spoke of "arriving already exhausted" and of "fifty residents for a handful of staff". In Germany and Poland, where staffing ratios are also strained, workers described the day as "a chain reaction" in which one delay affects the entire system. The result is a daily environment of reactivity, where carers are continually forced to prioritise urgent needs over meaningful interaction.

The *work pace* adds to this pressure. In hospitals and emergency departments, the tempo was described as "relentless", while in long-term care facilities the

pace was rigidly structured by institutional timetables—mealtimes, medication rounds, hygiene routines—leaving little space for personal connection. A French care worker summed up the moral dilemma this creates: "We're told to take our time with residents, but the schedule doesn't allow it. We either care fast, or we fall behind".

*Time pressure* was often experienced as the most stressful aspect of the job. Workers across countries spoke of ratios that are politically or administratively set but "not made by people who know what a nursing home is like". The impossibility of meeting care standards within these time constraints leads not only to exhaustion but to *moral distress*: the emotional pain of being unable to provide the kind of attentive, dignified care they believe residents deserve. For many, this mismatch between professional values and organisational reality was a source of strain.

Closely linked to these pressures were the demands related to scheduling and shift organisation. In many institutions, irregular rotations between morning, evening, and night shifts, extended workdays, and last-minute changes created additional fatigue and disrupted personal rhythms. Even when flexible arrangements—such as condensed schedules or longer rest periods—were introduced, these were often perceived as isolated exceptions rather than structural solutions. As a result, the management of time itself became a central source of stress, reinforcing the cumulative overload experienced by care workers.

*Country Nuances*: According to the focus group discussions, excessive workload and time pressure were common across all countries, although their expression varied according to organisational realities. In Spain, workers highlighted the constant disruption caused by staff absences and unforeseen incidents, which forced them to reorganise tasks and often extend their effort beyond working hours. In Italy, workers described a similar overload but framed it as a moral burden, feeling responsible for compensating others and distressed by the gap between professional ideals and real conditions. In France, the strict institutional schedules of EHPADs (residential establishment for dependent elderly people) created tension between efficiency and humane care, as staff frequently stayed beyond their shifts to ensure residents' comfort, turning dedication into exhaustion. In Germany, the main challenge mentioned in the focus groups was unstable scheduling, with frequent rotations between early, late, and night shifts that undermined rest and personal balance. In Poland, workers reported heavy workloads combined with rigid organisational structures and minimal flexibility, reinforcing a sense of chronic strain. Overall, despite different manifestations, the shared outcome was clear: institutional care across Europe continues to rely on workers' adaptability and personal commitment to sustain systems under structural pressure.

### 3.2 Tasks Beyond Duties

Another structural demand affecting well-being is the frequent expectation to perform *tasks beyond duties*, referring to the frequency of instances with which

care workers were required to carry out tasks not included in their job description or in the care receivers' care plan (Karlsson et al. 2020).

At the quantitative level, the results indicated that workers in institutional settings were fairly often asked to take on responsibilities outside their defined roles, with professional care workers reporting the highest levels. This factor had a negative impact on the care workers' well-being.

At the qualitative level, workers reported being asked to carry out procedures outside their qualifications—from clinical interventions, such as administering medication or inserting catheters, to tasks previously assigned to other categories, like cleaning or maintenance.

These situations are often justified by chronic understaffing and the urgency of daily care. Yet for workers, they represent a gradual erosion of professional boundaries. Care workers explained that they "do it because someone has to", but the repetition of this dynamic over time creates frustration and a sense of exploitation. As one Italian worker put it, "If you have one nurse for fifty patients, you end up doing her work too—but nobody acknowledges it".

This phenomenon illustrates a subtle but significant form of *role ambiguity*, where workers' identities blur between professions. It also reveals a moral tension: the choice between adhering strictly to one's job description or ensuring residents' needs are met. Many continue to take on extra tasks out of commitment to those they care for, but this dedication comes at a cost—reinforcing the cycle of fatigue, invisibility, and undervaluation.

*Country Nuances:* Tasks beyond duties were mentioned most frequently in Italy, where workers reported performing clinical procedures beyond their qualifications due to staff shortages, leading to discomfort and a sense of excessive responsibility. In Germany, the issue was more organisational, with care staff taking on non-clinical duties such as cleaning or maintenance, which increased both physical and emotional strain.

### 3.3 Emotional Labour: Emotional Demands and Hiding Emotions

*Emotional labour* comprises two key, intertwined psychosocial risk factors associated with care work: *emotional demands* and *hiding emotions* (Burr et al. 2019). *Emotional demands* refer to the emotional labour that arises from the interpersonal relationships involved in the job, which require workers to engage in emotionally charged situations. *Hiding emotions* reflects the psychosocial demand of maintaining a neutral demeanour when faced with unpredictable behaviour from care receivers, colleagues, or family members. Together, these factors capture the emotional intensity inherent to care work and its potential impact on workers' well-being.

In the quantitative analysis, workers often experienced emotionally demanding situations in their work and frequently felt the need to suppress or regulate their emotional responses in the workplace. Professional care workers reported higher levels of demands for hiding emotions, indicating that roles requiring higher qualifications or performed in institutional settings involve greater

expectations of emotional control. Both factors significantly impacted their general well-being.

In the qualitative analysis, emotional labour was classified into three dimensions identified by Wieck et al. (2021): *display*, *sensitivity*, and *sympathy*. *Display* refers to the need to express certain emotions at work (such as kindness or calm) while suppressing others considered inappropriate (like frustration or sadness). *Sensitivity* involves being attentive to and perceiving how care recipients feel, even when they do not express it verbally. *Sympathy* describes the emotional response to another person's suffering or emotions, without becoming personally involved. Additionally, the subcategory *involvement* was introduced to capture cases in which care workers developed deep emotional bonds with care recipients, making emotional detachment difficult.

In the focus groups, workers described the emotional demands as one of the most profound and universal challenges of care work. Beyond the physical effort, caring requires a constant management of emotion—one's own and that of others. Workers must remain calm and compassionate in the face of suffering, aggression, or death, while maintaining professional distance. In their words, it is "a job of heart, but also of control".

Many spoke of the need to "wear a mask" to project calmness and strength even when feeling overwhelmed. This *emotional display* is part of what makes care humane, yet it is also deeply exhausting. Several workers explained that residents can "read your emotions like sponges", which makes emotional regulation a continuous, delicate balancing act. The effort to hide sadness or frustration for the sake of those in their care often leads to what several workers called "invisible exhaustion".

At the same time, carers must cultivate *emotional sensitivity*—perceiving subtle changes in residents' mood or behaviour, choosing the right words to calm or reassure. This skill, while essential to quality care, comes with an emotional cost. A Polish care worker described it as "always being alert to someone else's feelings, even when your own are tired".

In addition, *sympathy* was reflected in the psychological burden of caring for patients with serious or terminal illnesses, with whom emotional bonds inevitably develop. This emotional closeness, although sometimes unavoidable, can intensify the psychological strain of care work.

For some, *emotional involvement* goes even further, creating bonds that extend beyond work hours. Testimonies reveal how relationships with long-term residents can become deeply personal. Workers admit to thinking about them after shifts or worrying about their condition at home: "You try not to, but they stay in your head". This blurring of boundaries reflects both the depth of empathy and the psychological toll it entails.

*Country Nuances*: Emotional labour was a pervasive feature of care work across all countries, though their intensity and expression varied. In Spain, workers described the pressure to maintain composure and show empathy even in situations of suffering or aggression, capturing the dual expectation to "smile while we suffer". In Germany, the emphasis was on emotional restraint—keep-

ing a "game face" despite fatigue or distress. In France, workers reflected on the transparency of emotions in care relationships, noting that residents "sense everything", which makes regulation a constant and draining effort. In Italy, the accounts highlighted both emotional sensitivity and moral involvement: workers felt compelled to say "the right word" to calm patients while struggling to maintain boundaries when relationships became too personal. In Poland, testimonies pointed to the emotional burden of attachment, as carers admitted that the strongest bonds "are brought home", extending stress beyond the workplace.

### 3.4 Intragroup Conflicts: Task and Relational Conflicts

*Intragroup conflicts* refer to the frequency in which care workers experience conflict within a team, with the care recipient, their family members, or other people at work, where members clash over work procedures (task conflict) or due to personality clashes (relational conflict) (Jehn 1995).

At the quantitative level, the results indicated a moderate frequency of conflict within care teams, which negatively impacted their well-being. Professional care workers reporting the highest levels of intragroup conflict.

At the qualitative level, conflicts within teams emerged as one of the most common and emotionally draining challenges in institutional care. While some workers described supportive teams where collaboration and emotional support acted as protective buffers, others depicted daily environments marked by tension, distrust, and lack of communication. These intragroup conflicts often took two forms—*task-related* and *relational*—both rooted in structural and organisational fragility.

*Task conflicts* arose from unequal distribution of duties, unmet responsibilities between shifts, and chronic staff shortages that forced workers to compensate for absent colleagues. Care workers spoke of covering shifts, taking on unassigned tasks, or correcting errors from previous teams. This imbalance not only increased workload but also generated resentment, particularly when left unacknowledged by management. The constant rotation of staff further aggravated these tensions, disrupting continuity and preventing the formation of stable, trusting teams.

*Relational conflicts* were expressed through destructive criticism, lack of listening, and authoritarian attitudes that undermined cooperation. Some workers reported disrespect or disregard for differing opinions, reflecting tensions rooted in communication and hierarchy. In many cases, however, participants pointed to an absence of effective mechanisms for conflict resolution or collective problem-solving, which often allowed frustration to accumulate and patience to wear thin—sometimes spilling over into interactions with residents. When communication broke down, workers reported that "it's the care receivers who end up paying the price", illustrating how team dysfunction affects care quality.

*Country Nuances*: In Italy, workers frequently discussed intragroup conflicts as a key relational challenge, often tied to unequal shift allocation, poor communication, and unfulfilled duties between teams. These tensions reflected both

task-related conflicts, arising from disagreements over work organisation and responsibilities, and relational conflicts, linked to communication problems and interpersonal frictions. The constant rotation of staff further weakened cohesion and trust. In Germany, workers reported similar problems of coordination and instability, noting that team climate depended heavily on the individual colleagues present.

### 3.5 Workplace Incivility

*Workplace incivility* is conceptualised as low-intensity deviant behaviour (by care receivers, family members, colleagues etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect (Cortina et al. 2013).

At the quantitative level, care workers in institutional settings reported moderate levels of incivility, and this significantly impacted their general well-being.

At the qualitative level, many care workers highlighted subtle but recurring acts of disrespect that quietly undermined trust and cooperation. Workplace incivility included sarcasm, gossip, or exclusion from information. Though rarely overt, these behaviours accumulated over time, creating emotional fatigue and weakening the sense of solidarity within teams.

Importantly, this incivility extended beyond peer interactions. Workers frequently reported similar disrespect from the relatives of residents, who expressed frustration through unjustified complaints, accusatory tones, or unrealistic demands. As one social worker described, "We are a bit of a punching bag for a lot of people and situations". These encounters, though seldom overtly aggressive, were emotionally exhausting and undermined workers' sense of professional worth. Many linked them to families' own distress or misunderstanding of the institutional setting, but the result was the same: cumulative psychological strain and loss of confidence.

*Country Nuances*: In Spain, incivility mainly took the form of excessive or contradictory demands from relatives, reflecting tensions between collective institutional routines and families' unrealistic expectations. In Poland, similar disrespect was reported from both families and some colleagues, with complaints and blame becoming part of the daily routine.

### 3.6 Exposure to Workplace Violence

A further relational challenge reported in institutional settings was *exposure to workplace violence*, defined as the frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace (Burr et al. 2019).

At the quantitative level, care workers occasionally experienced verbal or physical aggression from care receivers, family members or other individuals, with basic care workers reported the highest levels. This factor had a significant negative impact on their wellbeing.

At the qualitative level, it was revealed that physical and verbal assaults were not uncommon, particularly in hospital wards and nursing homes where staff cared for individuals with cognitive impairments, post-operative confusion, or neuropsychiatric conditions. Although these incidents were often framed as "part of the job", their psychological and physical impact was undeniable.

Workers recounted being shouted at, grabbed, or hit, sometimes repeatedly. Such experiences were rarely reported formally, partly due to the belief that these behaviours stem from illness rather than malice. The tendency to normalise or dismiss these events as inevitable created a culture of silence, leaving workers feeling exposed and inadequately protected.

The lack of institutional protocols or emotional support following these incidents further compounded the strain. Frontline staff, who spend the longest hours in direct contact with residents, bore the greatest burden. Many described the challenge of managing aggression while maintaining professionalism and empathy, often without debriefing spaces or psychological assistance.

*Country Nuances*: In Germany, workers frequently mentioned patient aggression following surgery or under medication effects, describing these episodes as highly stressful yet routine. In Poland, similar behaviours were reported but were more likely to be minimised or reframed as uncontrollable symptoms of illness, which contributed to their invisibility as an occupational hazard.

### 3.7 Emotional Support

*Emotional support* refers to feeling listened to, appreciated, and encouraged by people present at the workplace (Peeters et al. 1995)

At the quantitative level, care workers received emotional support in their workplace, which is a significant factor influencing their wellbeing.

At the qualitative level, care workers highlighted several resources that help protect and sustain them amid these challenges, preventing burnout and restoring motivation. The most frequently mentioned was peer support—the emotional and practical solidarity that emerges naturally among colleagues. This support is often informal: conversations in the corridor, shared jokes during breaks, or simply the reassurance of being understood. As one French worker put it, "When I cry, it's with my colleague, the one who knows exactly why".

Such moments of connection help transform isolation into belonging. In teams with strong mutual trust, workers described an atmosphere of empathy and tolerance, where they could express frustration without fear of judgement. In contrast, where this support was missing, even small problems felt overwhelming. The collective capacity to share experiences thus became a decisive factor in emotional resilience.

At an organisational level, emotional and instrumental support were key. Workers valued supervisors who listened, offered guidance, and encouraged open dialogue. Practical help—such as assistance during heavy tasks or clear information about changes in routines—enhanced predictability and reduced stress. When such structures were in place, staff described feeling more secure

and engaged: "If the communication is good, even when we're tired, we still want to come to work".

*Country Nuances*: In Spain, this support took the form of spontaneous exchanges—venting, joking, or talking after difficult shifts—which workers saw as essential for emotional release and maintaining composure. In France, colleagues were often the main emotional anchor in moments of grief or crisis, offering empathy and shared understanding when formal support was absent. In Italy, experiences were mixed: while many valued emotional openness and solidarity, others noted frustration due to unequal effort, generational differences, or a lack of institutional recognition of teamwork. In Poland, strong informal bonds provided a sense of belonging and emotional containment, described as a "community of mutual care" that compensated for limited organisational support.

### 3.8 Predictability

*Predictability* is understood as having adequate, sufficient and timely information needed to perform the job correctly (Burr et al. 2019).

At the quantitative level, care workers often reported having adequate and timely information to carry out their tasks and adjust to changes at work, and this is an important factor influencing the wellbeing of care workers in institutional settings.

At the qualitative level, workers highlighted that institutional care was characterised by highly standardised tasks and routines, with predictability referring mainly to workers' ability to anticipate shifts, tasks, and changes in daily schedules. However, in many institutions, unpredictable timetables, constant staff rotation, and last-minute changes were described as a hidden form of stress. Workers explained that not knowing their shifts in advance or facing irregular patterns made it impossible to rest properly or plan personal life, turning flexibility into yet another demand rather than a benefit. Ensuring greater temporal stability and transparency in work planning was therefore seen as essential to restoring a sense of control and balance.

Predictability not only reduces uncertainty but also reinforces trust and cooperation within teams. When routines, communication, and staffing structures are consistent, workers feel able to prepare emotionally and physically for the day ahead. This sense of anticipation—knowing what to expect and when—was repeatedly linked to reduced anxiety and a stronger feeling of safety in the workplace.

*Country Nuances*: In Germany, the lack of predictability was reflected in the continuous rotation between morning, evening, and night shifts—sometimes within the same week—, which made it difficult to anticipate work rhythms and plan for rest. This unpredictability led to accumulated fatigue and disrupted personal routines. In Italy, workers also highlighted the limited predictability of shifts and the lack of transparency in work scheduling, noting that apparent flexibility often translated into constant adaptation to service needs.

### 3.9 Possibility of Development

*Possibility of development* was defined as the extent to which job performance provides opportunities to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience (Burr et al. 2019). This dimension reflects how care work can foster professional growth and continuous learning, influencing both motivation and long-term engagement in the sector.

At the quantitative level, care workers generally perceived ample opportunities to utilise and enhance their skills within their current roles, which positively influenced their well-being in institutional settings.

At the qualitative level, care workers reported the possibility of development, which often manifested in the opportunity to grow and learn through experience. Beyond formal training, many described learning by doing as the most meaningful and transformative form of professional development. Everyday challenges—managing complex behaviours, coping with loss, or supporting residents with mental health conditions—were seen as catalysts for growth.

Through repeated exposure to demanding situations, workers refined their communication skills, emotional resilience, and problem-solving capacity, often developing coping strategies gradually over time. These strategies—such as emotional distancing, open expression, or even the use of humour—were not taught formally but emerged as adaptive responses that helped them preserve composure and professionalism in the face of suffering or tension. Over time, this experiential learning strengthened not only their competence but also their confidence in managing emotionally charged situations, reinforcing the sense that their work, though difficult, continually expands their abilities, insight, and humanity.

*Country Nuances*: In Italy, workers questioned the value of formal training, describing many courses as disconnected from real needs and sometimes self-funded, while stressing that real learning happens "in practice" through daily challenges. In France, institutional training was available but often designed to meet organisational needs rather than support individual growth. In Spain, on-the-job learning was seen as a natural process shaped by everyday interaction with residents and colleagues, helping workers develop practical and emotional skills. In Poland, development was described as gradual and experience-based, with resilience and adaptation emerging from repeated exposure to emotionally demanding situations.

### 3.10 Autonomy

*Autonomy* refers to the degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out (Bakker and Bal 2010).

At the quantitative level, care workers generally reported having a moderate degree of autonomy in performing their duties and organising their daily activities, which positively affected their well-being in institutional settings.

At the qualitative level, care workers identified autonomy as the capacity to make decisions and exercise judgement in day-to-day care activities. In institutional settings, where routines are tightly structured, even small margins of choice over how tasks are carried out provided a crucial sense of control and professional fulfilment.

This autonomy was experienced through everyday practices such as task prioritisation, time management, and boundaries management. Workers described the need to decide what to do first, how long to dedicate to each task, and when to adjust routines in response to residents' changing conditions. As one caregiver explained, "Even if something unexpected comes up, I carry on. You just go with the tasks as much as possible". In this sense, autonomy emerged as a constant negotiation between institutional schedules and the unpredictable realities of care work.

*Task prioritisation and time management* were key expressions of this autonomy. Care workers balanced efficiency with attentiveness, reordering tasks according to the immediacy and moral weight of residents' needs. "We leave the beds unmade, the cleaning, the dishes… everything waits. First comes the resident", said one care worker, summarising how flexibility allowed them to uphold the relational and human dimensions of care despite organisational pressure.

Autonomy also involved *protecting one's time and limits*. Many workers emphasised the importance of setting mental or emotional boundaries to avoid overload: "From three o'clock, when I leave here, only what's important matters to me". Others highlighted the ability to refuse tasks beyond their competence as a form of self-preservation and professionalism: "I've learned to say no, but to say it in a way that doesn't come across as negative". These small acts of self-regulation illustrated that autonomy was not about doing everything freely, but about knowing where to stop—a key skill for maintaining emotional balance.

Finally, autonomy was reflected in *proactive behaviour*—taking initiative to reorganise routines, anticipate problems, and adapt to unexpected changes. Workers described adjusting schedules, combining roles, or modifying procedures to ensure continuity of care. "I try to remain flexible in the face of change and the unexpected. Perhaps it's this ability to adapt that helps me get through the more complicated times", explained one care worker.

Overall, autonomy appeared as a psychosocial resource that nurtures competence, stability, and meaning. It allowed workers to humanise routines, transform pressure into manageable challenges, and preserve a sense of agency within hierarchical systems. Even small decisions—to prioritise, adapt, or set limits—became foundations of professional well-being. In this sense, autonomy was less about independence than about self-direction within interdependence: the freedom to care with judgement, responsibility, and integrity.

*Country Nuances*: In Spain, autonomy was closely linked to the ability to adapt and prioritise—workers described reorganising routines around residents' emotional and physical needs, even if this meant postponing other tasks. Flexibility and moral judgement were seen as essential for maintaining humane care in the face of institutional rigidity. In Italy, autonomy often meant setting boundaries—

learning to refuse tasks beyond one's role and to manage emotional exposure to suffering. Workers framed this as both self-protection and professionalism, asserting the right to say "no" without guilt. In Germany, discussions centred on time management and emotional detachment as strategies to sustain effectiveness under pressure, with autonomy understood as the ability to balance empathy with self-regulation. In Poland, autonomy was expressed through maintaining respectful distance and professionalism, emphasising emotional restraint as a way to preserve stability and protect oneself from overinvolvement. In France, proactive adaptation stood out, with workers describing the reorganisation of their duties, anticipating needs, and adjusting to change as ways to exercise agency within hierarchical structures.

## 4. Building Healthier Institutional Care Settings: Practical Recommendations

The voices of care workers across Europe not only reveal the pressures and emotional complexity of institutional care but also illuminate a path forward. Throughout the focus groups, workers articulated a series of proposals grounded in their lived experience, suggestions that aim to strengthen both the quality of care and the well-being of those who provide it. These recommendations are not abstract ideals but reflections of daily realities: the understaffed ward, the unpredictable shift, the silent fatigue that follows emotional exposure, and the persistent desire to keep doing the job well. Together, they outline a vision of institutional care that is not only more efficient but also more humane, stable, and sustainable.

### 4.1 Strengthening Structural and Organisational Conditions

*Political level*: At the foundation of all other improvements lies the urgent need to reinforce structural working conditions. Across countries, emphasis was placed on the idea that no level of commitment or vocation can compensate for chronic understaffing, low pay, and unrealistic workloads. Increasing staffing levels and adapting staff-to-resident ratios to the real complexity of care emerged as the top priority. Ensuring adequate staffing is therefore not a matter of comfort but of safety and professional integrity.

Closely linked to staffing is the question of fair remuneration. Workers called for salary increases that reflect the difficulty, responsibility, and emotional weight of care work. Fair pay was framed not simply as economic justice but as an expression of dignity and social recognition.

In addition, many workers argued that current retirement policies fail to consider the bodily wear accumulated over decades of physically demanding labour. Earlier retirement options or recognition of care work as a high-strain profession were seen as necessary political commitments to protect ageing workers and maintain workforce sustainability.

*Organisational level*: Beyond these structural pillars, better management practices and clearer professional roles were also emphasised. Excessive bureau-

cracy, unclear task distribution, and limited influence over work planning were identified as key sources of frustration. Workers called for participatory management models where care teams are regularly consulted and where responsibilities between nurses, assistants, and other professionals are better defined. These organisational improvements were viewed as crucial to ensure coherent coordination, effective leadership, and improved occupational well-being.

*Individual level*: At the individual level, workers underlined the importance of recognising their own limits and advocating for realistic workloads and fair treatment. While systemic change is essential, empowerment at the individual level—such as asserting professional boundaries and participating in internal consultations—was also viewed as a way to contribute to organisational improvement and personal sustainability.

### 4.2 Supporting Mental Health and Emotional Well-being

*Political level*: Participants stressed that mental health initiatives should be recognised within national and regional policy frameworks as essential components of occupational health in the care sector. Embedding psychological support in care institutions was viewed as a political responsibility comparable to ensuring physical safety at work.

*Organisational level*: It was widely emphasised that psychological support should not be treated as an individual luxury but as a structural necessity. The inclusion of psychologists or qualified mental health professionals integrated within care institutions was one of the most frequently mentioned proposals. Institutions were encouraged to create regular spaces for collective reflection, such as discussion groups or team debriefings, to reduce stress, strengthen solidarity, and rebuild trust among colleagues. Embedding professional mental health support within institutions therefore serves a dual purpose: preventing burnout and recognising the emotional depth of the profession itself.

*Individual level*: At the personal level, workers highlighted the importance of self-awareness and mutual care among peers—sharing experiences, expressing emotions, and supporting one another as everyday strategies for emotional survival. Individual openness to psychological assistance and collective reflection was seen as essential for normalising mental health care within the profession.

### 4.3 Expanding Opportunities for Learning and Professional Growth

*Political level*: Workers advocated for publicly funded access to specialised training, ensuring that continuous professional development is not a privilege but a right. Policy frameworks should guarantee equitable access to lifelong learning, particularly for lower-income and migrant workers, who are often excluded by cost barriers.

*Organisational level*: Within institutions, barriers such as unpaid training hours or lack of financial support should be removed. Workers called for more practical, human-centred, and relational training programmes that prepare them for the emotional and communicative challenges of care.

Structured linguistic and cultural orientation for foreign staff was also proposed to strengthen inclusion and teamwork.

Equally, institutions were encouraged to value informal and experiential learning through mentoring schemes, reflective supervision, and peer learning sessions.

*Individual level*: Care workers recognised their own motivation to learn and improve as a form of empowerment. They valued "learning by doing" and described experience as a source of wisdom and professional pride. Taking initiative in training opportunities and sharing knowledge with colleagues were perceived as individual contributions to collective growth.

### 4.4 Fostering Communication, Leadership, and Team Cohesion

*Political level*: At the policy level, workers recommended strengthening communication standards and inter-institutional coordination across the care continuum. Improved information sharing between hospitals, nursing homes, and rehabilitation centres was viewed as crucial for continuity of care and professional cooperation.

*Organisational level*: Within institutions, effective communication emerged as a cornerstone of well-being. Workers proposed regular coordination meetings, clear communication channels, and more responsive leadership. Participatory management and training in conflict resolution were seen as tools to enhance team cohesion. Managers were encouraged to foster open dialogue, constructive feedback, and horizontal information flow.

*Individual level*: At the individual level, workers stressed the value of empathy, respect, and proactive communication with colleagues and supervisors. Being able to "talk openly without fear" and supporting each other during conflicts or high-stress situations were considered everyday practices that sustain team harmony.

### 4.5 Promoting Work-Life Balance and Recovery

*Political level*: At a structural level, workers called for stronger labour regulations protecting rest time, limiting overtime, and ensuring predictable scheduling. Public policies supporting work-life balance, such as parental leave and flexible working schemes, were viewed as necessary to safeguard both worker health and gender equality.

*Organisational level*: Institutions were urged to implement flexible scheduling options, designate quiet spaces for breaks, increase vacation days, and respect personal boundaries. Promoting a workplace culture that values recovery and mutual respect among colleagues was seen as essential to retention and well-being.

*Individual level*: At the personal level, workers recognised their responsibility to protect rest and maintain boundaries between work and private life. They emphasised mutual respect and solidarity—acknowledging each other's right to rest—as foundations for emotional balance and team harmony.

### 4.6 Enhancing Recognition, Social Value, and Collective Voice

*Political level*: Workers called for national and regional campaigns to elevate the image of care work, recognising it as skilled, essential, and socially valuable. They also advocated for policies strengthening collective representation and unionisation, particularly in countries where professional associations are weak or absent. Recognition at the political level was linked to broader efforts toward professionalisation, pay equity, and social justice.

*Organisational level*: Within institutions, recognition should take tangible forms: transparent appreciation, inclusion in decision-making, and opportunities for advancement. Establishing internal mechanisms for consultation and representation was considered vital to ensure that policies and standards reflect the experience of frontline workers.

*Individual level*: On an individual scale, workers valued personal acknowledgment and peer support as everyday forms of recognition. Expressing gratitude, mentoring others, and taking pride in one's contribution were viewed as ways to sustain motivation and dignity in a profession often overlooked by society.

## 5. The Bottom Line

Institutional care work across Europe stands at a crossroads. The evidence presented throughout this chapter reveals a profession sustained by human commitment but strained by structural fragility. Chronic understaffing, excessive workloads, emotional labour, and blurred professional boundaries continue to erode the well-being of those who sustain long-term care systems from within. These risks are not isolated problems but interconnected symptoms of a system that relies too heavily on personal resilience and moral dedication to compensate for institutional deficits. The result is a cycle of exhaustion, distress, and turnover that undermines both worker health and care quality.

Yet the findings also illuminate a parallel reality: amid adversity, care workers generate and sustain powerful protective factors. Emotional support among colleagues, opportunities for development, predictability, and autonomy emerged as key anchors of professional well-being. These resources show that even within constrained environments, dignity and motivation can flourish when workers have the space to act with competence, connection, and control. In other words, institutional care is not inherently unsustainable—it becomes so when organisational and policy frameworks fail to nurture the human foundations on which it depends.

Taken together, the results underscore a simple but profound truth: the sustainability of institutional care is inseparable from the well-being of its workforce. Addressing risk factors without reinforcing protective conditions would only perpetuate the imbalance. Conversely, strengthening psychosocial resources—through fair staffing, supportive leadership, continuous learning, and genuine recognition—creates a ripple effect that enhances both worker health and quality of care. Emotional support, predictability and autonomy are not optional benefits, but essential conditions for providing high-quality, sustainable care.

The practical recommendations proposed by care workers themselves chart a concrete path forward. At the political level, investment in staffing, fair remuneration, and recognition of care work as a high-strain profession must become policy priorities. At the organisational level, institutions must foster participatory management, integrated mental health support, and fair, predictable scheduling that respects workers' lives beyond the workplace. And at the individual level, empowerment, peer solidarity, and self-care should be acknowledged not as personal responsibilities alone, but as practices enabled by supportive structures.

Ultimately, transforming institutional care requires rethinking the values and priorities that underpin the sector—from one that depends on vocation and sacrifice to one that sustains professionalism, reciprocity, and collective care. When care workers are adequately protected, valued, and heard, they not only endure their work—they redefine it. The bottom line, therefore, is not merely about preventing burnout or turnover, but about affirming that caring for those who care is the foundation upon which every humane care system must rest.

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CHAPTER 5

# Strengthening Home-Based Care: Practical Recommendations to Support and Value Home Health Aides

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## 1. Introduction: Why Home Health Aides Matter in Europe

Across Europe, we can observe an increasing trend of people receiving care or assistance in their own homes, as opposed to institutional settings such as nursing homes. Home health aides (HHAs) have made this shift possible. They help older people and those with disabilities get washed and dressed, move around safely, prepare meals, take their medications, and maintain social connections. They also often provide much-needed companionship. They are the first to notice small changes in their care receivers' health that could lead to bigger problems, such as a sudden wobble on the stairs, confusion with medication, or a bruise that shouldn't be there. In a sector that has long been organised around institutions, HHAs facilitate independence in later life.

### 1.1 A System Under Demographic Pressure

The European population is ageing, meaning more individuals are living with chronic conditions as they grow older. According to projections by the European Commission (2021), public expenditure on long-term care (LTC) could reach 2.9% of Gross Domestic Product by 2070, responding to the growing demand

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for assistance with daily activities. Consequently, most EU countries are shifting towards home-based care (HBC), instead of relying solely on institutional care services. This increase in demand for at-home assistance is partly due to people preferring to remain in familiar surroundings and closer to their communities.

Staying at home is often associated with better daily functioning, stronger social connections, and a greater sense of autonomy—all of which typically translate into a higher perceived quality of life (Eurofound 2020). However, shifting the burden of care from institutions to home settings creates new challenges and requires adaptation in this growing sector. HBC requires more reliable staffing, coordination, and travel between different households. Many countries are experiencing a shortage of qualified care workers to meet the current demand. To fill those labour gaps, there has been an increase in private, public, and hybrid care arrangements. These structural pressures contribute to the demanding nature of the working conditions of HHAs.

Legal frameworks also define the working conditions of HHAs, including protections, health and safety management, and employment arrangements. However, regulation is limited in HBC. Risk assessments are more challenging because the dynamics of each care receiver, household and family dynamics, are different. While some countries integrate HHAs into municipal services with clear contracts and training, others rely more on agencies and private households, which are subject to looser oversight. The same principle applies everywhere: rights that are easy to enforce in institutions require careful adaptation for HBC settings.

### 1.2 Why Home-Based Care is Preferred—and Why It is Hard

For older adults and their families, HBC is often the preferred option, as it enables them to maintain their routines and identities, and keep up with their community. However, the very features that make HBC more appealing also make it challenging to organise. In an institution, all patients are in the same building and all of them share important care resources. At home, however, HHAs have to travel from house to house, spending considerable time in traffic, looking for parking and waiting at doors.

While institutional protocols and procedures are more structured and standardised, every household has its own norms and ways of managing daily activities. This can lead to conflicts with care receivers or their family members. These small frictions can build up and escalate into conflict or aggression. This is why advance information, clear communication and care plans are important in helping to mitigate or prevent negative outcomes in HBC provision.

### 1.3 Home Health Aides: an Invisible Workforce

Europe's long-term care workforce is predominantly female, with an increasing proportion aged 50 and over. Many HHAs are migrants who often work in settings that offer limited structured training or supervision (Eurofound 2020).

While the profession is widely described as meaningful, satisfaction with working conditions remains below labour-market averages. Day-to-day, HHAs face precariousness, irregular hours, uncertain schedules, limited support, pressure to manage unrealistic workloads, and serious physical risks, ranging from heavy lifting in cramped spaces to exposure to aggression (Eurofound 2020).

Two broad arrangements shape the job: *live-out* and *live-in workers*. *Live-out HHAs* sleep in their own homes and travel between households during scheduled hours, sometimes making several short visits per day and sometimes caring for one person exclusively. *Live-in HHAs* live in the care receiver's home on working days, providing extended presence and night cover. These (live-in) roles bring with them blurred boundaries, constant proximity and a need for enforceable rest and privacy arrangements.

In the CARE4CARE Project—part of the Horizon Europe programme examining home-based care across six EU countries—about 16% of HHAs were live-in, staying an average of 5.85 days per week in clients' homes. The vast majority worked on a live-out basis. Living conditions for live-in caregivers were generally adequate, but they were not always comfortable. The workforce was predominantly female, with an average age of around 45 (approximately 39% were aged 35–49, and 36% were aged 50–64). Around 30% reported not having received some formal training in care, and approximately 25% said they had never received any safety training—a significant gap with clear implications for quality and safety in private homes. A notable proportion—around 30%—were migrants.

It is unsurprising that the sector is low-attractive in this context. Precarious conditions, uneven access to training, and heavy workloads make it harder to recruit and retain staff—especially when Europe needs more skilled HHAs to provide care at home.

### 1.4 What Do We Mean by "Well-Being"

In line with the World Health Organization's (2010) definition of health as encompassing physical, mental, and social well-being, we view well-being at work as involving both positive and negative dimensions, rather than merely the absence of distress. Negative aspects include emotional exhaustion (burnout), feeling physically drained, disengagement from work, work-life conflict, and the desire to quit. On the positive side, we analyse happiness, flourishing, and the idea that good work can enrich life outside work (work-life enrichment).

These dimensions are not mutually exclusive: an employee may feel proud of their accomplishments one week while feeling drained by the intensity of their work. In this chapter, we consider both aspects together because that is how people experience their jobs.

### 1.5 Risk and Protective Factors

According to Demerouti and Bakker's *Job Demand-Resource Theory* (2011), two types of factors influence well-being. The first type is risk factors, which

are the energy-consuming aspects of a job that increase the likelihood of strain in a given week. These are conditions that push people towards exhaustion and disengagement. For example, consider a work schedule that squeezes visits and travel into impractical timeframes: even a skilled worker would feel hurried and worn down. Second, protective factors are the job and personal features that motivate workers, help them manage risk factors, and facilitate positive well-being outcomes. They provide a sense of control, support decision-making, and facilitate recovery. For instance, a clear briefing sent in advance enables the worker to plan the itinerary, deliver care safely, and finish without rushing.

These factors rarely act in isolation. A risk factor can be amplified or neutralised by an available protective factor. Unpredictable changes cause less distress when explained early by a responsive coordinator, and a tense household is easier to manage when the worker knows they have support they can access. Similarly, protective factors work best in combination: timely information enables autonomy, using autonomy builds skills, and feeling supported helps workers endure tough days.

### 1.6 Why This Chapter and Why Now

HBC is here to stay, and the demand for HHAs will grow alongside it. However, chronic imbalances between supply and demand could lead to more families turning to private arrangements of uneven quality. To ensure that home care remains safe, compassionate, and sustainable, we must gain a comprehensive understanding of the realities of working in the home setting. To this end, we surveyed HHAs in several EU countries, asking them to identify the factors that most influence their well-being and to describe their day-to-day experiences—what wears them down, what helps, and why. Their accounts reveal a small set of risk and protective factors that consistently influence their experience of care work.

## 2. How We Listened and What We Measured

Working conditions fluctuate throughout a typical week. To capture these fluctuations, HHAs completed a questionnaire each week. We tracked both the negative and positive aspects of well-being (see Table 1). Key working conditions were also recorded, including risk factors such as workload intensity, as well as protective factors such as autonomy and opportunities to learn and use new skills. We present the results for HHAs as a whole and discuss some country nuances.

To understand personal perspective and give voice to the care workers, we also conducted focus groups with home health aides in each country. We explored everyday work patterns, the pressures and supports that shape their working week, and the areas they believe should be prioritised for action by policy-makers.

We recruited participants through agencies, municipal providers, and professional networks. The HHA sample includes both live-in and live-out workers across urban and rural settings. Because participation was voluntary, country

subsample sizes vary, with Spain being the largest and Sweden the smallest. Given the small size of some subsamples, cross-country comparisons should be interpreted with caution.

Table 1 – Definitions of the variables assessed in the weekly questionnaire.

| Dimension | Variable | Definition |
|---|---|---|
| Negative well-being indicators | Burnout | Job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress (Maslach et al. 2001). |
| | Physical exertion | Perceived level of physical effort required to perform job tasks (Borg 1970). |
| | Turnover intentions | Intention or desire to leave or abandon the job or profession (Price 1997). |
| | Work-Private life conflict | A form of inter-role conflict, characterised by clash between the demands of one's professional role and those of their personal or familial responsibilities (Greenhaus and Beutell 1985). |
| Positive well-being indicators | Work-Private life enrichment | A process at the work-private life intersection, in which the involvement in one role enhances the quality or performance in the other role (Greenhaus and Powell 2006). |
| | Happiness | General perceived level of personal happiness. |
| | Flourishing | The combination of subjective and psychological well-being, in which the individual is experiencing feelings of engagement, meaning, having personal resources and positive interpersonal relationships (Diener et al. 2009). |

## 3. What We Found

Across countries, a consistent picture emerges: a small set of risk and protective factors carries most of the weight for HHAs' wellbeing. On the risk side,

workload, role boundary strain (when the job spills beyond the care plan), emotional labour and social frictions are linked to worse well-being—more burnout, higher physical exertion, greater work-private life conflict, and stronger intentions to quit the job. On the protective side, autonomy, possibilities for development, predictability, and emotional support are associated with better well-being—more work-to-private life enrichment, happiness, and flourishing. The pages that follow walk through the factors that most strongly influence the well-being of HHAs.

### 3.1 Workload Intensity: Working Hard and Fast

*What did the HHAS tell us*: In this chapter, we treat workload intensity as two related risk factors: quantitative demands and work pace (Burr et al. 2019). While quantitative demands capture the pressure of having too much to do in too little time, work pace reflects the speed and intensity required to get through a shift. Across the European questionnaire sample, HHAs report frequent exposure to heavy workloads, carried out at a fast pace and within tight time windows—a major contributor to their strain.

The focus groups helped to explain this pattern. HHAs acknowledged working at a moderately high pace but contrasted this with the even faster pace of long-term care facilities. Home care workers draw a clear distinction between the relentless routine of institutions and the slower, more variable pace of working in people's homes. As one Spanish HHA put it, "We must go at their pace, not ours… Everything is more delicate, gentler and slower".

Nevertheless, the heavy workload and time pressure observed in the survey can be attributed to other aspects of home care, such as travelling between homes, short visit slots, and unexpected events that compel workers to "rush things" to keep up. This is not driven by a single cause, but by a chain of events: staffing gaps, last-minute rescheduling, unpaid travel or waiting time between visits, and administrative tasks that spill beyond working hours. HHAs describe the emotional and practical burden of doing "a bit of everything"—care, coordination and paperwork—on days when "the stress of responsibility and the workload can be overwhelming". In live-in arrangements, the workload can blur into near-constant availability.

In sum, HHAs walk a fine line. They aim to work at the person's pace, but staffing gaps, travel between visits and tight time slots keep breaking that rhythm. This push-pull is at the core of workload intensity in home care.

*Country nuances*: In France, HHAs repeatedly cite workload, time pressure, and pace as the main sources of stress on the job. These issues are closely linked to shift scheduling and the time spent commuting between visits. In Germany, particularly in live-in arrangements, overwork and ambiguous responsibilities extend working hours and increase time pressure. In Italy, the focus is on scheduling and role ambiguity, which together create time pressure even when "pace" is not explicitly mentioned. In Spain, workers explicitly highlight the fast work pace, which is often intensified by the physical effort involved in transfer tasks, such as supporting, carrying, or helping care receivers move.

### 3.2 Tasks Beyond the Care Plan: When the Job Spills Over the Edges

*What did the HHAs tell us*: Tasks beyond duties refers to how often HHAs are asked to perform tasks that are outside the scope of their defined responsibilities (Karlsson et al. 2020), such as activities not listed in their job description or care plan (e.g., additional household chores or quasi-clinical procedures). Across countries, HHAs report being frequently asked to perform tasks beyond their duties. Furthermore, these requests and expectations were one of the main reasons for the decline in the well-being of these workers.

This risk factor emerged as a familiar theme in the focus groups. HHAs describe being referred to as "the cleaner", or finding that a "quick visit" expands to include washing dishes after a family celebration, gardening, or caring for additional relatives, none of which was included in the care plan. The same boundary stretching also extends to clinical tasks, such as dressing wounds or managing devices without proper authorisation. Workers associate these tasks with legal risk if something goes wrong. Many HHAs admit that they accept these additional tasks to avoid confrontation or because the last carer did it, which redefines expectations for everyone who follows.

These stories are shaped by role ambiguity, such as paperwork that suggests a care receiver is self-sufficient while concealing their true level of dependency, sparse or unclear briefings about health conditions, and sudden requests for night-time presence "just this once" that gradually become the norm. When communication is sporadic, the strain on boundaries quickly becomes coupled with the strain on schedules and last-minute changes, making it harder to push back when the list of tasks grows.

In conclusion, role boundary strain is more than just a hassle. It creates an additional hidden workload, fuels conflict, and exposes HHAs to legal and emotional risks. Over time, it diminishes the capacity to uphold a distinct professional identity, particularly in settings where staff work independently with limited supervision and where families or intermediaries conflate care work with general cleaning services.

*Country nuances*: The picture varies across countries. In Spain, "extra tasks play" a central role in HHAs reports: once one colleague agrees to do more than planned, subsequent refusals can lead to conflict with families and even between carers. In France, this issue is present but less dominant than time constraints. Nevertheless, tasks not included in the plan arise where expectations have not been clearly set from the beginning. In Germany, HHAs associate taking on "responsibilities outside their role" with liability concerns when clinical boundaries are crossed without organisational support. In Italy, workers emphasise contractual mismatch and excessive workloads; boundary stretching does occur, but typically as an additional issue on top of these.

### 3.3 Emotional Labour: Caring With a Steady Face

*What did the HHAs tell us*: Here, we define "emotional labour" as two interlinked risk factors: emotional demands and the need to hide emotions (Burr et

al. 2019). The first is emotionally charged interactions, which involve the ongoing need to read, absorb, and respond to others' feelings while appearing warm and composed. The second is the pressure to hide one's own emotions, suppressing irritation, sadness, or fear while maintaining calm. In the focus groups, workers also described facets of emotional labour as display (remaining outwardly kind and calm), sensitivity (recognising unspoken feelings), sympathy (responding to suffering) and involvement (forming deep bonds that are difficult to detach from). Emotional labour was reported as an inherent part of care work across all countries. HHAs were frequently exposed to emotionally charged or challenging situations, which negatively impacted their well-being.

During focus groups, they defined emotional labour as the art of managing feelings. As a live-in HHA put it: "All I try to do is remain stoically calm and not show my irritation, even when I'm unwell". HHAs say they often become confidants—"you end up taking all the crap they've been bottling up…"—and sometimes act as a psychologist. The emotional connection can be very strong: "I haven't been able to detach from her because I give myself so fully to her", one HHA explained. Others take their work home with them: "You're always left with that uneasiness about what you will find the next day".

When safety or trust is insecure, care workers mask or deflect to maintain the quality of care. HHAs described using harmless pretense with care receivers with dementia: "I prefer to tell them that I am X… It's no good, but at least I can do my job". Alongside this quiet containment, exposure to suffering, decline, and death is usual for HHAs, who recount the strain of encouraging those who say they are "tired of living" and of facing aggression alone in people's homes.

In summary, HHAs describe constant emotional labour, which involves reading the room and managing their own reactions, often without formal recognition. The pressure to hide their emotions is most evident when workers are isolated in private homes, face dementia-related volatility, or lack support.

*Country nuances*: In France, HHAs describe deliberate emotion management, including subtle strategies in dementia care. They value brief debriefs with colleagues and recognise that positive feedback from families helps offset hidden strain. In Germany, levels are higher, especially among live-in caregivers, who emphasise the importance of maintaining an outward appearance of calmness and rely on time off as a vital coping mechanism. Conflicts with relatives and language barriers further exacerbate the situation. In Italy, accounts feature delicate situations and the effort to set boundaries without breaking trust. Spain implies the most involvement: HHAs absorb others' pain, provide steady reassurance, and sometimes face abuse alone. Small acts of kindness from care receivers and their families are what help them deal with this emotional toll.

### 3.4 Social Frictions: Everyday Offences and Personality Clashes

*What did the HHAs tell us*: In the survey, we examined two related risk factors within the "relational climate" of home care. First, workplace incivility encompasses low-level disrespect that violates norms of mutual respect (Cortina

et al. 2013). Examples of this could include sarcasm, eye-rolling, or being spoken over. Second, conflict reflects tensions with care receivers, relatives, and colleagues, especially when frictions stem from personality clashes (Jehn 1995). In the survey, HHAs reported moderate levels of incivility and relational conflict—factors that significantly impacted their overall well-being.

In the focus groups, social tensions among home health aides emerge less as explicit disputes and more as everyday disrespect and distrust within private households. Workers describe being micromanaged—"the family watches everything you do; you've got cameras pointed at you"—and facing suspicion or accusations ("if the mother says the carer steals, who do they believe? The mother"). Conflicts often arise over how care should be carried out (e.g., safe lifting, hygiene routines, or timing), with relatives contradicting the professional judgement of the aides. Without a responsive coordinator to mediate, the situation becomes increasingly stressful.

Alongside these conflicts, some HHAs report experiencing discrimination in the home, such as derogatory remarks or rejection based on their nationality. Others cite gender bias in assignment practices, such as "offers only for ladies", which sidelines male HHAs. These experiences of xenophobia and sexism are particularly stressful because they occur behind closed doors, with little oversight or institutional support. Language barriers can further intensify misunderstandings and stress, particularly in the early stages. In the survey, discrimination was not commonly reported, yet HHAs experienced it more frequently than workers in institutional settings. This pattern likely reflects the demographic profile of the group—HHAs include a larger proportion of migrant workers—and the uncontrolled, isolated nature of home care.

In sum, social frictions are everyday stressors. They occur in private homes, where there is little oversight, and minor insults can accumulate over the course of a week. Those in live-in roles are particularly vulnerable; for example, migrant HHAs face microaggressions and language barriers. Discrimination is more common in HBC settings than in institutions.

*Country nuances*: In France, HHAs describe a comparatively civil day-to-day tone, yet they still face being corrected in front of clients and value prompt mediation to prevent tensions from escalating. In Spain, frictions are sharper: workers report close monitoring (even by camera), snap judgments about *how* care should be provided, and disputes that escalate when a refusal follows a colleague's previous compliance. Germany's situation is more hostile, especially for live-in workers, where relatives challenge professional judgement. Language barriers for migrant HHAs can intensify the strain. By comparison, in Italy, blatant rudeness is less common, but workers still must deal with criticism related to household micro-norms and must handle disagreements carefully to maintain trust.

### 3.5 Autonomy: Freedom to Organise Their Work

*What did the HHAs tell us*: We define "autonomy" as the day-to-day freedom to organise one's work, including deciding how to perform tasks, in what order,

and with what approach (Bakker and Bal 2010). Across all counties, HHAs report a moderate level of autonomy, as they often have control over how they conduct their work. Having this level of influence over their own work positively impacts workers' well-being.

During focus groups, HHAs discussed autonomy in terms of having practical control over their shifts, such as choosing the order of tasks, adapting methods to the home, and pacing care according to what the person can manage. They value being trusted to use their judgement, such as adjusting routines and solving small problems on the spot, safe in the knowledge that they can escalate issues if necessary. Workers link this control to less stressful visits, fewer errors, and a stronger sense of professional esteem. A recurring sentiment is that autonomy works best alongside clear plans and predictable timings: too little structure can turn "freedom" into being left alone, whereas rigid schedules can reduce judgement to mere box-ticking. Many describe autonomy as a protective factor that cushions the impact of other pressures, such as emotional strain and a hectic pace, because it enables individuals to take control of their day rather than being overwhelmed by it. An interesting finding is the fine line between autonomy and isolation: the same discretion that empowers can lead to strain if support is unavailable. This highlights why having a voice and feeling of control are among the most significant factors that protect the well-being of HHAs.

In conclusion, autonomy is a key factor in improving the well-being of HHAs. It is most effective when exercised within clear plans and predictable timeframes, as this enables workers to personalise care, prevent errors, and maintain their professional self-esteem. Autonomy also mitigates other risk factors, such as emotional strain due to a fast-paced workload, as it enables workers to take control of their day. However, the same discretion that empowers can lead to isolation when support is absent, so decision-makers must not confuse autonomy with being left alone.

*Country nuances*: The notion of control differs across countries. In France, for example, while autonomy is valued, it is not the primary concern. In Spain, workers say that discretion, along with learning opportunities and protected rest, keeps the week manageable. However, when schedules are tight, this freedom to manoeuvre decreases. The situation in Italy is similar: HHAs can adjust their routines, but scheduling demands and role ambiguity can reduce their control. Live-in HHAs in Germany report lower decision-making control: discretion feels more restricted and rule-bound, with workers relying on formal guidelines rather than day-to-day flexibility.

### 3.6 Predictability: Clear and Timely Information to Prepare and Plan

*What did the HHAs tell us*: "Predictability" is the day-to-day stability of the job, which involves receiving sufficient and timely information to perform the work properly, as well as adapting to changes such as new tasks, methods, or structural changes (Burr et al. 2019). Across countries, HHAs reported moderate levels of job predictability. Receiving timely and sufficient information made their jobs more manageable and contributed to their well-being.

In focus groups, predictability involves clear plans and thorough briefings: knowing who they will see, what the priorities are for the visit, how much time they have, and what might require adjustments. When these elements are in place, home visits "flow"; workers can manage care effectively, anticipate needs and conclude visits without chaos. Where they don't, HHAs describe last-minute schedule changes, conflicting family requests, and gaps in information that force them to replan constantly on the spot. Across countries, workers associate steadier schedules and adequate information with fewer stressful visits and fewer errors—an everyday protective factor.

In summary, predictability protects the well-being of HHAs by reducing chaos and mental workload. When workers receive sufficient and timely information—clear plans, priorities, realistic timeframes and advanced notice changes—visitsts run smoothly. This allows for the care to be paced, risks anticipated, and errors avoided. Where predictability is lacking—for example, due to late updates, shifting instructions, and gaps in communication—workers are forced to re-plan constantly, which increases pressure and erodes confidence. Similarly, steadier schedules and clear briefings lead to smoother weeks, while blurred boundaries and unexpected tasks disrupt planning, particularly in live-in roles. Ultimately, it is prompt, clear information that keeps the job manageable.

*Country nuances*: In France, HHAs stressed that timely and concise client information, along with stable schedules, was key to ensuring that visits ran smoothly. They said that unpredictability mainly stemmed from late updates and miscalculations regarding travel time. In Spain, workers reported frequent last-minute rescheduling and changing instructions. When rotas are adhered to and information is provided well in advance, the week remains manageable; otherwise, small disruptions can have a snowball effect. Italy seemed more organised: aides often receive clear plans, but irregular hours and sudden requests still disrupt predictability unless time off and handovers are respected. In Germany, there is a greater need for advanced notice, especially for live-in HHAs, because blurred boundaries and unexpected tasks can disrupt planning. When employers adhere to legal rest day rules, it helps restore a sense of structure.

### 3.7 Possibilities for Development: Learning on the Job and Putting Skills to Work

*What did the HHAs tell us*: "Possibilities for development" were assessed to determine whether a job enabled workers to use their existing knowledge and continue learning (Burr et al. 2019), independently of formal promotion opportunities. HHAs consistently reported that they could use and develop their skills fairly frequently in all countries. Having this opportunity led to improved well-being.

Across countries, HHAs say that most development happens through doing the work, along with the occasional input from other professionals and tips from colleagues. As one HHA put it, "You go to a care receiver's home and learn something new from everyone you meet. Ultimately, our training comes from experience". Workers regard this daily learning as the development of practical skills, such as communication, de-escalation, safe transfer tasks, and dementia

care, which are honed on a case-by-case basis in private homes. Although formal training exists, HHAs report uneven access to it and variations in its quality. Several rely on peer support, online forums, and self-study to fill gaps ("I often learn from forums or my own internet searches"). At the same time, some HHA groups emphasise that continuing training also matters—provided it is practical and timely: "Even with experience, it's important to keep training and to ask for help".

In conclusion, the possibilities for development protect the well-being of HHAs by sustaining their competence, confidence, and professional identity. We can see a straightforward mechanism: when workers can apply their knowledge and continue to learn as they go, visits feel safer, smoother, and more meaningful. Most growth comes from learning by doing, which is enhanced by peer exchange and the occasional input of other professionals. The benefits are strongest when workers have enough autonomy to use their judgement and enough predictability to plan their work and reflect on it. Conversely, generic or hard-to-access training reduces the positive impact, forcing HHAs to rely on their own resources.

*Country nuances*: Across countries, HHAs describe development as learning by doing, but with some differences. In France, aides emphasised everyday learning, as well as short, practical refresher courses that build on experience. In Spain, workers emphasised case-by-case skill building, supported by tips from colleagues and other professionals—each home became a classroom. It was similar in Italy, yet more critical of generic, mandatory courses, with HHAs requesting short, job-relevant modules during working hours. The situation in Germany was the most different for live-in workers: development largely relied on experience and was self-directed. Workers leaned on peer exchange and coordinator guidance when available and wanted clearer routes to develop core skills, such as dementia care and safe transfer tasks.

### 3.8 Emotional Support: Being Heard, Encouraged and Backed-Up

*What did the HHAs tell us*: "Emotional support" involves feeling listened to, appreciated, and encouraged by people present at the workplace (Peeters et al. 1995). It is distinct from instrumental help, which is hands-on assistance with tasks. Across countries, HHAs report having access to emotional support at work, which is a key contributor to their well-being. As HBC can be solitary, HHAs rely more on emotional support than on instrumental help, which is often limited.

HHAs recount two realities. On good days, there's a sense of being backed by peers and coordinators who check in, share what went well or badly, and offer words of encouragement. They also describe receiving meaningful support from care receivers and their families, such as gratitude and kindness. Having a relative who checks in or stays reachable can also boost morale and validate their work. On hard days, however, the solitude of home care can be overwhelming: workers absorb grief, conflict, or frightening incidents, and then carry that weight alone. Reports note repeated exposure to suffering and end-of-life moments without structured debriefing sessions. Many HHAs want formal spaces

to process these experiences but often rely on private coping mechanisms or informal peer support.

In sum, emotional support protects the well-being of HHAs by reducing isolation and helping them cope with difficult experiences. In a largely solitary job where practical or instrumental support is scarce, being listened to, appreciated, and encouraged by peers, coordinators, and, at times, care receivers and their families act as a primary protective factor. It helps workers process exposure to distressing situations and moments at the end of life and regulates mood after conflict. Without emotional support, workers must cope alone with routine strains such as pace, friction, and boundary challenges.

*Country nuances*: In France, HHAs describe a sense of steady peer solidarity and regular check-ins with coordinators. However, they also request routine debriefings and access to psychological support following deaths. In Spain, support is mostly informal—colleagues help when they can, and dedicated spaces are scarce—though sincere gratitude from families can boost morale. In Italy, teams are responsive, but workers still want brief, facilitated reflection sessions. In Germany, the situation is more solitary, particularly for live-in workers. Informal friendship networks substitute for team support.

### 4. What Would Address the Needs of Home Health Aides Now

In addition to our own findings, a substantial body of research on workplace well-being indicates that risk factors such as time pressure, excessive workload and role conflict are consistently associated with poorer health and greater stress. For example, a rigorous research technique called "meta-analysis" involves taking high-quality individual studies on a specific topic and combining them to produce a well-founded conclusion. One such meta-analysis, conducted by Guthier, Dormann, and Voelkle (2020) found that sustained job intensity or exposure to job stressors erodes well-being over time, leading to negative outcomes such as burnout. This provides the basis for actions such as capping workloads, designing realistic rosters, paying for travel, and drawing clear boundaries around job content.

Emotional labour is particularly relevant in customer-service settings, where workers actively manage their emotional reactions when interacting with others. Different strategies can lead to mixed results. On the one hand, surface acting—the "put on a face" strategy—shows consistent associations with exhaustion (Hülsheger and Schewe 2011). In contrast, deep acting is a more proactive approach, where workers try to change how they feel as an emotion builds (such as reframing a tense situation to foster patience or empathy). This strategy is generally less harmful and can sometimes improve mood (Kammeyer-Mueller et al. 2013). These findings support proposals for emotion regulation training, access to debriefing sessions after challenging interactions, and protected recovery time throughout the week.

The interpersonal environment plays a crucial role in health and well-being (Sonnentag, Tay, and Nesher Shoshan 2023). Risk factors include exposure to

everyday incivility, discrimination, and harassment, all of which can lead to strain. These findings further emphasise the need for conflict management protocols, such as standards of respectful behaviour, rapid mediation when tensions arise in private households, and clear escalation routes for HHAs working alone.

In terms of resources, interventions that facilitate access to protective factors by increasing job control, autonomy, social support, and supportive leadership improve emotional and physical well-being (Nielsen et al. 2017). Predictability is also important, providing stable rotas and clear, timely information about visits and priorities. Increasing employees' control over their schedules, along with supervisor support, reduces reactivity to day-to-day stressors (Leger et al. 2022). Moreover, using and developing skills sustains confidence and coping capacity. This is because resource-building and job crafting—making small, proactive changes to job tasks or methods to better fit one's strengths and a client's needs—has been shown to be beneficial. When workers receive practical, job-relevant training and make small, proactive changes that add resources (for example, seeking feedback, adopting safer techniques or reorganising steps), exhaustion decreases and well-being improves (Lichtenthaler and Fischbach 2019; Nielsen et al. 2017).

Finally, recovery practices, such as brief breaks that allow people to switch off, improve daily mood and reduce stress (Sonnentag, Tay, and Nesher Shoshan 2023). Just going for a walk in the park during your lunch break can make you feel happier and more relaxed for the rest of the day. These findings support proposals for protected rest periods, short breaks between appointments, and debriefing sessions after challenging cases.

The following pages turn evidence into action for HHAs. For each risk and protective factor, we provide practical recommendations at three levels: for policymakers, care organisations and individual employers (care receivers and their families). These recommendations are based on weekly data and focus group testimony, and are also consistent with the findings of high-quality research into improving worker health and well-being. Think of them as a small set of interconnected levers: clear task scope, stable schedules, and timely information make autonomy usable; fair travel and protected breaks regulate pace; recognition and debriefs make the emotional load manageable; and practical, job-relevant training transforms experience into competence.

### 4.1 Work Intensity: How to Make the Workload and Pace of Work Manageable

*For Policy-Makers*

- Set HBC workload benchmarks (visits per day, realistic time per task, limits on split shifts) and link public funding or accreditation to meeting them. Do so by including the input of HHAs.
- Recognise travel time as working time, so routes are planned realistically and visits are not squeezed to make up for unpaid minutes on the road.
- For live-in arrangements, embed minimum standards for rest (daily and weekly), privacy, meals, and housing conditions; constant availability must be compensated with predictable time off.

- Require providers to publish simple rota quality metrics (late changes, gaps covered, breaks respected), and build predictability clauses—advance notice of shifts, limits on last-minute changes—into contracts.
- Fund the basics that remove avoidable time pressure: rapid access to essential equipment and home adaptations, and tools to schedule fairly, brief clearly, and intervene early.

*For Organisations*

- Design the week so workers can go at a safe, non-rushed pace. Give coordinators real authority to shape rotas, align visit lengths with tasks, and protect recovery time.
- Count, pay and plan travel—cluster visits geographically, include buffer minutes between appointments, and avoid excessive split shifts.
- Allocate cases fairly: maintain continuity where it helps the person, but rotate particularly demanding cases so the burden does not fall on the same shoulders.
- Build structured breaks into the day and monitor them. A missed break is a signal that the schedule is unrealistic, not that the worker is slow.
- Strip out time drains: streamline paperwork, pre-position equipment, and set up fast channels to fix access problems (keys, codes, parking).
- Before a new assignment, give clear briefings: priorities, risks, realistic time windows, who to call if things change. During the week, communicate changes early, not on the doorstep.
- For live-in HHAs, enforce quiet hours and rest days in practice, not just on paper, and make a named coordinator reachable to prevent small crises from cascading.

*For care-receivers and their family members*:

- At the start of care, take part in a short expectations conversation: what must be done each visit, what can wait, and how long things take when done safely.
- Share practical details (keys/codes, parking, lift access, pets) and update them promptly; this saves minutes that otherwise come out of care.
- Try to avoid last-minute changes unless urgent. When a change is unavoidable, give the agency notice so that the entire route can be adjusted.
- Allow workers to follow safe methods, even if they differ from family habits. Safe lifting and unhurried hygiene take time.
- If you have feedback, raise it with the coordinator rather than correcting the worker in front of the person receiving care.
- Remember that HHAs travel between homes when they have other responsabilities—leaving on time is how they arrive on time for the next appointment. Small acts of respect for the plan help turn a rushed day into a workable one.

### 4.2 How to Prevent and Respond to Requests for Tasks Beyond Care Duties

*For policy-makers:*

- Require written service agreements and care plans for home care that specify tasks, limits, and escalation routes when needs change.

- Build a "right to decline off-plan tasks" into labour and commissioning rules so that HHAs can refuse non-contracted or unsafe requests without retaliation.
- Distinguish legally between care work and domestic housekeeping in live-in arrangements, with minimum standards for rest and a prohibition on "all-purpose" contracts that blur roles.
- Make periodic plan reviews (for example, every 4–8 weeks, or when dependency needs rise) a condition of public funding so that growing needs trigger plan and price adjustments.
- Establish simple, independent complaint/mediation channels for workers and families; publish outcomes to deter abuse.
- Ensure liability and insurance coverage is clear: quasi-clinical procedures (for example, wound care) must sit with trained, authorised staff or be explicitly delegated with training, written consent and organisational backing.

*For organisations*:

- Introduce a short family orientation at start-up (in person or phone): what HHAs do, what they don't, who decides changes, and how to request them. Provide a one-page "What to Expect" sheet in the home and a visible contact for changes/complaints (not the worker).
- Equip HHAs and coordinators with boundary tools: scripts for declining off-plan requests kindly ("I can't do X today; let's ask the coordinator to add it to the plan"), and an easy logging button in the app to record requests outside scope. Coordinators review these logs weekly, adjust plans where appropriate, and close the loop with families. When needs rise, reassess promptly and amend the plan (and visit length/funding) rather than informally expanding duties.
- For any clinical-adjacent tasks (compression stockings, wound checks), set a decision tree: training → written delegation → clear protocols → documented consent → periodic review. If any step is missing, the task is not completed.
- Support your staff: state clearly that refusing off-plan or unsafe work is encouraged.
- Prevent role drift by aligning job titles and contracts with actual duties and auditing cases where mixed roles are necessary to ensure fair pay and time.

*For care-receivers and their family members*:

- At the beginning, agree on what must be done at each visit, what can wait, and how long safe care takes. If you need extra help or tasks change, call the coordinator to update the plan; don't ask the worker to stretch "just this once"—saying yes today sets a new expectation for tomorrow.
- Avoid asking HHAs to perform medical procedures unless the agency confirms training and authorisation. Keep household tasks within the agreed scope; large clean-ups or unrelated chores belong to a different service.
- If a request is declined, treat it as a process issue, not a personal slight—the plan likely needs to adjust.

4.3 How to Manage the Emotional Labour

*For policy-makers*:

- Build supervision and debrief time into commissioning and reimbursement so providers can conduct regular check-ins and offer support after deaths or critical incidents.
- Require psychosocial risk assessment for lone workers, with clear protocols for escalation and follow-up after aggression or traumatic events.
- Fund short, job-relevant training—communication, de-escalation, dementia-related behaviours, grief and loss—delivered on paid time.
- Protect rest and the right to disconnect, including quiet hours for live-in roles.
- Extend anti-harassment and anti-discrimination protections explicitly to private homes in publicly funded care, with a simple complaint and mediation route.
- Encourage language support for migrant HHAs, recognising how communication strain magnifies emotional load.

*For organisations*:

- Schedule brief, regular debriefs (e.g., a 10-minute huddle at week's end) and offer an on-call supervisor for emotionally difficult visits.
- After deaths, assaults or severe distress, trigger an automatic check-in and offer access to counselling—no self-advocacy required.
- Deliver scenario-based training that HHAs can use: calming an agitated person, responding to relatives' strong emotions, setting kind but firm boundaries, and self-regulation techniques between visits.
- Match and rotate emotionally heavy cases. Flag high-intensity households for longer visits and closer support.
- Recognise emotional work in appraisals and feedback. Capture compliments from families and share them with staff.
- Provide language and cultural mentoring for HHAs who need it, and make it easy to pause and document after a distressing event so the schedule reflects reality.
- Set clear contact rules (no routine messages outside hours) and support workers who follow them.

*For care-receivers and their family members*:

- Share sensitive information in advance (what upsets or soothes your relative) and keep routines consistent where possible.
- During tense moments—confusion, agitation, end-of-life—trust the aide's professional judgement and the de-escalation methods they've been taught.
- Avoid asking the worker to mediate family conflicts; take disagreements to the coordinator.
- Show ordinary appreciation—a sincere thank-you after a hard visit matters.
- Keep surveillance to a minimum and never record secretly. If cameras are needed for safety, agree placement and use with the agency.

- After bereavement or a difficult incident, allow a little space in the next visit and channel any changes through the coordinator rather than contacting the worker out of hours.

### 4.4 How to Prevent and Respond to Social Frictions

*For policy-makers*:

- Require providers to use written service agreements that include a mutual-respect charter for private homes (no harassment, no covert recording, clear complaint routes).
- Extend anti-harassment and anti-discrimination protections explicitly to home settings and give HHAs a right to withdraw from unsafe or discriminatory situations without penalty to pay or contract.
- Fund short, paid training in micro-de-escalation, cultural competence and language support, recognising that misunderstandings and bias amplify friction.
- Mandate simple, independent mediation channels for workers and families, and basic incident reporting (anonymous, non-punitive) so commissioners can track patterns and act.
- For live-in care, set enforceable quiet-hours and privacy standards to prevent constant low-grade conflict from proximity and fatigue.

*For organisations*:

- Start every case with a brief family orientation: what good interaction looks like, who gives instructions, how to raise concerns etc.
- Issue a one-page "Respect & Safety at Home" card to display in the house.
- Create a visible escalation ladder: when tone slips or instructions clash, coordinators respond within set times, mediate by phone or visit, and document decisions so the worker isn't left "in the middle".
- Use a no-blame incident log in your app for rudeness, contradiction of professional judgement, or discriminatory remarks. Review patterns weekly, adjust the plan (longer visits, different techniques), and reassign where personality fit is poor.
- Coach HHAs in micro-de-escalation and boundary language (how to correct kindly, how to pause and call the office).
- Recognise positive behaviour too. Collect family appreciation and share it in feedback and appraisal—it counterweights the drip of minor slights.
- For live-ins, agree house rules and schedule regular coordinator check-ins to catch tensions before they harden.

*For care-receivers and their family members*:

- At the outset, agree who gives instructions, what must happen each visit, and how to raise concerns—use the coordinator, not corrections in front of the older person.
- If you use cameras, discuss placement and purpose with the agency and the worker; avoid real-time micromanagement and never record secretly.

- Keep instructions consistent—choose a single point of contact in the family—and trust the aide's professional methods (for example, safe lifting takes time).
- If something worries you, call the coordinator for a quick review. Don't ask the worker to mediate family disputes.
- Small courtesies matter: a thank-you after a difficult visit, a calm tone when things run late, and sticking to agreed house rules.
- If a personality clash persists despite mediation, ask the agency to re-match—it protects the older person's comfort and the worker's wellbeing alike.

### 4.5 How to Promote Autonomy

*For policy-makers*:

- Embed clear, outcome-based care plans that specify goals and safety limits but leave room for aides to decide how to meet them (task order, methods, pacing).
- Tie commissioning to predictable rotas and timely information flows, because autonomy works best alongside stability.
- Fund short, job-relevant training (communication, de-escalation, dementia care, safe mobility) on paid time so aides have the confidence and skills to exercise judgement.
- Require providers to run regular supervision and debriefs (including after deaths or critical incidents), which sustain autonomy by preventing "freedom" from slipping into isolation.
- Strengthen participatory voice—involve home-care workers and their associations in standard-setting and oversight—so everyday practice informs rules rather than the other way round.

*For organisations*:

- In care plans, state the visit priorities and the red lines, then explicitly authorise aides to determine sequence and approach within those bounds, with an escalation route when needs or risks change. Pair this with stable, realistic scheduling (including travel buffers and clear briefings).
- Give coordinators real remit to protect rota predictability, balance caseloads and back staff decisions in the home.
- Build routine check-ins to prevent autonomy becoming "left alone", and ensure a reachable on-call contact for tricky visits.
- Invest in practical, scenario-based training that workers can apply the next day; align appraisals to recognise sound judgement and safe adaptations, not just task completion.
- Start every case with a family orientation: who sets priorities, how to request changes, and why aides may adjust methods to keep care safe; keep a visible coordinator contact so instructions don't bypass the plan.
- Reduce time drains (equipment delays, paperwork) so discretion is used for care—not for catching up.

*For care-receivers and their family members*:

- Agree at the outset what must be done each visit, what can wait, and who to call for changes. Then trust the professional method—safe lifting, unhurried hygiene and de-escalation techniques may differ from household habits.
- Use the agency coordinator for feedback rather than correcting the aide in front of the older person.
- Keep practical details (keys/codes, parking, routines that soothe/upset) up to date so the aide can plan and adapt smoothly.

### 4.6 How to Facilitate Job Predictability

*For policy-makers*:

- Make stable rotas and early notice of changes a condition of public contracts, with simple metrics (late changes per worker, breaks honoured) reported to commissioners.
- Require providers to strengthen the coordinator role so someone is accountable for plan quality, briefing, and fair leave planning. Fund the time this takes.
- Recognise that information in time is a core protective factor linked to better wellbeing across groups. Design standards around it.
- Align labour and payment rules so travel time is counted and planned, preventing on-the-doorstep re-planning that erodes predictability.
- Set a minimum for clear, written care plans and scheduled reviews so rising needs trigger plan updates—in writing—rather than informal drift.

*For organisations*:

- Give coordinators the power to produce rotas with realistic time windows and buffers, and to issue concise visit briefings (priorities, risks, access/parking, contact point).
- Optimise daily schedules to reduce fragmentation (limit split shifts), and build structured breaks. Monitor missed breaks as a signal the plan isn't realistic.
- Count, pay and plan travel. Cluster visits geographically and avoid sending HHAs into unfamiliar areas without orientation—much of the "chaos" comes from travel miscalculation.
- When change is unavoidable, communicate early, not at the doorstep. Log late changes so patterns can be fixed at source. Before the first visit, run a short start-up briefing (phone or in person) with the aide and family to align expectations about tasks and timings. Keep a visible coordinator contact so instructions don't bypass the plan.
- For live-in arrangements, schedule and enforce rest days and quiet hours—predictable off-time is part of a predictable week.

*For care-receivers and their family members*:

- Join the agency's preliminary conversation to agree what must be done each visit, how long safe care takes, and who the single point of contact is

for changes. Then stick to the plan whenever possible. If something needs to change, call the coordinator as early as you can so the whole route can be adjusted.
- Share practical details that save time (keys/codes, parking, lift access, pets, preferred routines that soothe or upset) and keep them updated.
- Avoid last-minute requests or on-the-spot re-prioritising that forces the aide to re-plan in your hallway. Use the coordinator to add or change tasks.
- Remember that HHAs work to realistic time windows across several homes, so letting them leave on time helps the next person receive care on time too.

### 4.7 How to Provide Possibilities for Development

*For policy-makers:*
- Commission ongoing, specialised training that matches real cases—safe mobility and postural hygiene, advanced dementia and palliative care, de-escalation and stress management—and fund it on paid time so HHAs can attend without loss of earnings.
- Build early-career support into contracts (mentoring, shadowing etc.) so new aides gain confidence with complex households.
- Encourage team-based learning models (case reviews, joint workshops across professions) to strengthen cooperation around clients and reduce the emotional load of learning alone.
- Embed regular plan reviews so rising needs trigger updated training and clear delegation pathways, not informal drift beyond competence.

*For organisations*:
- Offer short, practical refreshers tightly linked to everyday work (for example, safe transfers in cramped bathrooms, communicating with people with advanced cognitive decline).
- Provide practical, scenario-based training modules, avoiding generic courses.
- Create peer learning loops—brief case huddles, cross-disciplinary touchpoints with nurses and therapists—so tips flow and small problems are solved early.
- Remove access barriers. Run sessions on the clock, record them for later viewing, and recognise completion in appraisals (linking to progression and pay where possible).
- Map competence to tasks: where plans include clinical-adjacent activities, provide explicit training, written delegation, and refreshers. If prerequisites aren't met, the task should not be assigned.
- Support self-directed learning with curated resources (checklists, short videos, multilingual materials) since many HHAs already supplement with forums and personal research.
- Ask HHAs for feedback on what worked this week, then feed their insights into the next session.

*For care-receivers and their family members*:

- Share practical information that builds skill—what soothes or upsets, safe ways to move in your space, equipment that's available—so the aide can apply techniques correctly.
- When the agency proposes a skills update for your case, allow time for it and route requests through the coordinator so training matches the plan.
- Offer constructive feedback via the agency rather than correcting in front of the person receiving care. This protects learning and dignity.

### 4.8 How to Ensure the Access to Emotional Support

*For policy-makers*:

- Commission regular supervision and debrief time as part of contracts so providers can run routine check-ins and offer support after deaths or critical incidents.
- Workers across countries explicitly called for psychological support and structured "emotional release" spaces. Build these into reimbursement rules rather than leaving them to goodwill.
- Reinforce this with brief, job-relevant training (for example, grief, loss, de-escalation, dementia-related behaviours) delivered on paid time.
- Treat timely, sufficient information as a protective condition: predictable schedules and proper briefings reduce isolation and make support easier to access during difficult weeks.
- Recognise—at the level of national guidance—that emotional support is a predictor of better happiness, enrichment and flourishing among HHAs, and should therefore be monitored as a core quality indicator.

*For organisations*:

- Schedule short, regular debriefs and provide a reachable on-call supervisor for emotionally tough visits.
- After a death or traumatic event, trigger an automatic check-in and offer access to a psychologist.
- Offer practical, scenario-based sessions that workers can use, and run group reflection spaces (in person or brief video calls) to process grief, conflict and shock.
- Keep support accessible: make coordinators' check-ins routine, not exceptional, and anchor them in the week's realities (what went well/badly, what needs support).
- Capture and share recognition from care receivers and families—sincere gratitude and small gestures lift morale and offset hidden strain.
- For lone-working HHAs, treat information flow and rota stability as part of the support system. Clear plans and early updates reduce the need to "cope in private".

*For care-receivers and their family members*:

- Say thank you—workers report that genuine appreciation from families and care receivers helps them carry hard days.

- Be reachable when it matters (for example, a relative who can be called quickly), and share information that helps steady difficult moments.
- If a visit has been especially intense—end-of-life care, a frightening incident—allow a few minutes for the aide to regroup and route any changes through the coordinator rather than contacting them out of hours.

### 5. The Bottom Line

The aim of this chapter was to understand what makes home care sustainable for those who deliver it: HHAs. Two things stand out. First, a small number of risk factors largely account for the strain experienced by HHAs, such as working hard and fast, going beyond the care plan, bearing the emotional burden of the care work, and dealing with everyday difficulties in care receivers' homes. Second, a few protective factors consistently help: having the autonomy to organise shifts, receiving timely information for planning purposes, developing and utilising skills, and feeling emotionally supported. When these things are all in place, visits go well, there are fewer errors, and the job becomes more sustainable. When they do not, even the most dedicated workers will eventually exhaust themselves.

The weekly survey provided us with a clear picture. It showed that workload intensity is a frequent feature of the job, involving heavy task lists that need to be completed quickly and within tight timeframes. Focus groups helped explain why this is the case: travel between homes, short time slots and last-minute changes repeatedly disrupt the person-centred rhythm that HHAs try to maintain. This rhythm is also disrupted by role boundary strain, such as requests to take on tasks outside the care plan. This adds hidden workload and causes friction with families and colleagues. Similarly, emotional labour is a daily reality for aides, who are expected to hide and regulate their emotional reactions. The accumulation of social matters—being spoken over or corrected in front of the person receiving care—can be draining over the course of a week. The good news is that protective factors work much like well-placed levers. Autonomy, or clear goals with discretion over how to meet them, allows workers to tailor care to individuals and their homes. This results in less stressful visits and fewer mistakes. Predictability, which involves providing information in good time, setting realistic timeframes, and giving early notice of changes, reduces cognitive load and transforms a chaotic day into a structured one. Opportunities for development, such as learning by doing and short, job-relevant update training, enable workers to gain capability and self-confidence. Emotional support, such as brief check-ins, a responsive coordinator and sincere acts of gratitude, mitigates the isolation that accompanies working alone.

The context of HBC work matters. Live-in roles involve constant proximity and blurred boundaries, while live-out roles involve more travel and short timeframes. Although countries differ in terms of the amount of information provided in advance, the stability of work schedules, and the definition and enforcement of roles, the underlying mechanisms are similar everywhere. Where

plans are clear and timeframes are realistic, autonomy can be exercised. Where they are not, the same autonomy can feel like being left alone.

The families of care receivers play an important role. Most families want quality care and value the expertise of the caregiver. When expectations are clearly set from the outset, instructions are communicated through one channel, and appreciation is shown, things run much more smoothly. However, when rules are unclear or boundaries are blurred, tensions rise, leaving the worker to decide whether to follow the initial care plan or the directions of the care receiver (or their family). The goal is not to police families, but rather to establish a practical partnership with the HHA and coordination by providing a clear scope of duties, a designated coordinator, and respect for safe working methods.

There were some limitations to our data collection. Some of the samples for HHAs in certain countries are small. Furthermore, HBC is varied by definition: habits and house rules differ from one household to another. Nevertheless, the numbers and stories point in the same direction. The same factors emerged consistently as key to worker well-being, providing enough guidance for confident action.

Ultimately, what should we strive for? A week where visits start with a short, clear briefing; travel and task windows fit the workload; the HHA can prioritise tasks independently; information arrives promptly; heavy cases are identified and supported; and HHAs receive support and gratitude. Management should work to ensure these conditions are met in order to prevent negative health and well-being outcomes.

In summary, the well-being of workers and the quality of care are interconnected. The same structures that protect the HHA—time, information and support—also protect the person receiving care. In this sense, improvement is more about getting the everyday details right and having a follow-up system in place than about big reforms. If we want to sustain the HBC system, we must support the essential workforce that makes LTC provision possible. We must recognise HHAs as skilled professionals and organise their shifts around what helps them do their job well. If we are successful, visits will be conducted at a human pace, families will feel supported, and older people and those with disabilities will feel more at ease in their own homes.

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CHAPTER 6

# The Fragmentation of Care Workers' Status Hinders the Attractiveness of Jobs in the Sector in France

Isabelle Daugareilh, Guillaume Santoro, Haoussetou Traoré

## 1. Introduction

The care sector in France—and elsewhere—is in dire straits! The alarm bells rang during the lockdowns of 2020–2021. Promises of pay rises, praise for essential workers (ILO 2023) and frontline staff, showers of applause from balconies—all of this was forgotten in the aftermath of the pandemic. Since then, several ILO reports have called for investment in the care economy (ILO 2022), in both its structures and its services, so that this has an impact on working conditions, recruitment, the fight against occupational segregation and work-life balance. In 2023, the United Nations General Assembly proclaimed 29 October as the International Day of Care and Support.[1] The ageing population is contributing to an explosion in the need for care services in the coming years and will require the creation of a very substantial labour pool at global, national and regional levels. This is why public institutions are addressing the issue at each of these three levels, whether it be the ILO (ILO 2018), the EU[2] or

[1] United Nations General Assembly, Resolution, A/RES/77/317 (2023).

[2] Council Recommendation of 8 December 2022 on access to affordable and high-quality long-term care (2022/C 476/01); European Commission, Communication from the Commission

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their member states (El Khomri 2019; Daugareilh, Santoro and Traoré 2023a; 2023b; 2024). Social protection policies are at the heart of a care approach that promotes healthy ageing and the right of older people to long-term care. The ageing of the population resulting from increased life expectancy is a global and national phenomenon; it goes hand in hand with an increase in the number of people losing their independence due to age. According to the Libault report,

> the number of elderly people losing their independence (in the sense of being recipients of the Personalised Independence Allowance (APA)) is expected to rise from 1,265,000 in 2015 to 1,582,000 in 2030 and 2,235,000 in 2050. The increase would be around 20,000 people per year until 2030, but would accelerate significantly to nearly 40,000 people per year between 2030 and 2040, as the first baby boomers reach old age (Libault 2019, 10).

In France, the legislature intervened in 2021 to create the fifth branch of social security dedicated to autonomy (Coursier 2020).[3] And for the last time with the law of 8 April 2024 on measures to build a society of healthy ageing and autonomy. The strategy and political will of the public authorities is to keep people who are losing their independence at home for as long as possible, thus delaying as much as possible their entry into a residential care home for dependent elderly people (EHPAD) for economic reasons.

From a historical perspective, *care*[4] work is characterised by the following fundamental trends (Audard 2004, 211; Martin 2003; Laugier 2009, 160; Noël-Hureaux 2015, 7). Firstly, it was long confined to the domestic sphere and traditionally considered the duty and/or activity of housewives (Tronto 2019). Its recognition as work came late and unevenly, depending on the timing specific to each country, as a result of women's emancipation and their access to the labour market in the wake of wars, economic and demographic crises, and social movements (labour and feminist struggles). Secondly, it is an activity which, in line with the idea of charity and public/mutual aid, has been taken on by religious and/or secular hospitals whose legal status falls under either public or private law (associations). Thirdly, it is an activity that has more recently been the subject of public policies on the autonomy of people who are dependent due to their age or disability, which establish the principle of freedom of choice for individuals and place particular emphasis on home care for beneficiaries. Thus, the provision of care not only in institutions but also at home is the result of a combination of contemporary demographic (ageing population), sociological (desire for a wider choice of care), economic (for the State and local authorities) and political factors.

to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on the European Care Strategy, COM/2022/440 final.

3 Order no. 2021–1554 of 1 December 2021 on the implementation of the creation of the fifth branch of the general social security system relating to independence.

4 The Anglo-Saxon concept of care is difficult to translate into French.

In France, from a historical perspective, the State has played a major role in structuring the *care* sector through the creation of a social security system after the Second World War. For just over two decades, the State has been at the forefront of social policies on dependency, with the creation of the specific dependency benefit in 1997, followed by the personalised autonomy allowance (APA) in 2002 and the disability compensation benefit (PCH) in 2005. These policies, known as specific solvency measures for the elderly and disabled, have been developed at the expense of public funding for care, both directly by the state and indirectly by the departments. These social policies, which are under pressure, combined with tax policies over the last two decades that have been particularly advantageous for private employers and for-profit organisations, are contributing to crystallising and amplifying the historical fragmentation of actors in the *care* sector. Care work is now provided by four types of institutions—known as the "care diamond" (Razavi 2007, 21): the state, the private sector, the non-profit sector and families. This fragmentation is now marked by a fundamental trend towards the commodification of care, accompanied by a re-familiarisation of the burden, which increases social inequalities in terms of dependency and long-term care.

One of the objectives of this article will be to demonstrate how fragmentation is both a legacy of the history of the actors and sources of the legal framework governing *care* work in France, but also a contemporary political construct. This multifaceted fragmentation is controversial in that it appears to be an obstacle to resolving labour shortages and hindering the attractiveness of care professions. The state plays a major and highly ambiguous role in this regard due to its double game. On the one hand, it amplifies fragmentation through its social and fiscal policies by favouring the emergence of new actors over those that have historically existed, which leads to a fragmentation of the standards applicable to organisations and workers (1). At the same time, the state has undertaken general reforms of labour law applicable to all sectors of activity, which have led to a tightening of social actors on the employer and employee sides in the care sector, thereby reshaping the profile of fragmentation in the sector (2).

## 2. The Exacerbation of Fragmentation in the Sector Caused by Public Healthcare Policies

In France, the socio-historical non-profit model of care developed since the late 1940s has been in turmoil and under severe strain since the late 1990s; associations are now just one form of organisation among many others (Hély and Simonet 2023). They coexist with the state, which continues to provide some healthcare services but is gradually withdrawing by promoting the long-term establishment of for-profit organisations on the one hand, and on the other hand financially supporting home care, which is less expensive than institutional care, through the creation of the legal category of private employers. We are thus witnessing competition between care providers by the State (2.1), which will result in a diversification of contractual statuses (2.2).

### 2.1 Competition Between Care Providers Created by the State

Several factors contribute to the fragmentation of actors, both historical and contemporary. This results in a dual diversity of intersecting models: the historical home/institution model and the contemporary for-profit/non-profit model, whose coexistence is orchestrated and shaped by the state. While the distinction between institution and home is irreducible, the distinction between for-profit and non-profit stems from the state's contemporary desire to give free rein to laissez-faire care in institutions (2.1.1), while actively and legally working to diversify the modalities of home care (2.1.2).

#### 2.1.1 State-Imposed Competition Between Institutional Care Providers

Institutional care falls under three professional branches, the two oldest of which were created to meet the needs of specific beneficiaries (elderly people/people with disabilities) and are run by non-profit organisations (2.1.1.1), while the most recent is linked to the contemporary expansion of for-profit organisations (2.1.1.2).

##### 2.1.1.1 Care in non-profit institutions

Care in non-profit institutions has historically been structured around the characteristics of the most disadvantaged beneficiaries first, followed by people with disabilities.

Thus, the Federation of Non-Profit Private Hospitals (FEHAP) (Monteil 2023), created in 1936, has its origins in the tradition of religious works intended to assist the most disadvantaged in the 17th century. Private solidarity-based institutions are from the world of associations, foundations, mutual societies and social protection. Heirs to altruistic and human-scale actions, they respond to the needs of the people who are often at the origin of their creation and to societal needs that are not covered by the public sector and are not profitable for the private commercial sector. Relying on volunteers, these establishments are part of the social and solidarity economy. They are the ideal place for expressing humanist values and welcoming all citizens at all stages of life and for all pathologies. FEHAP is a member of the Confederation of Small and Medium-Sized Enterprises (CGPME). It is the employer organisation that signed the National Collective Agreement for Private Non-Profit Hospitals, Care, Treatment and Nursing Homes of 31 October 1951, which governs the professional sector (Collective Agreement 1951).

In the early 1960s, families of children with disabilities organised themselves to create care facilities that met their specific needs. The first employers' unions (SOP, SNASEA, UNAPEI and SNAPEI) were then created. Their aim was to negotiate a new collective agreement specific to the sector, but this attempt failed. In 1964, the first employers' federation was created: the Fédération des syndicats nationaux d'employeurs du secteur de l'enfance inadaptée (FSNESEI), which in June 2005 became the Fédération nationale des associations gestionnaires au service des personnes handicapées et des personnes fragiles (FEGAPEI). In 2010, the SOP and SNASEA merged to become SYNEAS, the union of employ-

ers in the social and medico-social sector. Until 2016, two employers' associations coexisted in this sector: FEGAPEI and SYNEAS. The national collective agreement for establishments and services for disabled and vulnerable persons of 15 March 1966 was revised on 15 September 1976.

Thus, in the non-profit model of institutional care, two professional branches coexist, each with its own national collective agreement (see below). This competition between non-profit organisations participating in the public hospital service was exacerbated by the rise of private for-profit hospitals from the 2000s onwards, encouraged by the political and economic disengagement of the State from public hospitals.

#### 2.1.1.2 For-Profit Private Hospitalisation

Public hospitals and private clinics coexisted during the 19th and 20th centuries and evolved in parallel to meet the needs of different clienteles and under different regulatory constraints (Bergoignan Esper and Dupont 2024, 166). From a legal standpoint, the hospital bills drafted between 1968 and 1970 were not very favourable to private hospitalisation, which was sometimes not even mentioned or reduced to a bare minimum. The hospital reform law of 31 December 1970 marked the beginning of a new era in the history of private hospitalisation, which was then recognised as part of the hospital system. As programmes progressed, measures hostile to private hospitalisation gradually faded away and were no longer called into question, as evidenced by the 1991 hospital law. In return, private hospitalisation was subject to the same controls as all other hospitals. In the early 2000s, the State implemented a process of dismantling the public hospital service, not openly and explicitly, but under the guise of modernising hospitals and improving their efficiency. The order of 17 June 2004 created the public/private partnership and helped to establish activity-based pricing accompanied by a principle of price convergence, aimed at remunerating public service activities and those of private clinics in the same way. In addition, since the 1980s, private for-profit healthcare institutions have undergone a process of concentration and financialisation for economic, financial, demographic and cultural reasons, with some now owned by pension funds.[5] This process has led to the expansion of a commercial model of healthcare guided by financial and profit-driven logic, sometimes associated with institutional forms of mistreatment of both workers and healthcare recipients (Castanet 2022).

Among the factors contributing to the growth of the for-profit hospital sector, the role of private hospital trade unions should also be mentioned. Several unions were created at the beginning of the 20th century,[6] which joined forces during the social crisis of 1936 to create the Fédération intersyndicale des maisons de santé

[5] IGS 2013; Bourgueil and Benamouzig 2013. See the investigation into the scandal involving the Ephads nursing homes that belonged to the Orpea group (renamed Emeis in 2024).

[6] National Union of Private Healthcare Facilities for Mental and Nervous Disorders, National Union of Medical Directors of Healthcare Facilities Open to Different Specialities, MCO Union, Parisian Union etc.

de France (Inter-union Federation of French Healthcare Facilities), the predecessor of the Fédération de l'hospitalisation privée (Private Hospital Federation). The first step towards bringing all clinics together was taken on 30 June 1936, with an agreement signed with the Fédération des syndicats professionnels des services hospitaliers et sociaux (Federation of Professional Unions for Hospital and Social Services). This group gradually grew to become the FIEHP. Following a split in 1970, the FIEHP and the UHP coexisted for 31 years. In 2001, the two unions merged to create the Private Hospital Federation (FHP), which today represents around 160,000 employees. A year later, the national collective agreement for private hospitals was signed on 18 April 2002.

In parallel with the 2004 ordinance that sealed the public/private partnership in hospitalisation, the State is preparing to intervene to bring about a restructuring of the home care landscape.

### 2.1.2 State-Imposed Competition Among Home Care Providers

Associations and families began organising themselves at the beginning of the 20th century to provide home care (2.1.2.1) and dominated this sector, which was opened up to competition by the Borloo Act of 2005 (2.1.2.2).

#### 2.1.2.1 Home Care, Historically the Preserve of Associations and Families

The historical non-profit model of home care originated in the aftermath of the First World War. In 1920, the first association, Aide aux Mères (Help for Mothers), was created in Paris to help mothers by providing "emergency mothers" with the aim of using everyday tasks as a basis for educational activities. In 1927, all the associations joined together to form a national federation, which in 1999 became the Fédération Nationale d'Aide et d'Intervention A Domicile (FNAID), confirming its expanded role in helping elderly and disabled people. At the end of the Second World War, the popular family movement and popular family assistance associations created the Fédération Nationale des Associations Populaires de l'Aide Familiale (FNAPAF), which from 1973 onwards devoted itself to developing services for disadvantaged elderly people. They formed associations that were the origin of the National Federation for Home Help for Retired People (FNADAR). The FNAPAF strengthened its commitment to families and was renamed the National Federation for Home Help (FNAFAD) in 1979. From then on, the two federations each worked for a different "audience" but shared the same priorities. In 2001, the FNADAR and the FNAFAD decided to create a federation called ADESSA. In 2005, it was the turn of the FNAID to merge with the home care network (UNACSS). This union gave rise to A DOMICILE Fédération nationale. On 1 January 2010, ADESSA and A DOMICILE formed the ADESSA A DOMICILE Federation.

In the aftermath of the Second World War, in 1945, the first associations to assist rural families were created to help families by offering young women in rural areas two new professions: family worker (TF) and rural family helper (AFR). In 1975, the AFR became the Aide à domicile en milieu rural (ADMR, or Rural

Home Help). They benefited from the creation of the profession of care assistant for the elderly or disabled in 1981 and the creation of representative associations for private employers in 1987. In 1992, the intermediation platform between assistants and home service providers created ADOMI-ADMR. The network is based on a unique network that anchors ADMR at the heart of each territory, both in rural and urban areas.

In 1954, the National Federation of Popular Family Assistance Associations (FNAAFP) was created to defend the rights of families, the elderly and people with disabilities and to structure home care services based on the values of solidarity and mutual aid. The FNAAFP also established strong links with the Confédération Syndicale des Familles (CSF) to assert its role in promoting social justice and the attractiveness of professions essential to solidarity and social cohesion.

Finally, in 1962, the Paris Union of Home Care and Services Associations (UPASSAD) was created. Then, in 1970, the National Union for Home Care, Services and Assistance (UNASSAD), bringing together personal service associations, was formed to develop the home care network. A non-profit association under the 1901 law, recognised as being of public utility, it is at once a militant social movement, a network and an employers' union whose aim is to promote a policy of home care by professionalising the sector.

This non-profit model of home care, which was boosted by the creation of a social security system after the Second World War, was initially put in competition with the private employer category (Hély, Simonet 2023), a legal category created from scratch by the State, which, like associations, does not pursue a profit-making objective.

Domestic employment by private individuals has long been characterised by a legal framework that is poorly differentiated and ill-suited to the situation. Over time, various measures have sought to structure it, both in terms of employee rights and tax benefits for private employers. At the turn of the 20th century, domestic work by "domestic servants" was an important sector.[7] In 1948, several associations of housekeepers came together to form the Federation of Domestic Employers (FEGM), whose mission was to coordinate groups of private employers and promote recognition of the specific characteristics of the "domestic servant" sector.[8] In 1963, the federation became the Federation of Domestic Staff Employers (FEPEM), replacing the term "domestic workers", which was considered pejorative by the relevant ministry.[9] In 2008, the FEPEM obtained the registration of the status of private employer in law, and in 2016, private employers were included in the Labour Code with the status of employer.

[7] It is estimated that around 1900, there were approximately 900,000 domestic workers. Domestic Employment Observatory.

[8] The evolution of the FEPEM reflects that of the sector: a shift from informal domestic work to the professionalisation of domestic employment between individuals.

[9] The FEPEM presents itself as the socio-professional organisation representing private employers, with around 3.4 million private employers in France and more than 1.2 million domestic workers.

Thus, since the 1990s, a "personal services" sector has emerged (Capuno 2017, 13–29) consisting of activities provided in the home by employees hired directly by private individuals. Numerous measures aimed at promoting direct employment by private individuals were then adopted, such as the 50% tax reduction on sums paid by private employers in 1991.[10] In order to promote home-based employment and combat undeclared work, the "service voucher" scheme was introduced on an experimental basis by the Act of 20 December 1993. In the name of freedom of choice for individual users, parliamentarians voted to extend the service voucher in the law of 29 January 1996 (Muller 1996, 403–15). This formula simplifies the employer's administrative obligations[11] to encourage individuals to hire an employee directly for their personal needs. In 2015, the government introduced a flat-rate deduction of 2 euros from employer contributions per hour worked; in 2017, it extended the tax credit to all employers. Every individual who employs a worker benefits from this tax measure, even if they do not pay taxes, including retired people. On 24 November 1999, the National Collective Agreement for Employees of Private Employers was concluded by the FEPEM.

The objective of structuring the service offering risked being undermined by the encouragement of private employment. Indeed, this method of employment offered significant financial advantages for private individuals, who benefited from greater exemptions than personal service associations. The appeal of employment by private individuals was also enhanced by the fact that the contractual status applicable to employees was less advantageous than that applicable to employees of home help associations. The differences in tax and social security contributions for identical services were not conducive to free choice on the part of private individuals, as they were tempted to choose the least expensive solution. After a sharp increase in direct employment in the sector as a whole, which accounted for 80% of paid working hours in 2001, this form of employment represents just over half (54%) in 2021. The same trends can be observed in the number of employers, which fell by 10% between 2012 and 2021 (Cour des Comptes 2021), while the share of the private for-profit sector has continued to grow since the 2005 "Borloo plan".[12]

#### 2.1.2.2 The Contemporary Introduction by the State of a Commercial Model for Home Care

The Borloo Act of 26 July 2005 opened up this sector to competition by granting private companies access to quality accreditation and operating licences that had previously been reserved for associations. It was within this framework that the FESP, Synerpa and Fedesap were created, signatories to the National Collective Agreement for Personal Services Companies of 20 September 2012.

[10] This process was extended to all private employers in 2017 by Article 82 of Law no. 2016–1917 of 29 December 2016 on finance for 2017.

[11] The service voucher exempts individuals from having to declare the employee by name to social security organisations and also replaces the need to provide a payslip.

[12] Law no. 2005–841 of 26 July 2005 on the development of personal services.

On 11 June 2001, Synerpa was created from the merger of three private sector unions for the elderly, thus becoming the first national union for private establishments and residences for the elderly. A member of the CGPME, Synerpa became involved in home care in 2015 and joined the collective agreement for personal services in 2017.

The Federation of Personal Services (FESP) is a non-profit association created in 2006 and affiliated with MEDEF. Its objective is to bring together all private actors in the personal services sector and to work towards improving service quality and professionalising the sector. It represents all stakeholders, service providers, agents, private employers and groups of self-employed workers. It includes the Union of SAP Companies (SESP), created in 1995, which, prior to the introduction of the Borloo Act, had set itself the task of representing, promoting and defending the interests of professionals regularly engaged in personal services. Since 2022, it has also welcomed the Union of Private Employers and Agent Companies (SPEEM).

In 2007, business leaders founded Fédésap, the leading federation for personal services and home help and support, which is a member of the CGPME.

Twenty years on, the threefold promise of the Borloo Act (mass creation of quality jobs; provision of care for dependent persons and promotion of individual well-being) has not been fulfilled. On the contrary, the law has reinforced the commodification of services and the subsidisation of demand in order to implement the slogan of free choice for consumers/beneficiaries, and has promoted private employment through the service employment cheque (CESU). According to experts, the state has organised

> the shift from social policy being handled by the social and solidarity economy sector to this social action being handled by for-profit companies and the consolidation of direct/private employment. [ … ]. We are gradually moving from a system of public transfers financed by taxes on private income to private transfers subsidised by the public sector (Devetter and Fl. Jany-Catrice 2010, 75).

While the care sector in France continues to be provided by private and public services and by market and non-market services, the public authorities have clearly given their preferential support to market services, creating an imbalance between fiscal and social policies, and even causing the latter to fall behind the former, thus creating difficulties for the non-profit sector of institutional and home care. This has a direct impact on the regulatory treatment of employment and working conditions issues.

### 2.2 The Diversification of the Legal and Contractual Status of Care Workers

The diversification of the status of care workers from a legal point of view depends on the legal status of the employer (2.2.1), while from a contractual point of view it results directly from the strategies of the social partners and indirectly from the State, which in France readily interferes in the field of collective/normative autonomy (2.2.2).

### 2.2.1 Diversification of Legal Statuses by Decision of the State

The diversification of legal statuses permeates the entire healthcare sector. With regard to institutional care, the law distinguishes between the private sector, which is governed by labour law, and the public sector, where workers are either civil servants or contract workers governed by civil service law. This is therefore the case for workers employed by a public health and social care institution (EPHAD for the elderly, for example). French civil service law underwent a major change with the order of 24 November 2021, which forms part of the General Civil Service Code.[13] This code applies to all civil servants with permanent status and all contract workers.[14] The 2021 reform unifies and updates the law applicable to public servants by establishing a common set of principles and rights for the entire civil service. It strengthens the framework for social dialogue and collective bargaining (Marc 2021, 133). Since 2021, civil service law and labour law have become increasingly similar. Some consider that labour law has been a direct source of inspiration for civil service law reforms, with some referring to the "labourisation" of the civil service.[15] However, this convergence, whether through attractiveness or mimicry, does not erase significant differences, including those relating to status, recruitment methods and job stability. All other *care* workers are covered by the Labour Code and collective agreements. However, the law distinguishes between employers who are legal entities or individuals pursuing a profit-making or non-profit-making objective and private employers.

In France, home care and support fall under two types of scenarios with their own legal regulations. If these activities are organised in the beneficiary's home by an institution, a commercial enterprise or a social and solidarity economy enterprise, and if they give rise to the conclusion of an employment contract, then all labour law applies. They are legally covered by the personal services regime defined by the Labour Code as follows:

> childcare; assistance to elderly people, disabled people or other people who need personal assistance at home or help with mobility in their local environment to enable them to continue living at home (Art. L. 7231–1 of the Labour Code).

However, if the activities are carried out by a worker at the beneficiary's home who is employed directly or indirectly by a private employer (Gauriau 2006)[16] pur-

[13] Since 1983, civil service law has comprised a "fronton" law of 13 July 1983 on the rights and obligations of civil servants and three "legislative pillars" on the state civil service (law of 11 January 1984), the local civil service (law of 26 January 1984) and the hospital civil service (Act of 9 January 1986). Together, these constituted the general status of civil servants in France.

[14] The Code is presented—like the Labour Code—in a thematic manner and is organised into eight books.

[15] Certain parts of the Labour Code are directly applicable in the civil service, such as the rules on health and safety at work.

[16] Associations that place workers with individuals and carry out administrative formalities and social security and tax declarations related to the employment of these workers on behalf of these individuals only act as agents under the law of 23 July 2010, as individuals are

suant to Article L. 7221–1 of the Labour Code, then they are considered domestic work and enjoy a legal status that largely derogates from common law from a legal and contractual point of view. In fact, only the legal provisions on moral and sexual harassment,1 May, paid leave, leave for family events, medical supervision[17] and safety obligations (Bagot 2021)[18] apply under Article L.7221–2 of the Labour Code. To this must be added, according to case law, the law on the minimum wage;[19] however, the rules on working hours (Radé 2004),[20] the calculation of severance pay,[21] dismissal on grounds of physical incapacity,[22] redundancy[23] and undeclared work[24] do not apply. The French legislator has thus chosen not to treat home care workers equally, based on the unique legal status of private employers who, according to Article L. 7221–1 of the Labour Code, are not profit-oriented and employ workers to meet their personal needs, particularly family needs, to the exclusion of those relating to their professional life. The French legislature thus maintains this form of care work in its historical context by linking it legally to domestic service and, in essence, to a gendered view of this activity, with all the consequences that this implies in terms of lack of qualifications, lack of recognition etc. Added to this is the fact that the same legislator has still not ratified ILO Convention 189 on domestic work. Thus, from a legal point of view, care workers employed by private individuals are kept in a state of sub-employment, which will gradually be tempered by the relevant national collective agreement.

While legal status is determined solely by the State, the status under collective agreements results both from the social partners' collective autonomy and from their interactions with the State, especially when the aim is to extend the collective agreement for the sector by ministerial decree, thereby giving it *erga omnes* effect for employees of all companies within its scope, whether or not they are members of the employers' organisation that signed the agreement.

### 2.2.2 Diversification of Collective Agreements Due to the Social Partners and the State

The fragmentation of collective bargaining standards in the public sector is currently potential (2.2.2.1), given that the order of 17 February 2021 did not come into force until 1 January 2023 (Marc 2021, 133). On the other hand, the fragmen-

the sole employers of the workers. Soc. 28 November 2000, Bull. civ. V, no. 371, *RJS*, 2/01, no. 261, p.171; Soc. 23 November 2005.

17 Soc. 28 September 2011, *Dalloz Actu*, 15 October 2011.

18 Civ. 2ème 8 April 2021, no. 20–11 935 P., *D.*, 2021, p. 702.

19 Soc. 31 March 1982, Bull. civ. V, no. 242.

20 Soc. 13 July 2004, no. 02–43 026 P.; Soc. 7 December 2017, no. 16–12809 P., *Dalloz Actu.*, 2017, 2541; Soc. 8 July 2020, no. 17–10 622 P, *Dalloz Actu*, 2020, 1466.

21 Soc. 20 June 2011, *Dalloz Actu*, p. 1909.

22 Soc. 10 July 2013, *Dalloz Actu*, p. 1906.

23 Soc. 21 January 2015, no. 13–17850, *Dalloz Actu*, 2015, p. 272.

24 Soc. 20 November 2013, *Dalloz Actu*, 9/12/2013.

tation of collective bargaining law in the private *care* sector affects care workers in institutions (2.2.2.2) and home care workers (2.2.2.3) differently for historical and contemporary reasons and is as much the result of social actors as it is of the State, and of the compromises that may or may not have been reached between them.

#### 2.2.2.1 The Potential Diversification Of Collective Agreement Statuses In The Public Care Sector Due To The State

The Order of 17 February 2021 on collective bargaining and agreements in the civil service contains three key elements. Firstly, the text establishes that negotiations on remuneration and purchasing power can only take place at national level between representative national trade unions and government representatives. The exclusivity of the national level is based on respect for the principle of equal treatment between public servants and undoubtedly responds to budgetary concerns. Secondly, collective bargaining on exhaustively listed topics[25] may take place at national or local level between trade unions representing civil servants and administrative and territorial authorities, bearing in mind that a "lower-level agreement can only clarify a national-level agreement or improve its general economy in accordance with the essential provisions".[26] Thirdly, the 2021 text stipulates that majority agreements concluded on the listed areas are legally binding. The collective labour agreement thus becomes an autonomous source of law in areas that do not fall within the statutory domain,[27] thereby acquiring binding force, a Copernican revolution in French civil service law. While the legal merger of the civil services[28] tends to erase their differences, these could reappear as a result of the negotiation of collective agreements. Thus, despite a unified legal framework, the 2021 reform favours potential fragmentation in terms of agreements. The public authorities are clearly playing an ambivalent role by promoting institutional simplification (merger, reduction in the number of actors, harmonisation of rules) on the one hand, while paving the way for conventional diversification on the other. This dialectic between unification and differentiation is one of the central issues of contemporary governance of labour in the civil service.

[25] These include working hours, teleworking, quality of life at work, commuting arrangements, the impact of digitalisation on the organisation and conditions of work, social support for service reorganisation measures, the implementation of actions to combat climate change, the preservation of resources and the environment, and the social responsibility of organisations, apprenticeships, collective profit-sharing and the implementation of compensation policies, changes in occupations and forward-looking management of jobs and skills, and supplementary social protection.

[26] The legislator is here reiterating a general principle that prevailed in labour law prior to the reforms of the last two decades.

[27] Working hours and working time arrangements are among these areas, even though the Council of State had ruled that they were statutory rules, CE 9 October 2002, nos. 238070 and 238138 Fédération des personnels des services des départements et des régions CGT-FO, Lebon.

[28] Namely the state, hospital and local civil service.

#### 2.2.2.2 The fragmentation of collective bargaining standards in the institutional care sector

In this sub-sector, there are three national collective agreements, two of which—the oldest—apply to non-profit organisations that originally targeted different audiences and specific professions.

The FEHAP (Federation of Private Healthcare Institutions) and the CFTC, CGC, CGT and FO trade unions signed the National Collective Agreement for Private Non-Profit Healthcare and Care on 31 October 1951, known as CCN 51. The FEHAP's aim was to ensure that staff enjoyed conditions equivalent to those of public sector employees, while maintaining the flexibility necessary to take into account the specific characteristics of the private non-profit sector (Cottin-Marx 2022, 121). This agreement was extended by decree on 27 February 1961.

At the same time, in the early 1960s, the sector for children with special needs saw an explosion of associations of institutions (UNIOPSS and UNARSEA), which led to the creation of two employers' unions: SOP and SNASEA, to which UNAPEI and SNAPEI were later added. These unions joined forces within the so-called "Place Saint Georges" Federation to defend the idea of a collective agreement specific to the sector for children with special needs against the State, which supported their integration into the aforementioned 1951 agreement. On the employee union side, the CGT and CFTC opposed this and defended integration into the CCN 51. The 1966 CCN was nevertheless signed by the employers' unions, the CFDT, FO and the national inter-professional union for children with special needs.[29] In "retaliation", the State put an end to the extension of the 1951 CCN and did not extend the 1966 CCN or any other national agreement concluded subsequently.[30] Of the 800,000 employees working in the non-profit health, social and medico-social sectors, more than 200,000 are not covered by a collective agreement, a situation that will continue until 2021 (Cottin-Marx 2013, 125–26).

In addition to these two historical branches of institutional care, there is a third, that of private hospitalisation, which has its origins in the interwar period two world wars but which developed from a process of concentration in the 1980s, followed by a convergence of the management rules for public and private healthcare establishments as a result of the law of 31 July 1991 on hospital reform, which established the concept of healthcare establishments. Until 2002, the private hospital sector was covered by several separate collective agreements, which presented difficulties in terms of application and uniform coverage.[31] It was thanks to the merger of

[29] The 1966 CCN is considered to be the text that sealed the professional maturation of the profession of specialised educator, which was awarded a state diploma in 1967 and a favourable contractual status in terms of career, working conditions and pay scale.

[30] The agreement for cancer centres (CLCC) signed in 1951, the working agreements for accommodation and social reintegration centres (CHRS) in 1974, for specialist doctors in 1979 and for the Red Cross in 1992.

[31] Five previous agreements included: convalescent clinics and care homes for the elderly; private hospitalisation (UHP) with the Agreement on Private Health and Social Care Establishments of 22 January 1992; private for-profit hospitalisation (FIEHP) with the

employers' organisations completed in 2001 with the creation of the FHP that the national collective agreement for private hospital care was concluded on 18 April 2002 and extended in 2003.

Like care in institutions, home care will also be covered by three extended national collective agreements.

#### 2.2.2.3 Fragmentation of collective agreement standards in the home care sub-sector

Today, three professional branches structure the collective agreement law for personal services (Lefebvre 2013, 99).

One of these branches, home help, is the result of a merger of three non-extended national agreements concluded in the 1970s and 1980s,[32] reflecting the development of home help professions and changes in public *care* policies. The four employers' federations (UNA, Fnaafp-Csf, UN-ADMR and the Adédom federation) signed a series of agreements during the 1990s, culminating in the signing of the unified collective agreement in 2010, which was extended in 2011 to all employees in the home care sector. In the 2000s, the four employer federations joined forces to form a trade union for the sector, USB-Domicile. However, each of them continues to stand in professional elections while defending a common position vis-à-vis the public authorities and trade unions. A second professional sector, that of employees of private employers, emerged from the gradual recognition of domestic workers as salaried employees. An initial national collective agreement for domestic workers, signed by the Federation of Private Employers of France (FEPEM) in 1980, was revised in 1999, giving rise to the collective agreement for employees of private employers in 2021.

The two sectors mentioned above differ in three key ways: domestic workers are not healthcare professionals like those working in the home care sector; despite their status as employees, they do not enjoy the full protection of the Labour Code; and their employers are private individuals rather than legal entities committed to the values of the social economy. The result is a collective agreement for the sector that falls far short of that for home care, if only because it is not based on the minimum foundation provided by the Labour Code. Whether on the employer or employee side, these very different characteristics are enough to rule out any possibility of unification or rapprochement between the two sectors. This situation crystallised with the introduction by the State of the universal service employment

National Collective Agreement, Private For-Profit Hospitalisation Establishments, 4 February 1983; medical-social establishments for children/adolescents with the National Collective Agreement for Medical Establishments for Children and Adolescents of 12 June 1975, revised on 12 March 1982 and approved on 2 July 1982; private follow-up and rehabilitation establishments with the National Collective Agreement for Private Follow-up and Rehabilitation Establishments (non-medical staff) SNESERP of 14 October 1970.

[32] These were the collective agreement for family workers' organisations of 2 March 1970, the collective agreement for home helpers in rural areas (ADMR) of 6 May 1970 and the agreement for home help and home care organisations of 11 May 1983.

cheque and with the tax deduction and advance payment for private employers declaring their employees, and was further blurred by the development of agency services from 1987 onwards.

The third branch of private personal services companies originated from an idea put forward by French employers—the CNPF, now Medef—to create a new sector and support the creation in 1995 of the union of personal services companies (SESP). The State did the rest with the law of 29 January 1996, opening up this field to private for-profit companies, and above all with the Borloo law of 2005, which triggered the opening of negotiations for a specific collective agreement between two employers' organisations—the FESP, affiliated to Medef, and the Fedesap, a member of the CGPME—which led to the conclusion and extension of the national collective agreement of 20 September 2012. The interaction between the State and the employers' organisations was key to the successful creation of this sector from *scratch*, wich is not unique to this sector (Dressen and Mias 2008, 7). "Competition between service providers in the same 'market' for personal services will exacerbate the challenges in terms of regulating competition" (Dressen and Mias 2008, 108; Naville and Nyssens 2002), which has resulted in disputes between employers' organisations over the scope of the sectors (Lefebvre 2013, 99) and the coexistence to date of three different contractual statuses for strictly identical activities.

The result of these overall developments is that in the private care sector in France, while the criterion of the private home as the place of work is decisive, it is also influenced by the status of the employer, the employment model and the values defended (social/commercial logic) promoted by employers' organisations and workers' unions, which have created sectoral cultures that are very different, if not opposed, to one another. As an accomplice and/or initiator of the fragmentation of actors and standards in the care sector, the State will undertake labour law reforms which, without going so far as to eliminate this fragmentation, will contribute to its deconstruction.

## 3. The Deconstruction of Fragmentation in the Care Sector Brought About by Labour Law Reforms

The structure of the care sector, in terms of its stakeholders and standards, resulting from public social and fiscal policies relating to the care of people who have lost their independence, will be affected by labour law reforms that pursue the exact opposite objective: simplifying the collective bargaining landscape. Thus, reforms to collective bargaining law and training law will impact the sectors (3.1), while the law on the representativeness of professional organisations will have an effect on the position occupied by each of the social partners (3.2).

### 3.1 The Impact of Reforms to Collective Bargaining and Vocational Training Law on Branches in the *Care* Sector

Since the 2000s, several reports (de Virville 2004; Poisson 2009; Combrexelle 2015) have called for the consolidation of professional branches. With the laws of

8 August 2016 on labour, the modernisation of social dialogue and the securing of career paths, and the Macron ordinances of 22 September 2017, the State has given itself the means to compel social actors to reorganise by blowing hot and cold (between spontaneous initiative by the partners and dictated initiative) in order to merge the branches by reconfiguring their respective scope (3.1.1), which it has done in the care sector (3.1.2).

### 3.1.1 The Merger of Conventional Branches Under State Control

In 2016, the public authorities launched a vast programme to restructure the branches (Porta 2018),[33] the legal framework for which stems from the law of 8 August 2016 on labour, the modernisation of social dialogue and securing career paths. The 2016 legislation set a target of 200 active professional branches, compared with nearly 700 in 2015. The aim was to rationalise a long-fragmented collective bargaining landscape in which large, structuring agreements coexisted with a multitude of small, inactive branches. The aim of this merger was to strengthen the social partners' ability to negotiate effectively and to pool the resources for social dialogue. The order of 22 December 2017 is part of a public policy to rationalise the French collective bargaining landscape, with the aim of making social dialogue more transparent, coherent and effective. France was faced with excessive fragmentation of its professional sectors, a consequence of the historical stratification of collective agreements by profession or sub-sector, which is undoubtedly the case in the *care* sector. This fragmentation leads to inequalities in treatment between employees, a loss of regulatory consistency and weak collective bargaining, particularly in small, unrepresentative sectors.

The legislator wished to leave the initiative to the social partners in the sectors to achieve this objective, but provided, as a supplementary measure, for an administrative merger mechanism (Caillaud 2022, 492). Thus, in order to steer the process, Article L. 2261–32 of the Labour Code empowers the Minister of Labour, in view of the general interest attached to the restructuring of professional sectors, to merge by decree the scope of one sector with that of another sector with similar social and economic conditions (Coco et al 2017, 3; Frouin 2017, 9; Champeaux 2017, 2; Vachet 2018, 899). The sectors whose scope of application is likely to be attached to that of another sector (known as the "attached sector") are those that meet one of the following six criteria: low number of employees (fewer than 5,000 employees), low level of collective bargaining activity (in terms of the number of collective agreements signed and the topics covered in negotiations), regional or local geographical scope, lack of legitimacy of the professional employers' organisations participating in negotiations (less

[33] Techniques for restructuring sectors include mergers, broadening the scope of application, refusal of extension by the Minister of Labour, refusal to draw up a list of representative employer and trade union organisations, which prevents the social partners from negotiating and concluding a sectoral agreement aimed at establishing a collective bargaining scope that combines that of several existing agreements. Article L. 2261–32 of the Labour Code.

than 5% of member companies in the sector), the absence of a permanent joint committee for negotiation and interpretation, and finally the sector's inability to fulfil its responsibilities in the area of vocational training.

This power of the administration to order the merger of several collective bargaining areas[34] was at the heart of a priority constitutionality issue raised by trade unions and referred by the Council of State to the Constitutional Council. In its decision of 29 November 2019, the Constitutional Council[35] considered that the reform of the restructuring of the sectors pursued an objective of general interest and could therefore justify the use of administrative merger. However, the possibility initially provided for in Article L. 2261–32 of merging the scope of application by decree in order to strengthen consistency was censured, as the Constitutional Council considered that the wording of these provisions was not sufficiently precise (Thomas 2020; Gomes 2020; Bergeron-Canut 2020).

However, in the context of a merger by decree, the minister does not decide unilaterally on the choice of the branch to which the sector will be attached. First, the initiative is left to the social partners of the sector concerned. Secondly, the merger proposal put forward by the administration is subject to extensive consultation with the social partners at national inter-professional level, who meet within the sub-committee on the restructuring of professional branches (SCRBP), which is part of the National Commission for Collective Bargaining, Employment and Vocational Training (CNNCEFP). SCRBP members may oppose the merger proposal and submit a counter-proposal for affiliation. If the administration nevertheless wishes to maintain its initial choice of affiliation sector, it must reconvene the subcommittee. The procedure begins with the publication in the Official Journal of a merger notice inviting any interested person or organisation to submit their comments on the proposed merger within 15 days, which allows organisations that are not members of any of the CNNCEFP member organisations to submit their comments in advance so that they can be taken into account. To date, the administrative merger procedure has only been used by the Minister to restructure branches that meet one of the first three criteria and in the absence of a voluntary merger project by collective agreement. The *care* sector has experienced both types of merger: spontaneous and administered.

### 3.1.2 Branch Mergers in the Care Sector

Well before the 2016–2017 reform of collective bargaining law, the State intervened in the *care* sector to encourage the social partners, and particularly the employers' organisations, to join forces and merge into a single branch. The

[34] The challenge concerned the conformity of Articles L. 2261–32, L. 2261–33 and L. 2261–34 of the Labour Code relating to the restructuring of sectors.

[35] Bergeron-Canut 2020; Bugada 2019; Champeaux 2019; Dutheillet de Lamothe 2019. Constitutional Council, Decision no. 2019–816 QPC of 29 November 2019; *D.*, 2019, p. 2306.

public authorities were particularly active in the creation of a private non-profit health, social and medico-social sector (BASS), setting up a joint committee in 1966 to harmonise the sector's collective agreements and conventions. Their action consisted of finalising texts on subjects common to CCNs 51, 66 and 79 (trade union rights, staff representatives, works councils etc.) that did not affect working conditions *in the strict sense*. The sector is considered to have been created in 1993 when several organisations came together to form the Union of National Federations and Trade Unions of Employers in the Private Non-Profit Health, Social and Medico-Social Sector (UNIFED). The social partners then created, by agreement of 11 March 1996, the Joint Commission for the Professional Sector, on which UNIFED sits. Created on the initiative of five employers' organisations in the private non-profit health, medico-social and social sector, Unifed (Unir et fédérer) in its capacity as an employers' federation, affirms the identity of the sector, negotiates sectoral agreements, and acts as a liaison with public authorities and SSE stakeholders. The approved and extended agreements cover vocational training, the latest of which is addendum no. 5 of 7 December 2017, trade union rights (agreement of 23 April 2015), part-time work (agreement of 22/11/2013, extended on 19/04/2014), the organisation and reduction of working time (agreement of 01/04/1999 and its amendments), night work (agreement of 17/04/2002 and its amendment), on on-call duty (agreement of 22/04/2005), on retirement (agreement of 28/04/2004). Agreements, one of which concerned health at work, were opposed by a majority of employee unions at the time of their signing and are therefore considered null and void. In reality, the impetus for the creation of UNIFED was the reform of vocational training law by the Act of 20 December 1993, which transformed the FAFs into OPCAs (approved joint collection agencies). A common sectoral strategy was developed around training, but it remained confined to this single issue. UNIFED is governed by the principle of subsidiarity, with each member organisation retaining its independence, so that regulation of the sector has remained limited, or even without effect on salaries, careers, hiring conditions and technologies.

Following the reforms of 2016 and 2017, several spontaneous mergers of professional branches have already affected the *care* sector. Under an agreement dated 14 March 2019, the scope of the national collective agreement for thermal spas was merged with that of the national collective agreement for private commercial hospitals dated 18 April 2002, designated as the relevant sector.[36] The scope of the national collective agreement for accommodation and social rehabilitation centres has also been merged with that of the national collective labour agreement for establishments and services for disabled and handicapped persons of 15 March 1966, designated as the relevant sector (ministerial decree of 5 August 2021).

For home-based workers employed by private individuals, the merger involved two coexisting collective agreements: the national collective agree-

[36] Decree of 28 July 2020 extending the agreement of 14 March 2019 on the alignment of the collective agreement for thermal spas and the collective agreement for private hospitals.

ment for employees of private individuals of 24 November 1999, extended by ministerial decree on 2 March 2000, and the national collective agreement for childminders employed by private individuals of 1 July 2004, extended by ministerial decree of 17 December 2004. The process of restructuring the private employer sector began with a method agreement concluded on 21 November 2018 to formalise the principle of a merger between the private employer employee branch and the private employer childcare assistant branch. Under the terms of a second agreement on methodology signed on 16 December 2019, the social partners defined the issues to be negotiated and set out the organisation of the negotiation process with a view to concluding, in the first quarter of 2021, a collective agreement organised around a common base and two specific bases specific to each of the two branches. The new branch is called the "private employers and domestic employment sector" and presided over the conclusion of a single collective agreement for private employers and domestic employment on 26 March 2021, which was extended on 6 October 2022 (Nadal 2022).

On the other hand, the collective agreement for accommodation and social reintegration centres (CHRS agreements) was merged in a directive manner. A decree published in the Official Journal of 5 August 2021 provides for its attachment to the national collective agreement of 15 March 1966. The 2020 Ramain report on the restructuring of sectors directly aimed at creating a single agreement for the non-profit healthcare sector, bringing together the current sectors of non-profit hospitals, medical-social establishments, CHRS and cancer centres, which employ more than 800,000 people (Ramain 2020).

The public hospital sector, represented by the Fédération Hospitalière de France (FHF), illustrates another aspect of this modernisation of collective bargaining law. Created under the 1901 law on associations, the FHF, which resulted from the merger of five regional unions (Fédération Hospitalière de France 2015), represents public hospital and medical-social employers, while actively participating in public debate. While each establishment remains legally autonomous, the FHF plays a central role in unifying and representing them. The public hospital service, which has more than 5,000 establishments and 100,000 professionals, is facing challenges related to the ageing, precariousness and feminisation of its workforce. Collective bargaining, conducted at national level by the Ministries of Health and the Civil Service, has evolved since the Ségur healthcare agreement in 2020 to include more issues such as careers, remuneration and work organisation. Trade unions, notably the CFDT and CGT, play a key role in this process. The CFDT Santé-Sociaux, which represents employees in the public and private sectors, deplores the limited scope for collective bargaining in the hospital civil service, where local agreements often remain non-binding. CGT Santé et Action Sociale, for its part, criticises the increasing precariousness of healthcare professions and the weakening of hospital status, particularly since the law of 6 August 2019. It also denounces the deterioration of working conditions following mergers of professions and the loss of professional recognition.

Thus, the restructuring of the collective bargaining landscape, supported by the public authorities, is not limited to administrative rationalisation. It is part of a profound reorganisation of social dialogue in the healthcare sector, where the balance between organisational efficiency, trade union representativeness and recognition of professions remains a central issue for the future of the healthcare system. From this perspective, they constitute a lever for modernising the collective bargaining system, making it possible to group together related fields of activity, ensure better coverage for employees and avoid regulatory competition between agreements.

Ultimately, this consolidation process, although underway, remains incomplete. Indeed, certain emblematic mergers, such as the one envisaged between the collective agreement of 15 March 1966 for establishments and services for disabled and handicapped persons (not extended) and the collective agreement of 31 October 1951 for private non-profit hospitals, care, treatment and nursing homes (not extended) (*Lapagedesprofessionnelles.fr* 2025) are still pending. Their outcome, which is particularly eagerly awaited in the medico-social field, would constitute a decisive step towards a more coherent and equitable restructuring of the collective agreement system in the health and social action sector. Another labour law reform could contribute to this, namely that of the right of representation of professional organisations.

### 3.2 The Impact of Reforms to the Law on the Representativeness of Professional Organisations on Healthcare Providers

The law of 20 August 2008 reformed the rules governing the representativeness of trade unions. To be considered representative, a trade union must meet a set of cumulative criteria (respect for republican values, independence etc.), including sufficient support in professional elections. Support is measured by aggregating the scores recorded by trade unions during 1) professional elections organised in companies with more than 11 employees; 2) votes organised in very small companies and among home-based employees; 3) elections to departmental chambers of agriculture for agricultural production employees. To be recognised as representative (at national, inter-professional and branch level), a trade union organisation must obtain at least 8% of the votes cast. Since the 2008 law, there have been five election cycles for employee trade unions (2009, 2013, 2017, 2021, 2025), which have changed the landscape not only for employee trade unions but also for employer federations (3.2.1). The latter have also embarked on a new process of rapprochement and even merger to strengthen their position in institutional relations with a view to advancing the idea of a single agreement, at least for care in institutions (3.2.2).

#### 3.2.1 The Effects of Trade Union Representativeness Law on the Reconfiguration of the Players in the *Care* Sector

Care sector stakeholders are seeing their status as social partners evolve in line with professional elections.

Table 1 – The decrees issued after the professional elections in each sector.

| Title of the agreement | Legal status of the agreement | Employee union | Employer organisations |
|---|---|---|---|
| PE agreement (private employers) | Scope in (no approval required) | Decree of 13 December 2021, *Official Journal* of 26 December 2021<br>- CGT: 25.40%<br>- UNSA: 20.62%<br>- CGT-FO: 15.83%<br>- SPAMAF: 15.76%<br>- CFDT: 12.58%<br>- CSAFAM: 9.81% | Decree of 23 January 2022, *Official Journal* of 13 February 2022<br>- FEPEM: 100% |
| | | Decree of 27 November 2025, *Official Journal* of 26 December 2025<br>- CGT: 28.18%<br>- UNSA: 22.05%<br>- SPAMAF: 22.02%<br>- CGT-FO: 15.43%<br>- CFDT: 12.32% | Decree of 8 July 2025, *Official Journal* of 9 July 2025:<br>- FEPEM: 51.39%<br>- SPE: 48.61% |
| AfDB Agreement – 2010 (associations) | Approved in 2011 and extended in 2012 (approval required for extension) | Decree of 6 October 2021, *Official Journal* of 23 October 2021<br>- CFDT: 44.78%<br>- CGT: 39.49%<br>- CGT-FO: 15.73% | Decree of 6 October 2021, *Official Journal* of 23 October 2021<br>- USB-Domicile: 100% |
| | | Decree of 24 June 2025, *Official Journal* of 8 August 2025<br>- CFDT: 46.04%<br>- CGT: 38.39%<br>- CGT-FO: 15.57% | Decree of 24 June 2025, *Official Journal* of 7 August 2025<br>- USB-Domicile: 100% |
| 2012 SAP agreement (personal services companies) | Extended in 2014 (no approval required) | Decree of 6 October 2021, *Official Journal* of 13 November 2021<br>- CFDT: 39.66%<br>- CFTC: 26.75%<br>- CGT: 19.26%<br>- CGT-FO: 14.33% | Decree of 13 November 2021, *Official Journal* of 19 December 2021<br>- SESP: 44.2%<br>- Fédésap: 37.38%<br>- SYNERPA: 10.47%<br>- FFEC: 7.95% |
| | | Decree of 30 October 2025, *Official Journal* of 8 November 2025<br>- CFDT: 32.29%<br>- CFTC: 28.00%<br>- CGT: 12.16%<br>- CGT-FO: 9.11% | Decree of 23 December 2025, *Official Journal* of 26 December 2025<br>- SESP: 41.14%<br>- Fédésap: 40.97%<br>- SYNERPA: 9.68%<br>- FFEC: 8.21% |

Table 2 – Healthcare providers in private institutions.

| Title of the agreement | Legal status | Employee union | Employer organisations |
|---|---|---|---|
| Private commercial hospitalisation agreement | Extended in 2003 | Decree of 6 October 2021, *Official Journal* of 21 October 2021<br>- CFDT: 39.20%<br>- CGT: 34.35%<br>- CGT-FO: 15.26%<br>- UNSA: 11.20% | Decree of 6 October 2021, *Official Journal* of 20 October 2021<br>- FHP: 58.92%<br>- SYNERPA: 41.08% |
| | | Decree of 6 November 2025, *Official Journal* of 27 November 2025<br>- CFDT: 35.57%<br>- CGT: 35.76%<br>- CGT-FO: 14.93%<br>- - UNSA: 10.74% | Decree of 30 October 2025, *Official Journal* of 8 November 2025<br>- FHP: 60.16%<br>- SYNERPA: 39.84% |
| 1966 Agreement on Institutions for Disabled and Handicapped Persons | Updated in 1966, not extended | Decree of 6 October 2021, *Official Journal* of 21 October 2021<br>- CGT: 36.47%<br>- CFDT: 35.94%<br>- SOLIDAIRES: 15.30%<br>- CGT-FO: 12.30% | Decree of 6 October 2021, *Official Journal* of 21 October 2021<br>- AXESS: 100% |
| | | Decree of 23 December 2025, *Official Journal* of 3 January 2026<br>- CGT: 37.01%<br>- CFDT: 35.03%<br>- SOLIDAIRES: 15.85%<br>- CGT-FO: 12.11% | Decree of 27 November 2025, *Official Journal* of 3 January 2026<br>- AXESS: 100% |
| 1951 Agreement on private non-profit hospitals, care facilities, treatment centres and nursing homes | Not extended | Decree of 6 October 2021, *Official Journal* of 24 October 2021<br>- CFDT: 36.50%<br>- CGT: 33.15%<br>- CGT-FO: 16.28%<br>- CFTC: 9.58%<br>- CFE-CGC: 4.49% | Decree of 6 October 2021, *Official Journal* of 23 October 2021<br>- AXESS: 100% |
| | | Decree of 23 December 2025, *Official Journal* of 3 January 2026<br>- CFDT: 36.89%<br>- CGT: 32.81%<br>- CGT-FO: 16.48%<br>- CFTC: 9.16%<br>- CFE-CGC: 4.66% | Decree of 27 November 2025, *Official Journal* of 19 December 2025<br>- AXESS: 100% |

The above table allows us to make the following observations:

- On the employer side, only one sector has put an end to fragmentation, namely home care with USBSoins à domicile, which is part of the social and solidarity economy.
- The private employer branch has three employer organisations, two of which have been representative since the last elections in 2025, putting an end to the supremacy of the FEPEM.
- The personal services sector comprises four employer organisations affiliated with Medef and CGPME. FESP, which was the leading representative organisation following the 2021 elections, fell to second place in the last elections in 2025 behind FEDESAP, which is affiliated with CGPME and was founded in 2007 by business leaders. It is the leading federation for personal services and home help and support in terms of number of companies, bringing together more than 4,300 organisations that support more than 850,000 individuals or families each year thanks to its 170,000 employees. In the last professional elections, it became the leading representative employers' organisation with a score of 53.5%, giving it a legal right of veto over the conclusion of a sectoral agreement. In the last professional elections, Synerpa remained the third largest employers' organisation in the sector.
- On the employee side, the CFDT has a large majority in home care and personal services, reflecting its position as the leading trade union at national and inter-professional level. However, the CGT and UNSA have a majority in the private employer sector. FO is in third place in all three sectors.

As things stand, the negotiation of a single agreement is still provoking the ire of the CGT, FO and Sud unions, while the CFDT is in favour. The CFDT became the leading representative union between 2017 and 2020 with a 26.77% share, while the CGT obtained 22.96%, FO 15.24%, the CGC 11.92% and the CFTC 9.5%. In 2021, the CFDT remains in first place and has improved its score to 38.53%, closely followed by the CGT with 35.17%, FO with 14.67% and Solidaires with 11.63%. Negotiations on the single agreement are also stalling because the government is not meeting employers' expectations in terms of its financial contribution. It is clear that one of the main reasons for this merger movement is the need to establish a balance of power within the union in the face of a state that is competing with the commercial sector and which, for budgetary reasons, is undoubtedly less able today than yesterday to finance healthcare. This is why we have seen major merger manoeuvres among non-profit organisations in the health and medico-social sector.

### 3.2.2 Major Manoeuvres by Non-Profit Organisations

The proposed merger of the various national collective agreements for the non-profit health, social and medico-social sector (BASS) is a long-standing issue that has divided employer and employee organisations for several decades. However, employer organisations facing economic and social difficulties have

evolved significantly on this issue. A major movement to unify employers' organisations in the non-profit residential care sector was launched 10 years ago in the disability sector. Following a general meeting of the FEGAPEI (national federation of associations managing services for disabled and vulnerable people) and SYNEAS on 25 June 2015, the principle of a merger was adopted to create a new professional employers' organisation, Nexem, which was launched in 2017. Nexem represents more than 11,000 establishments and services employing more than 350,000 professionals in five fields of activity: disability, child protection, independence for the elderly, legal protection for adults and the fight against exclusion. Nexem aims to promote the associative model as an efficient response to supporting the most vulnerable, in the service of an inclusive society. The values it espouses are those of its founders: the values of the Republic, respect for democracy, secularism, fundamental rights and equality for all before the law, principles of social cohesion and living together. These values, which are enshrined in the statutes of the professional organisation, are also those of the social and solidarity economy (SSE). Nexem defends the right to be different, the participation of individuals in all fundamental rights and the exercise of full citizenship, and the development of people's ability to act for themselves. Nexem is a member of the CGPME.

This movement towards intra-sector unification, which led to the creation of Nexem, was followed by a confederation movement with the private non-profit hospital sector, which included only one employers' federation, Fehap. In order to respond to the major challenges facing the sector, Axess-Employeurs Santé Social was created by Fehap (CCN 1951) and Nexem (CCN 1966). The Axess confederation has two aspirations. The first is to make the sector strong, identifiable, recognised by the public authorities and open to all players in the private non-profit sector. Secondly, it aims to negotiate a single collective agreement that can be extended in order to meet the needs of attracting and retaining professionals, facilitating and developing career paths within the sector, and strengthening the influence of non-profit sector players within the OPCO Santé (Daugareilh, Traoré 2026). Thirdly, the aim is to work on the sector's identity in relation to other SSE partners and those in the public and for-profit health, social and medico-social sectors. Axess as a whole represents 779,000 employees, 16,997 establishments and 3,766,000 people cared for. If these negotiations are successful, there will only be two national collective agreements, one for non-profit organisations and the other for commercial organisations (FHP and Synerpa). Conversely, in the more recent for-profit healthcare sector, division and restructuring are still the order of the day, with competition in full swing, as evidenced by the results of the professional elections for the calculation of representativeness.

In conclusion, across all sectors, the State plays a truly ambiguous role in structuring the care sector in terms of its actors and standards. It causes divisions by supporting its opening up to for-profit organisations, thereby putting non-profit organisations under severe competitive pressure, while at the same time seeking to erase historical divisions by forcing them to unite, willingly or unwillingly. The state plays this double game by relying on regulatory instru-

ments relating to social and fiscal policies. It is also the state that is driving profound political changes in healthcare while at the same time disengaging from it. This phase of deinstitutionalisation goes hand in hand with a strategy of commodification and individualisation of care that directly disrupts the non-profit care sector in terms of both its values and its resources, and whose restructuring has no other purpose than to create a balance of power that is more favourable to them vis-à-vis the public authorities and their competitors in the market for care for dependent persons.

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CHAPTER 7

# Vocational Training: an Imperfect Lever for Securing and Enhancing The Career Paths of Healthcare Workers in France

Isabelle Daugareilh, Haoussetou Traoré

## 1. Introduction

Vocational training for care workers is a necessary step in the professionalisation of these activities, which have long been considered naturally suited to women who, because of their gender, are believed to possess the qualities required to perform these activities, giving rise to systemic discrimination (Tronto 2009; Brugère 2019; Daugareilh, Santoro, and Traoré 2023). The demographics of care workers still largely reflect this today. Globally, women perform more than three-quarters of unpaid care work, to which they devote an average of 4 hours and 25 minutes per day, compared to 1 hour and 23 minutes for men (ILO 2024). This weighs heavily on these women's access to decent work and productive employment. In addition, two-thirds of paid care workers are women employed part-time so that they can provide care in their own homes (ILO 2024). "Occupational segregation" (ILO 2024) is a reality in this sector. "Domestic workers earn half the average monthly wage of other employees […] and nurses and midwives in 49 countries are paid less than the average for highly skilled workers" (ILO 2024). How can we combat the persistence of such gender inequalities in households and in the labour market? How can we guarantee decent work for care workers? (ILO 2022; 2023).

The initial training required to practise care professions is one factor that explains gender inequalities. In France, of the three professions selected for

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the CARE4CARE Project—nurse, nursing assistant and care assistant—only the first two require a national diploma to practise. These two professions are, moreover, closely linked from their origins, as shown in the brief history below.

The first nursing school was established in Paris in 1878. In 1922, a decree introduced a professional qualification certificate. Nurses were then responsible for both care and hygiene. In 1946, a law required them to hold the state diploma created in 1942. For those who continued to provide care but did not have the national diploma, another status was created, that of nursing assistant, which was recognised as a grade in vocational training in 1949. Providing hygiene care, the training of nursing assistants became essential and was introduced in several stages. A diploma course was set up in 1956, leading to a certificate of aptitude for nursing assistant duties (CAFAS). In 1960, the CAFAS became compulsory for practising as a nursing assistant; it allowed the holder to provide general hygiene care, but not medical care. In 1978, nursing assistants were authorised to practise in psychiatry and psychiatric services. In 1981, they were authorised to work in home care services for the elderly. In 1986, the CAFAS was replaced by the professional nursing assistant diploma (DPAS). Care was then included in the prerogatives of nursing assistants (oral care, bedsores etc.). In 2007, the state nursing assistant diploma was created, making it a profession regulated by the Public Health Code and integrated into the field of medical auxiliaries. In 2021, their role evolved towards greater collaboration with nurses, which resulted in an overhaul of their training and a revision of their professional classification, moving them from grade C to grade B in the hospital civil service from 1st January 2022. This was a demand made by the CFDT trade union since 2014 and is now one of the achievements of the Ségur healthcare agreement in the wake of the COVID-19 pandemic.

Unlike the two professions mentioned above, it is not mandatory to have a degree to work in personal care services. However, certain activities require qualifications, particularly those involving assistance to "vulnerable" groups (elderly and disabled people, children under three years of age), such as care workers/home care workers. In France, these two professions are distinct. Care assistants support elderly or disabled people in essential everyday tasks, including personal hygiene and mobility, for which there is a state-recognised qualification in educational and social support.[1] A home care worker is a professional who provides daily support to people who have lost their independence, helping them to carry out everyday tasks in their own homes. No qualification is required, as home helps focus on everyday tasks such as housework and shopping. However, in theory, they must have a Level V qualification (CAP, BEP, Baccalauréat Pro etc.). To work as a home care worker, it is advisable to hold a DEAES (State Diploma in Educational and Social Support[2]).

[1] Since 2016, this diploma has replaced the social care assistant diploma. It is a level 3 diploma that takes approximately 10 months to complete (in initial training or continuing education).

[2] To enrol on the DEAES course, you must hold a diploma in the health and social care sector at CAP level or above.

Training is undoubtedly not the only way to positively influence the attractiveness of care professions. Action on the multiple risks in terms of health and safety at work,[3] a reduction in daily and weekly working hours and in the length of time required to contribute to the lifetime pension scheme, as well as a reassessment of remuneration in comparison with salaries paid in male-dominated sectors of activity, are undoubtedly equally necessary levers. However, vocational training is the tool that allows direct and structural action to be taken on job classification, pay and career progression, and indirectly on systemic discrimination.

In 2022, the European Commission presented the European Care Strategy and recommended that Member States take measures to improve the working conditions of care workers by promoting collective bargaining and social dialogue, ensuring safe and healthy work environments, designing training systems that encourage lifelong learning for care workers, and ratifying and implementing ILO Convention 189 on domestic workers of 2011 (European Commission 2022).[4]

No country is immune to the structural problems in this sector, which include: labour shortages and understaffing, difficulties in recruiting and retaining workers; excessive working hours and workloads; the physical and emotional burden of care work; shortcomings in occupational health and safety; exposure to violence, harassment and discrimination on the grounds of gender and origin etc. However, the WHO estimates that there will be a shortage of 18 million healthcare professionals by 2030, mainly in low- and middle-income countries (Who 2016; ILO 2024).

Vocational training, understood as training that follows initial training and accompanies adults "throughout their lives" (Daugareilh, Santoro, and Traoré 2025), is now an essential pillar of skills management in the healthcare sector in France, which is marked by the aforementioned structural tensions (labour shortages, professional burnout, changing health and societal needs) (Daugareilh, Santoro, and Traoré 2025). It appears to be a strategic response to the difficulties encountered, both in terms of securing career paths and promoting employees[5] and improving the quality of service provided to users.

This article aims to analyse the following question: How can training become a strategic tool for enhancing the attractiveness and professionalisation of the care sector, while meeting immediate needs for skills and retention? The aim will be to highlight a twofold movement: on the one hand, the gradual universalisation of the right to training,[6] supported by legal provisions applicable to care workers; on the other hand, the central role of the social partners, through joint management and sectoral agreement strategies implemented by skills operators (OPCO) in the care sectors. We will first examine the legal framework

[3] Biological, chemical, physical, ergonomic and psychosocial risks.

[4] To date, France has still not ratified ILO Convention 189.

[5] Article L.6111-1 of the Labour Code.

[6] Law of 5 September 2018 on the freedom to choose one's professional future.

underpinning the right to training and its limitations in the care sector, which looks like a "mille-feuilles" (2), before looking at the levers and innovations that could transform training into a genuine strategic tool for professionalisation, retention and attraction (El Khomri 2019) (3).

## 2. Vocational Training, a Multi-Layered Structure for Healthcare Workers

Since the first law of 1971 enshrining the right to vocational training for workers, French legislators have continued to refine the law on vocational training by diversifying the sources, methods and pathways of continuing training (2.1). Nevertheless, healthcare workers—like many others—find it difficult to take advantage of the pathways offered by the legislator (2.2).

### 2.1 The Diversity of Legal Pathways to Continuing Education (Maggi-Germain 2004)

Continuing vocational training aims to enable all individuals, throughout their working lives, to acquire, maintain or develop their skills in order to advance professionally and secure their career path. It is based on mechanisms created and regulated by law to guarantee an effective right to training for all individuals in employment. These mechanisms are aimed at employees, job seekers, self-employed workers and civil servants through individual training rights in the form of training accounts (Gautié, Maggi-Germain, and Perez 2015). However, this system is based on a dual structure that distinguishes between the private sector (2.1.1) and the public sector (2.1.2).

#### 2.1.1 Legal Training Provision in the Private Sector

This legal provision is either a legal obligation for all employers or an initiative that employees are entitled to take.

Employers have a general obligation to maintain the employability of their employees. To this end, they must implement a skills development plan. This is a major avenue for access to training, enabling companies to fulfil their obligation to adapt employees to their jobs and support technological, digital and organisational change. In addition, under the law of 24 October 2025,[7] employers must offer a career development interview[8] every four years, separate from performance reviews, to examine the skills used in the job, how they have evolved in light of changes in the company, the employee's situation and career path, training needs, and the employee's wishes for career development or retraining. This interview must be offered systematically at certain times of resumption of work (maternity leave, pa-

[7] Law no. 2025-989 of 24 October 2025 transposing national interprofessional agreements in favour of the employment of experienced employees and relating to the development of social dialogue.

[8] An initial interview must be organised within one year of hiring by the company.

rental leave, adoption leave, sabbatical leave, long-term sick leave, trade union mandate etc.).[9] Every eight years, a review is carried out to check that the interviews have been conducted regularly and that the employee has benefited from at least one training course, certification or salary or career advancement.[10] The interview must also be organised within two months of the mid-career medical examination in order to discuss the prevention of occupational burnout and the adaptation of the position. Finally, during the first interview two years before the employee's 60th birthday, the prospects for continuing in employment and end-of-career arrangements are discussed.[11] The career path interview is considered a structuring tool for forward-looking management of jobs and skills (GPEC) and a mechanism for making employers accountable for training. The scheme is part of a broader drive to secure career transitions and build skills jointly between employers and employees. This interview can also be seen as a preventive measure in the face of changes in employment and a tool for building professional mobility (Berthier 2024).

Employees have a personal activity account (Lafargue 2016; Maggi-Germain 2016) which combines their personal training account,[12] professional prevention account and civic engagement account. The aim is to give everyone the opportunity to build their career path independently, while ensuring that their rights are portable, regardless of changes in employment or status. The personal training account is the main component. It allows each worker to acquire rights in euros that can be used to finance training leading to a qualification or certification. When used outside working hours, employees can use their personal training account without the prior consent of their employer, thus increasing their freedom of action. This individual right reflects a new philosophy of employee empowerment and autonomy, with employees taking control of their own professional development. Other legal measures complement this framework. One such measure is the professional transition project, which offers employees the opportunity to undertake long-term training with a view to retraining (Negroni and Mazade 2019), while benefiting from funding. This measure is an important lever for professional mobility and secure retraining, enabling everyone to evolve or change careers under favourable conditions.

The legislator has provided for measures to promote the development of skills falling within the scope of vocational training law. These measures include skills assessments and career guidance.[13] Skills assessments[14] enable workers to analyse their professional and personal skills, as well as their aptitudes and motivations, in order to develop a career plan and, where appropriate, a training plan. It can

[9] Article L. 6315-1, I, paras. 6 to 6323-13 of the Labour Code.

[10] In companies with at least fifty employees, a corrective contribution to the Personal Training Account is due if these obligations have not been fulfilled.

[11] Article L. 6315-1, V of the Labour Code.

[12] Article L. 6111-1 of the Labour Code.

[13] Article L. 6313-1 of the Labour Code.

[14] Article L. 6313-4 of the Labour Code.

only be carried out with the employee's consent, and refusal to participate does not constitute misconduct or grounds for dismissal. In addition, there are counselling and guidance services to support employees in their training, such as career development counselling (Luttringer 2013; Maggi-Germain 2013; Dole 2014), a free support service provided by public guidance services. which is designed to help individuals define a coherent plan and mobilise the appropriate resources (Luttringer 2018; 2014; David 1976) in order to improve their qualifications. Given all these training opportunities, the challenge for the coming years will be to strengthen the support provided to beneficiaries, to better supervise the training on offer and to consolidate confidence in this individual right, which has become a pillar of employability and career security policies (Maggi-Germain 2013).

### 2.1.2 Legal Training Provision in the Public Sector

Vocational training is a key element in the careers of civil servants (Ferreira 2025). Recognised as a lifelong right by the General Civil Service Code,[15] it promotes their development, mobility, promotion and adaptation to changes in their professions. It also contributes to equal access to grades and jobs, particularly between women and men, and supports the progression of the least qualified civil servants.[16] Every public servant, whether in the state, local or hospital civil service, acquires training rights expressed in hours,[17] up to a limit of 150 hours and 400 hours for unqualified Category C public servants (Fort 2023). Since an order dated 26 May 2021, the latter are guaranteed priority access to training and personalised support (Fort 2023). Thus, the administration cannot oppose a request to use the personal training account to take a training course that falls within the predefined knowledge and skills base .[18] Where applicable, entry into this training course may be deferred until the year following the request.[19] Another priority situation concerns the prevention of physical incapacity. When the professional development project aims to anticipate a situation of medically certified physical incapacity, the rights of the employees concerned may be supplemented by additional hours, up to a limit of 150 hours in general cases or 400 hours for category C employees, in order to facilitate access to training.[20] Finally, requests to use the personal training account for the validation of professional experience or preparation for civil service competitions and professional examinations are also considered a priority.

[15] Articles L. 421-1 to L. 424-1 of the General Civil Service Code.

[16] Article L. 421-1 of the General Civil Service Code.

[17] And not in euros as in the private sector. These rights can be used to take training courses eligible for the personal training account (CPF) and designed to promote professional advancement, mobility, retraining or preparation for a competitive examination. Training courses are given priority during working hours, subject to service requirements.

[18] Article L. 6121-2 of the Labour Code.

[19] Article L. 422-12 of the General Civil Service Code.

[20] This is also the case for employees in the private sector.

In the hospital civil service, the decree of 21 August 2008 on professional training defines a comprehensive framework guaranteeing the continuous adaptation of skills, professional development and mobility of employees throughout their careers.[21] Overall, lifelong professional training in the hospital civil service is based on a balance between the initiatives of the institution and those of the employee. The administration defines a training plan that meets collective needs, while employees can exercise their individual rights.

The training plan (known as the skills development plan) drawn up each year by the institution is designed to meet the collective needs of the department, the requirements for adapting to changes in the profession and the career development prospects of employees. This plan covers initial training, skills maintenance or development activities, preparation for internal examinations or competitions and, where applicable, retraining measures. The plan is one of the pillars of the institutional training policy, enabling the needs of the department to be aligned with the career paths of staff members.

With regard to individual rights, since the introduction of the Personal Training Account (CPF) applicable to the civil service,[22] hospital staff can use their hours to finance training courses aimed at obtaining diplomas or professional qualifications, or to prepare for a retraining or mobility project. The personal training account can be used: 1) in combination with professional training leave, 2) in addition to leave for the validation of prior learning and skills assessment, 3) to prepare for administrative examinations and competitions, where applicable in combination with the time savings account.[23] The use of the personal training account is subject to agreement between the public servant and their administration. The roll-out of the CPF also includes a significant digital component. Professional development periods are another measure. They enable employees to alternate between training and professional activity in order to strengthen their skills, develop professionally or consider a career change. These periods are a lever for improving employability and ensuring the versatility of staff within the hospital civil service.[24] In addition, the 2008 decree provides that employees may take selected professional training leave, known as training leave or professional training leave (CFP), when they wish to pursue studies or training not offered directly by their employer. This leave allows employees to pursue a personal or professional training project, possibly with a view to retraining or further training.[25] Vocational training leave is an individual initiative within the

[21] Decree no. 2008-824 of 21 August 2008 on lifelong professional training in the hospital civil service.

[22] Law no. 2016-1088 of 8 August 2016, followed by Order no. 2017-53 of 19 January 2017 on various provisions relating to personal activity accounts, training and health and safety at work in the civil service, paved the way for the transposition of the Personal Training Account (CPF) into the hospital civil service.

[23] Article L. 422-10 of the General Civil Service Code.

[24] Article 8 of Decree no. of 21 August 2008.

[25] Article 9 of Decree no. 2008-824 of 21 August 2008.

framework of lifelong vocational training. In the same vein, professional transition leave, available to certain employees, allows them to undertake long-term training as part of a career change, with a view to pursuing a new career in the public or private sector.[26] This formalised scheme makes it possible to radically change one's career path, while respecting the needs of the institution.

Finally, it is important to highlight access to the very specific hospital service scheme known as *Études promotionnelles*, which enables hospital service employees to obtain a diploma or certificate in the health, social or medico-social sector. These fall within the general framework of the right to training.[27] The diplomas available through this scheme are set by ministerial order, in accordance with the aforementioned decree of 21 August 2008. The training courses include, in particular, state diplomas in nursing assistance, nursing or educational and social support.[28] The scheme is open to permanent, contract or trainee staff employed by public health, social and medico-social institutions. During the training, the employee remains in active service.[29] They continue to be paid by their institution and receive their full salary, allowances, bonuses and other supplements that do not constitute reimbursement of expenses. Remaining in active service means that they retain their rights to promotion, retirement and leave. In return, employees automatically sign up to a commitment to the institution that has funded their training[30] for a period equivalent to three times the duration of the training, up to a maximum of five years.[31]

Despite the wealth of legal training opportunities available, healthcare workers find it very difficult to take advantage of these tools.

### 2.2 The Difficulties of Healthcare Workers in Appropriating Professional Training Methods

Although the right to continuing vocational training has undergone constant evolution since the 1970s (Caillaud and Luttringer 2021)[32] towards individualisation of rights and democratisation of access, its implementation remains

[26] Article 10 of Decree no. 2008-824 of 21 August 2008.

[27] Articles L. 421-3 to L. 422-8 of the General Civil Service Code.

[28] Order of 23 November 2009 establishing the list of diplomas and certificates in the health and social sector acquired at the end of promotional studies by employees of the establishments listed in Article 2 of the Law of 9 January 1986 laying down statutory provisions relating to the hospital civil service.

[29] Article 6 of Decree no. 2008-824 of 21 August 2008.

[30] Article L. 423-15 of the General Civil Service Code.

[31] Article 9 of Decree no. 2008-824 of 21 August 2008 on lifelong professional training in the hospital civil service. In the event of early termination, the employee may be required to reimburse the costs incurred. In the event of a change of institution, a training buy-back mechanism may be set up between institutions, which is not possible if the training was financed by the pooled funds of the Association for the Training of Hospital Staff (ANFH).

[32] Law no. 71-575 of 16 July 1971 on the organisation of continuing vocational training within the framework of lifelong learning, known as the Delors Law.

uneven. Although numerous and ambitious, the measures in place are still struggling to be fully utilised by workers and businesses. This difficulty stems from the complexity of the legal mechanisms, a lack of training culture in certain professional circles, and insufficient institutional support (Daugareilh 2025).[33] Two emblematic schemes illustrate these tensions in the care sector: the validation of prior learning (2.2.1) and the personal training account (2.2.2). Both are means of accessing professional qualifications, based, in the words of Jean-Marie Luttringer (2019), "on the legally guaranteed individual initiative of". Their study highlights the structural and cultural obstacles that hinder the spread of a true culture of lifelong learning.

### 2.2.1 Validation of Acquired Experience (VAE), a Promising but Underused System

Validation of acquired experience (VAE),[34] established by the law of 17 January 2002, is a system that allows skills acquired outside the school system (Maggi-Germain 2002) through professional, associative or voluntary activity to be officially recognised. It offers the possibility of obtaining all or part of a certification listed in the National Directory of Professional Certifications (RNCP), or of accessing a certification training course[35] without any prior diploma requirements (Cibois 2023). Designed as a tool for social advancement, VAE facilitates the professional mobility of people with few or no qualifications, values real experience and helps to reduce inequalities in career paths. It also acts as a lever for employment policy by supporting professional transitions and responding to the needs of sectors under pressure.

However, the process of validating prior learning has a personal and symbolic dimension that can deter some candidates. Having to "prove" the value of one's experience before a jury (Caillaud 2004)[36] can be experienced as an ordeal, a source of stress and uncertainty, especially for workers without qualifications who may have failed at school, as is often the case for some of the least qualified care workers. Furthermore, the validation of prior learning is often perceived as a mechanism reserved for certain sectors or specific groups. A recent report reviewed the experiment in the elderly care sector and noted that the low take-up and success rates can be explained by the complexity of the system (Khecha, Soubien, and Rivoire 2020). Information campaigns, considered too general or too technical, do not reach the employees who are furthest removed from training: manual workers, low-skilled employees, precarious or part-time workers. As a result, the scheme is suffering from a decline in popularity and is experiencing a downward trend "over the decade, from 67,000 applicants who

[33] This is the case for platform workers. for example.
[34] Article L. 6111-1 para. 3 of the Labour Code.
[35] Article L. 6313-7 of the Labour Code.
[36] Article L. 6412-3 of the Labour Code.

submitted an application in 2018 to 42,000 in 2020, its lowest level since 2004" (ibid. Khechan Soubien and Rivoire 2020).

In light of these findings, the public authorities have made several attempts to reform and simplify the system.[37] The Labour Market Act of 21 December 2022 (Khecha, Souben, and Rivoire 2020; Caillaud 2023)[38] marked an important step in simplifying and opening up VAE, with the creation of a dedicated public service and the removal of certain conditions (year of experience, possibility of validating a single block of skills, doubling of VAE leave)[39] financed by the Transitions Pro associations (Crouzatier-Durand 2003; Conseil d'État 2019; Marchand-Arvier and Deumier 2014; Daugareilh 2023).[40] The 2022 legislation introduced the[41] trial of "reverse VAE",[42] allowing skills to be acquired and validated directly in the workplace. The reverse VAE experiment thus offers a training programme carried out directly in the workplace, leading to professional certification. It combines the acquisition of skills through employment and training with their assessment through the validation of prior learning. For the implementation of this experiment, the law provides that exemptions may be made from Articles L. 6314-1, L. 6325-1, L. 6325-2, L. 6325-11, L. 6325-13 and L. 6332-14 of the Labour Code.[43] In other words, the rules relating to eligible qualifications, contract beneficiaries, the organisation of work-study programmes, the minimum duration of training, the duration of professional development ac-

[37] Law no. 2016-1088 of 8 August 2016 on labour, the modernisation of social dialogue and securing career paths, reducing in particular the length of experience required to enter the process from three years to one year.

[38] Law no. 2022-1598 of 21 December 2022 on emergency measures relating to the functioning of the labour market with a view to full employment, Articles L. 6411-1 and L. 6411-2 of the Labour Code. This public service for VAE was preceded by the creation of a state start-up as part of the "Beta.gouv.fr" scheme, whose mission was to pave the way for the future Public Digital Service for the Recognition of Experience and Validation of Acquired Skills (SPN REVA).

[39] Article L. 6422-3 of the Labour Code.

[40] Association Transitions Pro is the name given to the regional inter-professional joint committees (CPIR) created by the law of 5 September 2018 and governed by the decree of 28 December 2018 on the organisation and functioning of regional inter-professional joint committees and the conditions for opening and remunerating professional transition projects. These are joint structures approved by the State, with legal personality and managed by the social partners, which are committed to skills development, professional transition and, more generally, employment in the regions.

[41] Experimentation falls within the framework defined by Article 37-1 of the French Constitution, which authorises Parliament to adopt provisions derogating from the principle of equality before the law on a specific subject and for a limited period. The use of experimental laws is now fully integrated into French positive law. It is used to support public policies that promote innovation based on evaluation. For further information on the legal basis for this right to experiment.

[42] Law no. 2022-1598 of 21 December 2022 and Decree of 26 May 2023 and Order of 26 June 2023 governing the three-year trial of reverse accreditation of prior learning.

[43] Article 11 of Law no. 2022-1598 of 21 December 2022.

tivities and the financing arrangements for professional development contracts may be adjusted within the framework of this experimental use. The objective of this reform is clear. It is to enable people who already have experience but do not hold a qualification or diploma to gain access more quickly to a recognised professional certification, particularly in sectors under pressure. The professional training contract then becomes a tool for direct access to qualification, without the obligation to go through a long traditional work-study programme if experience already allows for the assessment of skills. The aim is to accelerate integration, retraining or upskilling by adapting the law to the needs of the labour market. This experiment is still being evaluated, and the results will determine whether it is renewed or rolled out more widely.

However, some experiments are controversial. The accelerated pathway for nursing assistants to obtain a nursing diploma, reduced from three years to three months, has been criticised for its lack of harmonisation and the risk of undermining candidates, illustrating a misuse of VAE in the service of a rapid response to labour shortages.[44] Indeed, although the decree of 3 July 2023[45] and the instruction of 2 August 2023[46] established a specific pathway allowing nursing assistants with five years' experience to enter directly into the second year of nursing school, the practice sometimes deviates from the initial objectives. Some training courses, condensed into three months instead of three years, place candidates in difficulty due to insufficient reinforcement of theoretical knowledge. These "*low-cost* diplomas", to use the terms of the social partners, risk undermining professionals rather than enhancing their value.

In general, democratising VAE remains a challenge: its success undoubtedly depends on personalised support, greater recognition by employers and seamless integration with training programmes (Cibois 2023; Caillaud 2019; Luttringer 2022). To this must undoubtedly be added the unparalleled motivation created by belonging to a working community driven by a collective and shared professional development project. These are the drivers mobilised by member companies of the Synerpa employers' union, which decided to experiment with "collective VAE" by setting up exchanges between workers involved in the project, writing workshops, preparation for the jury and coordination by the company's management, which helped to reduce dropouts and secure the pathways.[47] The value of this collective approach also lies in the enhanced support provided by the professionals involved in the experiment. VAE is no longer an individual challenge but a collective project. This experiment highlights the weaknesses and criticisms that can be levelled at the so-called individualisa-

[44] Report on the training days organised as part of the CARE4CARE Project.

[45] Order of 3 July 2023 amending the order of 31 July 2009 on the state nursing diploma, Official Journal of 5 July 2023.

[46] Instruction no. DGOS/RH1/2023/129 of 2 August 2023 on the establishment of a specific pathway for nursing assistants to enter the second year of nursing training.

[47] See interview with Nicolas Hurtiger, President of Synerpa Domicile, conducted by us in December 2024.

tion and empowerment training policy, whose intrinsically neoliberal nature is absolutely detrimental to the least qualified, most precarious and most isolated workers, such as many care workers (Daugareilh 2025).

The limitations of the VAE system are also those that undermine the other individual training system, the personal training account, whose access, funding and use are also subject to criticism.

### 2.2.2 The Personal Training Account, a Tool for Autonomy That is Still Poorly Understood

The personal training account (CPF), created in 2014 and reformed in 2018, aims to give everyone the power to influence their career path through a universal, individual and portable right (Luttringer and Soldini 2018). Now funded in euros and accessible via the "Mon Compte Formation" app, it was intended to simplify access to training and increase the autonomy of the working population. However, awareness of the scheme remains limited: many people are unaware of the conditions of use,[48] eligible training courses or co-financing options, creating a gap between the ambition for autonomy and its actual implementation.[49] The lack of systematic support exacerbates these difficulties, particularly for the least qualified members of the public. Recent data confirm this fragility: in 2023, enrolment in training via the CPF fell by nearly 28% (Balini and Bismut 2023), and approximately 11% of training courses started were abandoned midway through compared to 2022 (Balini and Bismut 2023). Furthermore, short and inexpensive training courses are the most popular, limiting the effect of real professional advancement (France Compétences 2023). In addition, the opening of the market to numerous private operators (France Compétences 2023)[50] has led to commercial abuses (fraud, aggressive marketing (Caisse des dépôts et Consignations 2022), requiring tighter regulation (Caisse des dépôts et Consignations 2022).[51] Financing is also an obstacle: accumulated rights are often insufficient to cover qualifying training courses, forcing workers to seek other sources of funding and/or self-financing, which is incompatible for low-income workers or the working poor, which includes many care workers.

In sectors under severe strain, such as home help, medico-social care and nursing, employers are reluctant to release employees for training due to a lack of replacements and the need to maintain continuity of service. Even when employees exercise an individual right such as the CPF, it is often impossible to

[48] Articles L.6323-1 to L.6323-3 of the Labour Code.

[49] Article L.6323-4 of the Labour Code.

[50] Law no. 2018-771 of 5 September 2018 on freedom to choose one's professional future. This opening up was achieved through the launch in November 2019 of the Mon Compte Formation website.

[51] Law no. 2022-1587 of 19 December 2022 aimed at combating fraud involving personal training accounts and prohibiting the solicitation of account holders. Training organisations are placed under the control of the Caisse des Dépôts et Consignations.

organise time off work. Service requirements are a powerful and very real obstacle to the effective exercise of this individual right. The challenge is to reconcile operational constraints with career paths in order to restore the primary purpose of the CPF, which is to enable everyone to gain qualifications and advance professionally.

In the public sector, conditions for accessing training may be more favourable. Public servants are entitled to professional training leave (CFP) under the General Civil Service Code,[52] as well as VAE leave.[53] In principle, they can be replaced, even for long periods of absence, which makes access to training more realistic in public administrations and institutions. However, this structural difference cannot be transposed to the private sector, where the systematic replacement of absent employees is neither legally required nor economically viable in many cases. Nevertheless, reports highlight the reality of the use, and even misuse, of vocational training, which particularly affects the "lower" civil service (Ferreira 2025; Chevalier 2019; Crozier 1955; Jourdan 1995).[54] Various surveys show that the number of training days remains very low across the civil service as a whole: in 2022, category C employees received an average of 2.2 days of training, of which only 0.2 days were devoted to preparing for examinations and competitive examinations, while category B employees received 3.8 days and category A employees 2.1 days (DGAFP 2024, 141–42).

A double difficulty generally hinders effective access to continuing education programmes for workers in the public and private sectors. First and foremost is the lack of support, which is a major obstacle. Whether it is a VAE (validation of acquired experience) process or the use of the CPF (personal training account), individuals rarely have someone to talk to who can first motivate them, then guide them, and finally assess the relevance of their project and help them identify the appropriate funding. The complexity of the system, marked by the multiplicity of actors (France Compétences, OPCO, Transitions Pro, Regions etc.) and a set of standards that has become labyrinthine, hinders the clarity of the offer and particularly penalises small structures, where the absence of structured training and human resources departments makes the dissemination and appropriation of the schemes more difficult and leaves the most disadvantaged workers to face the harshness of individualisation and accountability, principles governing the right to vocational training in France at the beginning of the 21st century. Secondly, there are technical and legal obstacles that limit access to foreign employees who hold a receipt for a residence permit renewal application and/or a residence permit that is less than five years old.[55] The digital

[52] Articles L.422-1 et seq. of the General Civil Service Code.

[53] Articles L.423-4 of the General Civil Service Code.

[54] Without constituting a strictly legal concept, the term covers subordinate agents, sometimes described as "low-level civil servants" or even "rank-and-file" employees who find themselves in the shadow of senior civil servants:

[55] Article L. 431-3 of CESEDA.

identification process required to access the CPF requires foreigners to present a valid residence permit valid for at least five years (Caisse des dépôts et Consignations 2023),[56] excluding permits with a shorter duration as well as receipts that are nevertheless recognised as proof of legal residence by the Code on the Entry and Residence of Foreigners and the Right of Asylum. This situation calls for two comments. On the one hand, this condition creates an inconsistency/contradiction between the unanimously shared observation of a structural labour shortage and a lack of attractiveness of care professions, and the virtues of vocational training as the ideal means of social and professional integration and advancement. On the other hand, it results in an un e barrier to accessing acquired rights, affecting people who are legally resident but technically unable to activate their CPF, even though these people represent up to 30% of the workforce in certain care professions. This situation appears to be an obstacle to the French legislature's 2016 and 2018 plan to universalise the right to vocational training (Luttringer and Soldini 2018), as expressly stated in Article L.6111-1, paragraphs 1 to 4, of the Labour Code, which applies to "any person". Consequently, this situation appears to be contrary to the principle of non-discrimination on the basis of origin enshrined in Articles L.1132-1 and L.6111-1 para. 1 to 4 of the Labour Code, Article 10 of Parts I and II of the Social Charter, Article 14 of the ECHR and Article 1 of Additional Protocol no. 1 to the ECHR. This situation could justify referral to the Defender of Rights.

These cumulative barriers to accessing vocational training reinforce each other, meaning that the main challenge under current legislation is not to add new measures, but to make the system simpler, more transparent and, above all, better integrated into human resources management practices, with a stronger role for the social partners.

### 3. Vocational Training, a Strategic Tool in the Hands of the Social Partners

Vocational training law in France has historically been associated with joint management (Debruyne 2018) in terms of the management of funding collection bodies and legal obligations for collective bargaining at the level of professional branches. The coexistence of legal and contractual provision therefore does not reflect competition but complementarity. Legal provisions can be supplemented by initiatives from social partners in the sector, skills operators (OPCO)[57] or

[56] This title is required by France connect+ and La Poste and appears in the list of identification documents presented by the Caisse des dépôts et consignations.

[57] Created by the law of 5 September 2018 to replace the former approved joint collection agencies (OPCA), skills operators (OPCO) are structures administered jointly by the social partners. They play a central role in implementing training policies and managing training funding within professional sectors. Their mission is to provide technical and financial support to companies, particularly small and medium-sized enterprises and micro-enterprises, which often have limited resources to manage training. OPCOs operate at several levels: they help define skills needs, assist companies in developing their skills development plans,

employers to finance longer or more expensive training courses (Seiler 2014). The law entrusts social partners with defining the priorities, objectives and means of vocational training, establishing an obligation to engage in collective bargaining every four years at sector level.[58] Collective agreements make it possible to adapt national schemes to the economic and social realities of sectors and companies, specifying the terms and conditions for access to training, funding priorities or and the conditions for using the personal training account. These agreements reflect a desire to strengthen the momentum for skills development, taking into account the specific needs of each sector. In the care and support sector, which is particularly exposed to demographic, technological and organisational changes, several professional sectors have concluded ambitious agreements to support the upskilling of employees and respond to new challenges in the workplace. Differences in the nature, qualifications and conditions of access to jobs, career paths and work organisation, depending on whether care is provided in the beneficiary's home (2.1) or in an institution (2.2), have an impact on the needs and provision of conventional training.

### 3.1 Training Provision in the Home Care Sectors

Home care is linked to three conventional sectors. Home help, support, care and services fall under the institutional remit of the OPCO Cohésion sociale-Uniformation (3.1.1); personal care is linked to the OPCO Entreprises de proximité, as is private employer care (3.1.2).

#### 3.1.1 Training Provision in the Non-Profit Home Care Sector

In the OPCO Cohésion sociale, run by Uniformation,[59] out of 217,609 employees, 37% underwent training in 2021, resulting in 119,506 funded training courses, nearly half of which were part of professional development programmes.[60] There are between 1,200 and 1,300 employees in apprenticeships, an equivalent number on professional training contracts, and a significant volume of validations of acquired experience (VAE; see La Branche – aide à domicile n.d.). This dynamic illustrates the sector's significant investment in training, even if there is still room for improvement.

However, the social partners in the sector highlight the under-use of personal training accounts, with an access rate of just 9%, representing around

finance training initiatives, and support professional certification and qualification through schemes such as the CPF, Pro-A and work-study programmes. They also play a coordinating role in observing occupations and anticipating sectoral developments, in particular through the national joint committees for employment and vocational training (CPNEFP).

58 Article L.2241-1 of the Labour Code.

59 This OPCO covers a wide range of activities including the social and solidarity economy, entertainment, sport, social housing and, above all, home care and services.

60 Figures presented on the website of La Branche – aide à domicile n.d.

536 workers (see La Branche – aide à domicile n.d.). Aware of this issue, in 2021 they adopted a national sectoral agreement on vocational training that sets out an ambitious strategy based on three priority areas. The first aims to develop continuing vocational training designed to strengthen employees' operational skills and promote their career development (Delay and Duclos 2016). The second focuses on certification training, which enables employees to obtain diplomas or qualifications recognised within the sector (Caillaud 2021; 2022),[61] thereby helping to secure their career paths. The third concerns training related to quality of life and working conditions (QVCT), with a view to preventing psychosocial risks and improving well-being at work. This agreement was amended in 2024,[62] setting the following priorities[63] for 2024, 2025 and 2026: obtaining qualifications for low-skilled or unskilled job categories, implementing career paths to facilitate employee retention, apprenticeship contracts, professionalisation contracts, training to prevent and address occupational risks, particularly those related to arduousness and psychosocial risks, in order to improve quality of life and working conditions (QVCT). To address structural recruitment and retention challenges, the sector has also introduced innovative measures, including on-the-job training (AFEST), which embeds training in employees' daily activities while supporting new entrants through tailored integration pathways. This model promotes practical and progressive learning, while strengthening the transfer of know-how within teams through professional mentoring.

The guidelines set for 2025 focus on the major transformations ahead in the sector: the shift towards home care, which aims to strengthen home care for elderly and dependent people, changes in work organisations, the modernisation of management practices and the rise of digital technology. To support this dynamic, the social partners have decided to increase the financial contribution to vocational training to 2.04% of gross payroll, well above the legal requirement of 1.1%. This measure reflects a desire to increase the resources allocated to training and to support the development of work-study programmes, particularly apprenticeships. It also aims to promote skills development, internal mobility and secure career transitions in a sector facing significant employment pressure. Through this strategy, the home care and services sector is seeking to reconcile two major objectives: ensuring a high level of professional qualification and making the professions more attractive in a context of growing labour needs. This policy of massive investment in training reflects the conviction that improving the quality of service provided necessarily involves

[61] Pursuant to Article L. 6324-3 of the Labour Code, the social partners in the sector have decided to give priority eligibility to certain professional certifications. Article 20-2.1 of the 2010 CCN and its amendment no. 63/2024 of 20 March 2024 refer to state diplomas and, in addition, all certifications recognised by the sector.

[62] Addendum no. 63/2024 of 20 March 2024 on extended continuing vocational training.

[63] Article 25 of the 2010 CCN. These priorities are set out annually by the CPNEFP, which communicates them to the designated OPCO.

the continuous development of skills and working conditions that encourage employee engagement.

### 3.1.2 Training Provision in the Personal Care and Private Employer Sectors

The 2012 National Collective Agreement for Personal Services Companies targets two types of priorities: those relating to training initiatives and those relating to the target audiences. Training initiatives must aim to modernise and professionalise the sector by implementing skills training programmes, diversifying the methods of access to training and skills validation through VAE (validation of acquired experience) and the personal training account[64] to promote bridges between different jobs in the sector. The priority target groups are unqualified workers, young people and senior citizens,[65] regardless of the size of the company. The aim is to facilitate access to continuing professional development for these employees by developing literacy programmes, combating illiteracy, and providing introductory and advanced French language courses.[66] Particular attention is paid to professional training contracts. Work-based learning is a key part of the strategy developed by the OPCO *Entreprise de proximité*.

OPCO *Entreprises de Proximité* (EP),[67] the personal services branch, assists companies in recruiting apprentices and work-study students and supports professionalisation initiatives to facilitate the integration of job seekers. The Panorama 2022 report (OPCO EP 2022) provides the following figures:

- Between 2021 and 2022, one of the two main training programmes prepared by work-study students is the professional qualification (TP) in family care assistant (23%). On the other hand, training programmes in personal care and services with an option for home services (2%) are in low demand.
- 96% (health and social services) and 88% (family care assistant) of work-study students are women.
- 6% of work-study contracts within the OPCO EP concern the sector.

[64] Article 4 of the 2012 CCN and Article 2 of the Agreement of 2 October 2015 on lifelong professional training.

[65] The 2012 CCN devotes a specific chapter to the forward planning of employment and skills for senior employees (those aged over 45). In particular, it provides for all such employees to undergo a career review (second-half-of-career interview) in the year following their 45th birthday.

[66] Article 5 of the 2012 CCN and Article 3 of the Agreement of 2 October 2015 on lifelong professional training and its Addendum of 25 September 2019.

[67] OPCO EP is active in a variety of sectors, including personal services, which are central to the care economy and social cohesion. Its mission is to support companies, often small ones, in analysing their skills needs, financing training, and implementing work-study and professionalisation programmes. The training courses mainly focus on professional expertise, with an emphasis on supporting elderly or disabled people, and the digital skills needed for the digitisation of the sector. OPCO EP actively promotes certification and qualification training programmes, in particular through the personal training account, the professional qualification certificate and the CléA skills base.

Within the sector, in 2022 (OPCO EP 2023), 9,081 work-study contracts were signed. Of these contracts, 7,393 were apprenticeship contracts (up 23% compared to 2021) and 1,688 were professional training contracts (up 14% compared to 2021).

48% of contracts are signed within very small enterprises (VSEs) with fewer than 11° employees.

- In the sector, nearly half of work-study contracts began in establishments with fewer than 11 employees. Conversely, establishments with 11 to 49 employees and 50 or more employees are more strongly represented in the sector (31% and 21% of contracts signed respectively, compared with 20% and 13% in retail and local services for individuals).
- Most of those signing apprenticeship and professional training contracts are women (90% and 92% of contracts respectively).
- Work-study students in the personal services sector are slightly older, with more work-study students aged 21–24 (42% compared to 36%) and aged 25 and over (26% compared to 17%).
- The majority of work-study students in the professional sector are preparing for a CAP-BEP level qualification (58%). Baccalaureate and BTS levels are much less represented among work-study students in the sector than in these activities (5% and 14% respectively, compared to 11% and 30%).

With regard to private employers, Appendix 2 of the 2021 CCN establishes a cross-sector framework agreement aimed at implementing a professionalisation policy in the private employer and domestic employment sector, which encompasses various occupations, including those related to the care of elderly, frail or dependent persons. The sector is characterised by the fact that work is carried out in private homes, the employer is not profit-oriented and a high proportion of employees have multiple jobs. The 2018 law and decree recognised these specific characteristics and adapted the organisation and financing of vocational training, in particular through the *Association paritaire nationale interbranche* (APNI), the OPCO for local businesses and IPERIA. The inter-branch agreement aims to promote the attractiveness of the professions, secure career paths, develop skills, combat illegal work and support demographic, technological and environmental changes. For the branch of employees of private employers, the aim is to meet the growing needs for home care and improve professional practices. Employees benefit from professional interviews every two years and an assessment every six years to evaluate their skills, career path and training needs.

Regardless of the sector, training for home care workers focuses on professionalisation and career security, particularly through work-based learning, certification and the validation of skills in the workplace. What differs are the material and human resources put in place by each sector to achieve these objectives. These differences are even more pronounced when compared with the resources mobilised/mobilisable by the institutional care sectors.

### 3.2 Training Provision in the Institutional Care Sectors

Care institutions can be private or public. In terms of training, the former are attached to a single OPCO, OPCO Santé (3.2.1), while the latter fall under an OPCA associated with the public hospital service[68] (3.2.2).

#### 3.2.1 Training Provision in Private Healthcare Institutions

Private healthcare covers two sectors. One comprises non-profit healthcare and medico-social establishments that have joined together under a single employers' organisation, Axess, which has initiated two extended agreements on vocational training. The other brings together private hospitals that have signed an extended sectoral agreement on vocational training.

The non-profit health and medical-social institutions sector invests significantly in training by granting more extensive rights than those provided for in the Labour Code and by contributing financially well beyond its legal obligations. The agreement of 7 December 2020 on promotion and retraining through work-study programmes (Pro-A), which has been extended,[69] reinforces the relevant rights provided for in the Labour Code.[70] The agreement is aimed at a wider audience, namely part-time employees and professionals whose qualifications are not recognised at level 6[71] for historical and regulatory reasons. The agreement also broadens the range of eligible certifications[72] by establishing a list based on the work of the *Observatoire des métiers* (Observatory of Professions), which specifically targets professions for which skills development is a priority. The agreement also introduces major changes to the duration and intensity of training courses, adding the possibility of extending the duration to 24 months, or even 36 months for young people without a diploma, and authorising a training duration of up to 2,200 hours. From the point of view of Pro-A governance, the agreement gives the CPNE-FP a decisive role in establishing the amounts to be covered, selecting priority certifications and monitoring the evolution of the sector's needs. This results in a total investment by employers in the private non-profit health, social and medico-social sector set at 1.9965% of the gross annual payroll, subject to specific rules for employers with fewer than 11 employees, for whom the legal contribution is set at 0.55%, i.e. a total training investment for employers with fewer than 11 employees of 1.5465%.[73]

[68] The OPCA for local public services, which public healthcare establishments can join, will not be examined in this contribution.

[69] Extension order of 6 April 2021.

[70] Articles L. 6324-1 to L. 6324-8 of the Labour Code.

[71] This level corresponds to a Baccalaureate + 3 qualification.

[72] The Labour Code is limited to the National Register of Professional Certifications (RNCP): Article L. 6324-3 of the Labour Code.

[73] Article 3.6 of the 2020 agreement.

As for the agreement of 9 September 2020 on training and skills development, which has also been extended,[74] it also contains a set of particularly favourable provisions on vocational training, including those relating to professional training contracts.[75] It provides that the duration of this contract may be up to twenty-four months for all qualifications and diplomas in the sector, as well as a training volume of up to 2,200 hours, whereas the Labour Code limits the duration to twelve months in principle, except in special cases. It also provides for remuneration above the legal minimum, particularly for young people and those with a baccalaureate-level qualification, thereby improving the attractiveness of the scheme. The rules relating to mentoring are also clarified and reinforced by reference to Article 1.1.3 of the same agreement.

The OPCO Santé (Health Joint Commission for Collective Training)[76] has an observatory known as the Employment-Training Barometer, created in 2022 to support social partners in analysing and anticipating developments affecting companies and employees in its development of multi-year employment and training policies, in order to highlight needs to institutional partners. Among the professions covered by OPCO Santé, three of them represent a quarter of the workforce, including nursing assistants. The overall percentage of women across all professions is 76%; 85% of employees are on permanent contracts (CDI) and turnover stands at 12%. The most popular diploma courses funded by OPCO Santé in the sector include the State Diploma for Nursing Assistants (DEAS). Since 2022, the Employment-Training Barometer has confirmed strong recruitment pressure, particularly in the nursing and nursing assistant professions. Establishments in the sector are unable to meet the qualification needs of their employees due to a lack of funding. On the other hand, the number of work-study contracts, particularly apprenticeship contracts, doubled between 2020 and 2023, reaching more than 10,000, exceeding the target set in the 2020 agreement. Furthermore, among the five professions with the highest demand for VAE (validation of acquired experience), nursing assistants rank second (6,930 candidates from July 2023 to 31 December 2024). Breakdown of pathways by qualification: Nursing Assistant Diploma – DEAQS: 26.7%, State Diploma in Social Work – DEASS, 2.6%; Professional Title in Family Care Assistant – ADVF, 0.2%; Professional Baccalaureate in Personal Care and Services, 0.2%. (OPCO Santé, 2022).[77]

The healthcare sector faces several challenges in terms of training, mainly related to the shortage of certain healthcare professionals. Two professions are experiencing the most significant shortages:

[74] Decree of 2 July 2021 JORF 18 Sept. 2021 and approved by decree of 17 December 2020 JORF 23 December 2020.

[75] Articles 1.2.1 to 1.2.4 of the agreement of 9 September 2020.

[76] Created in 2019, OPCO Santé brings together non-profit and for-profit establishments in the health, social and medico-social sectors.

[77] As the 2025 Employment Barometer has not yet been published, all data is taken from the 2022 Employment and Training Barometer, see OPCO Santé 2022.

- Nurses (IDE): Demand is constantly increasing, particularly in private non-profit organisations such as nursing homes, but also in private hospitals.
- Care assistants (CAs): This profession, which is essential in patient care, is in high demand, particularly in the home care and medical-social establishments sectors.

To meet these needs, OPCO Santé supports several professional development pathways, such as Pro A (work-study professional development), which allows employees already in post to undertake training while continuing to work. This enables them to update their skills and adapt them to changes in the sector.

The main challenge remains the attractiveness of the healthcare sector. Despite high demand, it is often difficult to retain professionals. This is due to several factors, including working conditions, lack of recognition and relatively low salaries in certain sectors such as healthcare, medico-social and private non-profit social services. To remedy this, OPCO Santé and the professional branches are seeking to develop targeted training courses that directly address labour shortages. Joint committees are working with regional delegations to tailor training to the needs of each region and sector, to better respond to local shortages and support the professionalisation of employees in high-demand occupations. While schemes such as apprenticeships and professional development offer opportunities, their effectiveness largely depends on the financial resources available. Employees are often faced with difficult choices about their professional future: leave their job to train or continue working without improving their qualifications. Public funding does not always meet the urgent needs of the sector and may be subject to budgetary restrictions, making these schemes inaccessible to certain categories of workers. In response to this, solutions have been identified (OPCO Santé 2023).

Firstly, apprenticeships are a proven model. The results of the 2021–2023 reviews show that this model is fairly well received in the various sectors. The high proportion of women (around 80% of the sector) is also reflected in the apprenticeship participation figures. These data are particularly interesting because they show that women benefit greatly from these training opportunities, which is a positive sign for equal opportunities in access to professional qualifications. However, even though apprenticeships are an effective training solution, they do not always meet all the needs of the sector, particularly in the case of specialisation (OPCO Santé 2023).

Secondly, professionalisation is proving to be a real springboard for qualification. It is another relevant and particularly useful mechanism, as it meets specific qualification needs. The resulting certifications enable real career progression, particularly in social and health care professions. However, a significant proportion of workers remain excluded from these schemes due to the complexity of the administrative procedures, the lack of visibility on funding and requirements that are sometimes too strict for unqualified profiles (OPCO Santé 2023).

Thirdly, solutions have been found to address the shortage of nursing assistants. Many of them wish to progress to nursing roles. To meet this growing

demand, a measure has been put in place: the decree of 3 July 2023 allows nursing assistants who have worked for more than five years, including at least three years full-time, to enter directly into the second year of nursing school after completing a specific three-month training course. This programme, introduced in 2023, is a significant step forward, enabling nursing assistants to accelerate their career progression and helping institutions to overcome the shortage of nurses.

Fourthly, it is necessary to mention Pro A, which is mainly aimed at employees with qualifications below Bac+2 level. This programme aims to support these workers in obtaining a professional qualification or certification through theoretical and practical training lasting between 6 and 24 months. Although this scheme concerns a smaller category of workers, it offers opportunities for skills development to employees who wish to advance their careers. In the current context of shortages in certain professions, particularly in the health sector, Pro A helps to diversify profiles and open up pathways to new qualifications.

The shortage of staff in healthcare facilities is finally prompting more and more hospitals and medical establishments to recruit beyond national borders. Although this solution sometimes raises debates about the integration of foreign workers, it has become necessary to maintain the quality of care in a context where demand is constantly increasing. Aware of this reality, public authorities are facilitating recruitment by including these professions in lists of so-called shortage occupations, for which access is facilitated. However, these carers recruited from abroad do not always have a sufficient command of the French language, which creates communication difficulties with patients, but also with work teams and health authorities. This is why measures have been implemented to facilitate the integration of foreign workers in the care sector in certain regions, to improve their language skills and enable them to integrate more easily.

The private hospital sector is also experiencing recruitment pressures, as confirmed by the 2022 OPCO Santé barometer, with 9.2% of nursing assistant positions vacant and 13.1% of nursing positions unfilled (OPCO Santé 2022; 2023). In this context, the sector's social partners have identified strategic guidelines in the agreement of 3 July 2025 on vocational training (Convention 1966) and applicable apprenticeships. These are based on prioritising qualification and diploma courses, particularly for carers, supporting professional development and retraining, and a dynamic qualification policy based on co-financing and expanding the range of certification options. The agreement promotes vocational training that incorporates technological, digital and artificial intelligence developments. It thus organises its programme around four key areas: the development of work-study programmes as a tool for recruitment and upskilling, the use of personal training accounts, the strengthening of the skills development plan and the mobilisation of the resources necessary for the advancement of employees' skills and qualifications: The measures include the professionalisation contract and the Pro-A scheme to promote the retraining, promotion or professional development of existing employees, particularly in high-demand professions, through work-study programmes that combine training and professional activity, with continued remuneration and financing of teaching, practical and

salary costs by the OPCO Santé. They also include the Personal Training Account (CPF), the Professional Transition Project (PTP) and the skills development plan. To meet these needs, the sector is mobilising resources beyond its legal obligations: a contractual contribution of 0.10% of the total payroll, supplemented by internal training budgets and co-financing.

### 3.2.2 The Offer in the Public Hospital Sector

In June 2007, the National Association of Hospital Staff (ANFH) became the approved joint collection agency (OPCA) for the hospital civil service.[78] It has been authorised by the Ministry of Health to collect and manage funds dedicated to the training of nearly 956,000 employees. In addition to this fund management mission, the ANFH offers its members extensive support in the areas of training, skills and career management. It provides regulatory monitoring, up-to-date information, a diverse training offer, as well as methodological tools and communication materials. Based on three core values - joint management, solidarity and proximity (ANFH 2024) - the ANFH is jointly administered by representatives of institutions and trade unions at the local, regional and national levels. Its work helps to ensure equal access to training and skills development for employees in public health, medical-social and social institutions.

The 2020–2024 strategic project was designed to build on the actions and measures implemented as part of the 2016–2019 project. The main framework includes the development of skills for all staff and the development of certification, strengthening the link between training and the strategies of institutions, and increasing the number of access points to training and the Association's services for staff and institutions. In its new strategic project for the period 2025–2028, the ANFH has set itself two major ambitions: to continue to offer training provided by training organisations recognised for their expertise; and to improve the visibility and clarity of training and support offers for staff and institutions in the public hospital sector. The ANFH's strategic guidelines are the result of joint efforts involving local, regional and national authorities. The ANFH's strength, which is recognised by workers and their trade unions, lies in the pooling of financial resources and the sharing of tools and data relating to vocational training.

Since its creation in 1974, the ANFH has been actively involved in implementing key principles such as social advancement, continuing education, second chances, recognition of professional expertise, skills development, promotion of diversity, support and mentoring, and internal mobility within the public hospital service. The ANFH offers a wide range of continuing education and professional mobility programmes for hospital staff, thereby promoting their professional development (ANFH 2025, 17).

[78] Decree of 29 June 2007 approving the National Association for Continuing Education of Hospital Staff as a joint collecting body.

Over the next four years (2025–2028), the Association intends to guarantee the maintenance of skills and facilitate access to promotion and qualification through training, tools and support from training services. One of the challenges will be to strike the right balance between individual aspirations, the needs of institutions and those of the healthcare system as a whole. The 2025–2028 strategic project is therefore based on all the actions carried out that make up the strength and specificity of the ANFH. The aim is to consolidate the ANFH's role as a major player in supporting and assisting institutions with issues of retention and attractiveness, as well as professionals in the hospital, medico-social and social sectors in their professional development and career progression (ANFH 2025, 20). By recognising the importance of changes in care methods and technologies in the sector, including digital technology, this strategic project also aims to meet needs and strengthen control over these changes, while combating the digital divide (or digital illiteracy).

In conclusion, sectoral agreements can also establish specific professional qualification certificates (Guilloux 1998) that serve as genuine pathways to qualification and facilitate the recognition of skills acquired in the field. However, one of the problems that arises relates to the excessive number of certifications at national level, as established by a CESE report (Gilier 2016). The authors of this report highlight the difficulty of cataloguing these certificates, particularly in order to reduce the risk of illegibility and to ensure their consistency and awareness among companies and employees. Despite the efforts of the social partners, vocational training remains an imperfect lever for securing and enhancing the value of care work careers in France. Indeed, the effectiveness of the right to vocational training in the care sector suffers from the multi-layered nature of the legal and contractual provisions, the individual responsibility of employees for their training pathways and the adverse effects of the fight against fraud. The goal of universalising the right to vocational training is therefore far from being achieved in the care sector, which is in such dire need of it given its structural labour problems.

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CHAPTER 8

# From a Patriarchal Welfare to a DIY Welfare. A Short History of Care Workers in Italy

Silvia Borelli

## 1. Introduction[1]

The recent pandemic crisis clearly demonstrated the poor working conditions and the many forms of labour exploitation suffered by care workers. To understand why the sector is so undervalued and exploited, it is necessary to clarify how the national welfare system was set up and how it works. In Italy as well as in other States, care workers' conditions deeply depend on how the welfare system is structured.

The article presents why and how, in Italy, the traditional *patriarchal welfare* system has been transformed into a *DIY welfare system*, and the effects of this transformation on care workers. The analysis adopts an *intersectional feminist perspective* that examines simultaneously gender, racial and class domination.[2] Adopting this intersectional feminist perspective is of paramount importance to examine *global care chains*, exploited to solve care needs in richer countries—

[1] A first version of this article has been published on "Forging a Feminist Labour Law", *Global Labour Rights Reporter* 3, 2, 43–51. The issue is available here: <https://www.ilawnetwork.com/ilaw-network-journal-the-global-labour-rights-reporter/> (accessed June 13, 2026).

[2] As clarified by Dahl, "it is not possible to analyse gender and gendering without including elements of race and class as these dimensions intersect and form the way gender is performed" (Dahl 2021, 7. See also bell hooks 2021).

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including Italy—at the expense of poorer countries.[3] The massive engagement of female migrants as exploitable and vulnerable care workers has been considered a "good" solution to increasing care needs. Good from the perspective of the Italian wealthy families that can pay for care work and of the Government that can displace care responsibilities on migrants and reduce public expenditure; extremely bad for the poorer countries where migrants come from that suffer from a care crisis and for the workers themselves.[4]

The article focuses mainly on paid care workers. However, it largely considers the interconnection between paid and unpaid care.[5] First, the need for paid care depends on the unavailability of unpaid care. Currently the need for paid care increases because of the decreasing amount of unpaid care due to women's entry in the labour market and the changing structure of families. Unpaid care is also negatively affected by working time regulation and employment flexibility. In fact, unpaid care is shrunken both by the broad power recognised to employers to vary the timing of work performance and by on-demand contracts.[6]

The precariousness of many types of employment, as well as related in-work poverty, has threatened the male breadwinner family model and has forced the shift towards a dual-earner family model, further decreasing the amount of available unpaid care.

Therefore, a *care – job insecurity trap* is generated: the dissemination of precarious jobs, as well as the unpredictability of work schedules increase paid care needs that must be supported by the State and/or by families. However, due to poor salaries, wage stagnation and inflation, families often cannot afford to pay much to satisfy their care needs and look for low-cost solutions. States struggle to face the costs entailed by the increased care needs. According to the European Commission, between 2019 and 2070 the costs of ensuring care to an aging population is expected to rise to 1.9% of the GDP (European Commission 2021).

Moreover, the costs of a public care system should be covered by taxation. In Italy, as well as in other European countries, tax burden falls mainly on workers; in fact, free movement of capital has gone alongside the progressive decrease of taxes on capital (Piketty 2023, 245; Staglianò 2026). In this context, public care services risk promoting a redistribution from poor to rich: while the latter can

[3] On global care chains see: Ehrenreich and Hochschild 2003; Hochschild 2000; Kofman and Raghuram 2015. For Italy see Vallauri 2025.

[4] Therefore, "'costs of care' are not just a question of the changing relationship between the state, market, family and community, but of geopolitical inequalities between states affecting individuals in gendered and racialised ways" (Williams 2001, 470). See also Williams 2018; Spanger, Dahl, and Peterson 2017.

[5] According to the ILO (2018), paid care refers to any care provided by a service provider or a worker for a salary or a fee; unpaid care refers instead to care provided by family members, close relatives, friends, neighbours or volunteers.

[6] According to the ILO (2022, 61), "on-call work negatively affects work–life balance due to the unpredictability of the work schedules that are often associated with this working-time arrangement. Poor work–life balance is associated with workers having unpredictable schedules and lacking control over their working hours".

benefit from job precariousness and the global movement of capital, the former have to pay higher taxes for financing public services and social treatments needed.

## 2. The Main Features of the Patriarchal Welfare System

Turning now to the analysis of the types of welfare State and their impact on care workers' conditions, it should be recalled that Italy belongs to the *familistic welfare model* (Saraceno 2003; D'Onghia 2025, 705). In the country, welfare was developed to support and preserve male breadwinners facing events that prevent them from working (Ferrera 1984, 23). Social insurance was conceived as a tool to deal with economic insecurity generated by men being unable to earn an income from the labour market. Therefore, monetary transfers have been much more important than in-kind services and solidarity has been understood mainly as redistribution of economic resources (Balandi and Buoso 2023, 63).[7]

A main feature of the familistic welfare model is the separation between private and public spheres. Care was generally delegated to families, where it was mostly performed as "unpaid and invisible labour" by women (Borelli 2025, 618; Müller 2019). Social services were underdeveloped and underfinanced and the State's intervention was limited to cases where families "failed" to fulfil their role as social safety net (Giorgi and Pavan 2021, 13).Consequently, care become invisible, marginalised and devalued in terms of the practices it encompasses, the people who perform it and the values it represents (Tronto 2013, 144).

Since the traditional gender-role division is very present in Italy, women have been and are mainly responsible for care. The Italian legislature has widely supported the male breadwinner/female caregiver family model and has intervened on care services only occasionally, upon pressure from feminist movements, sometimes supported by trade unions (for example, the Law no. 1044/1971 on kindergartens).

In line with the neoliberal way to conceive human beings, individuals are considered autonomous, independent and self-sufficient entities, responsible for their own development and in competition with each other (Fineman 2010). Care has been concealed and care needs denied.

The separation of the public and private sphere and the naturalisation of caring has boosted the idea that care is not "work like any other". The exoneration gained through this strategy of separation and naturalisation of caring has released men's energies for other activities, without them feeling the need to recognise their dependence on care or the care work on which their existence depends.[8] Therefore, "women's responsibilities for care and unpaid domestic

[7] According to the Italian Statistical Office (ISTAT 2023), in 2020 monetary transfers represented the 77.3% of the expenditure for social protection, far above the European average (66%).

[8] As pointed out by Brunella Casalini (2020b, 61), "those who are privileged do not need to know and can thus overlook the costs that others bear to let them have their privileges. To maintain their privileged position they sometimes even need actively not to know, to hide and ignore, in order not to think of the oppression and injustice on which their privileges may be based".

labour underpin gender hierarchies and women's unequal inclusion in politics and markets" (Orloff and Laperrière 2022, 351).

For the above-mentioned reasons, the familistic welfare model has also been called patriarchal welfare (Ascoli 2002, 215).[9] The patriarchal welfare has a huge advantage for the State because it lays the burden of care mainly on families—i.e. on women—and liberates the State from this responsibility. However, its stability depends on women's oppression. The patriarchal welfare also generates a huge advantage for capital since it lowers reproduction costs, i.e. the costs necessary to reproduce the workforce that must be covered by wages (Del Re 2020, 38. See also Federici 2020). The unpaid reproductive work carried out by women has allowed employers and owners to maintain low salaries for productive work and thus increased the surplus value for capital. However, care is also threatened by capitalism, because its drive to unlimited accumulation tends to destabilize the very processes of social reproduction on which it relies.[10]

## 3. From Patriarchal Welfare to the DIY Welfare

The patriarchal welfare model has been strongly affected by the growing entrance of women in the labour market, as well as by an ageing population, low fertility rates, changing structure of families, higher youth mobility and greater job insecurity. These elements have both reduced the care capacity of families and boosted care needs, especially for elders.[11]

Due to high public debt and the rigid constraints imposed by European economic governance, Italian public administrations can hardly maintain the few existing public services or develop new ones.[12] Besides, costs caused by population ageing are assessed in the evaluation on debt sustainability and recommendations on the reduction of these costs are constantly addressed to Member States in the European semester.[13] Therefore, a *DIY welfare model* has progressively replaced the traditional patriarchal welfare model. In the *DIY welfare model*, families should find alone, in the private market, a solution to their care needs.

This type of welfare has been fuelled by several factors. On one side, the movement for women's emancipation, corresponding with women's mass entry in la-

[9] Any feminisms recognise patriarchy as a social system in which positions of dominance and privilege are primarily held by men, and criticises it as a primary cause of women's oppression (Finlayson 2016, 6; see also Saini 2023).

[10] According to Nancy Fraser (2016, 102), "social reproduction is an indispensable background condition for the possibility of economic production in a capitalist society".

[11] Italy is the country with the oldest population in Europe (see Eurostat 2026). In 2050, 34.3% of the Italian population will be older than 65.

[12] Unlike the funding for the defence, the funding for care services does not benefit from the National Escape Clause that gives Member States additional budgetary flexibility (cf. Council of the European Union 2025).

[13] The European Semester is the European Union's framework for the coordination and surveillance of economic and social policies. For further information see European Union 2026.

bour market, caused a deresponsibilisation from care whose burden has been externalised. Due to the lack of public services and the very low availability of men to provide unpaid care (for cultural, economic and legal reasons[14]), care has been displaced onto care workers and care services available on the market (the so-called *care marketization*).[15]

The *DIY welfare* model presents a problem of reverse redistribution. Instead of playing the redistributive role that State welfare should play, this system increases the differences between the rich who can afford high quality care services, and the poor that have to accept low-cost solutions for their care needs. The cost of paid care strongly affects caretaking choices. Families can opt only for care arrangements that are affordable for them. Therefore, in order to satisfy care needs, *DIY welfare* must provide families with *low-cost solutions* (Borelli 2020, 24). In Italy, the cheapest caretaking option is domestic care work.

Finally, in the *DIY welfare model*, the costs of paid care have to be lower than wages received by unpaid carers whose participation in the labour market would be otherwise severely affected. Therefore, wage stagnation and inflation have a further negative impact on wages received by care workers.

In 2023, a law reforming long-term care was adopted. However, its implementation was required to be cost-neutral, with no increase in public expenditure. This constraint has significantly undermined—and continues to undermine—the effectiveness of the reform.

In order to comply with fiscal requirements, the government has postponed key elements of the reform, deferring their implementation to future ministerial decrees that have yet to be adopted. At the same time, the scope of beneficiaries has been progressively narrowed. Finally, the role of public care services has been reduced, while greater emphasis has been placed on providers within the social economy.

## 4. The Many Forms of Legal and Illegal Exploitation of Domestic Care Workers

In Italy, long-term care is mainly provided by domestic workers (called *badanti*).[16] The large majority of these workers are women from foreign countries.[17]

[14] Paternal leave has been introduced in Italy only recently and is much shorter than the maternity leave (see Militello 2020; Vallauri 2020).

[15] "Marketization broadly describes policies, which use markets and market mechanisms in the provision of welfare services". Markets "can be understood as practices that construct care as a commodity and the individual in need as a consumer" (Burau et al. 2017, 1023).

[16] In the past, the word "badante" was used to refer to a person that looks after animals (see *Redattore sociale* 2013). Thus, the use of the word "badante" reflects the weak value given to care work, linked to negative stereotypes on what is still perceived as a female task and on immigrants that are relegated to what are considered as "second-class" occupations.

[17] According to Domina (the main employers' association in the sector), 68.6% of domestic workers are foreigner and 88.9% are women (Osservatorio Nazionale Domina 2025).

Many migrants accept live-in care work so they can receive accommodation and food. Besides, they are not exposed to immigration oversight since labour inspections are much more difficult to conduct in private houses (Ambrosini 2013). In Italy, a person can be employed as a domestic worker without any qualifications. In fact, the debate on care quality has never been developed in this sector since care has been (and often is) considered an activity performed naturally and free of charge by women within the family. Domestic work "mirrors tasks traditionally performed by female household members without pay", so it "is perceived as unskilled and lacking in value" (ILO 2012, 73).

Exploiting the low societal recognition for care work and being aware of the paramount role of domestic workers to face increasing care needs of families, the legislator has deliberately developed methods to reduce the cost of domestic work. Labour violations in the sector have been widely tolerated and inspections have been rarely performed.[18] Therefore, domestic workers suffer many forms of legal and illegal exploitation to keep their cost very low (Borelli 2021, 281).

A first form of legal exploitation concerns migration law. In Italy, the procedure for obtaining a work permit is so complex that, in practice, foreign workers find it almost impossible to enter the country legally (Chiaromonte 2020, 241; Papa 2026). An irregular migrant who turns to the authorities to ask that her rights be respected risks being punished for the offence and being deported (Legislative Decree no. 286 of 25 July 1998 Article 10-bis). A domestic worker who dares to protest her working conditions risks being dismissed, as domestic work is excluded from the just case protections extended to other forms of work and a notice period is sufficient to dismiss (Frosecchi 2025, 390). Live-in workers risk also losing accommodation. Moreover, the dismissed worker could hardly find a new job, given the impact of bad references in the sector. And without a job, the migrant may lose her residence permit. Therefore, foreign workers are more hesitant to enforce their employment-related rights that thus are "more symbolic than real" (Fudge 2012).

Recently, the legislature authorized the admission of up to 14,000 domestic workers per year into Italy (Article 2 of Law Decree 145/2024). These migrants are required to remain in domestic work for at least 12 months. This measure further reinforces the ethnic segmentation of the labour market, whereby jobs are effectively allocated on the basis of workers' nationality. It also appears to run counter to the 2024 Single Permit Directive (Directive 2024/1233), which seeks to decouple migrants' residence status from a specific employer or sector.

Noting the widespread presence of migrants in the sector, Bettio and others have referred to a move from a family model of care to a migrant-in-the-family model of care (Bettio, Simonazzi, and Villa 2006). Other have talked about

[18] According to Labour Ministry (Ministero del lavoro e della previdenza sociale 2022, 10), 52.3% of domestic work is irregular. It should be also underlined the bad perception of controls and sanctions by families that, in the *DIY welfare*, are obliged to find alone a solution to their care needs.

"distorted emancipation" that fails to produce a more equal division of caring time inside the family and maintains traditional gender hierarchies related to care work (Ezzedine 2021, 3).The legal exploitation of domestic workers is also facilitated by maintaining a special regime created in 1958.[19] While the functions of domestic workers have changed and their number has significantly increased in response to growing demand for elder care (Sarti 2016, 201), Italy has not adapted the legislation to guarantee equal treatment or to protect them from the risks entailed by homecare. Not even on the occasion of the ratification of the ILO Convention no. 189, which Italy did before any other EU country, was there any change to the 1958 legislation, which, as a result, remains, in several respects, non-compliant with the provisions of the Convention (Borelli 2020, 181). In fact, the special regime for domestic workers consists of excluding them from the ordinary labour legislation with regard to working hours, wages, health and safety at work, maternity, paternity and parental leave, dismissal, work accident, social contribution and other protections (de Martino 2021, 57). Consequently, this special regime clearly infringes one of the main pillar of the ILO Convention: recognising domestic work as "work like any other" (Blackett 2019).

Due to the weak legislative framework, domestic work in Italy is regulated mainly by national collective agreements. There are several national collective agreements for domestic work many of which are signed by employer associations and trade unions whose representativeness is unknown, in order to lower labour cost established by the main national sectoral collective agreement.[20]

Moreover, collective agreements for domestic workers are sometimes applied by companies or associations that provide them to families. This practice is highly questionable as it is not clear why a special discipline for domestic work, dictated to meet the needs of a particular employer (the family), should be applied to an entity providing services in the market (Borelli 2020, 171).

Abuses to which domestic workers recruited or placed by private employment agencies are often exposed (Amorosi 2022, 78), are denounced by Article 15 of the ILO Convention 189. Notwithstanding the many risks that this practice can entail, private employment agencies providing domestic workers are increasingly present in Italy since they free families from the burden to manage domestic work. The way in which domestic work is provided depends both on the economic convenience and on the controls carried out by the labour inspectorate. In other terms, employment agencies adapt the legal form of their operations in order to be competitive and evade controls (Amorosi, Borelli, and Sarti 2024).

Some agencies provide domestic workers hired in foreign countries, exploiting the comparative advantage deriving from the regulation on transnational

[19] The law of 1958 is a result of the battles of feminists to recognise domestic work as a work (Del Re 2020, 37).

[20] In Italy, collective agreements do not have an *erga omnes* effect: a service provider has to apply the agreement signed by the employers' association to which it is affiliated; if it is not affiliated to any association, it can freely decide to apply or not a collective agreement and which collective agreement to apply.

posting of workers in terms of lower labour costs and less risks to be controlled by public authorities.[21]

Cash-for-care payments are another tool to provide low-cost solutions to care needs. These schemes have "not only affirmed a conception of care as a commodity that care-seekers turned consumers can freely purchase on the market" (*commodification of care*; Farris and Marchetti 2017, 112); they have as well contributed to worsen domestic workers' conditions because their use is very often unlinked to the regular engagement of the latter. In the main cash-for-care scheme for elderly and disabled people (the *indennità di accompagnamento*), for example, the State provides an amount (552.27 euros per month in 2026) that does not cover the cost of a full-time regular domestic worker. It is therefore no surprise that families often use this allowance to pay undeclared or under-declared care workers (Da Roit and Le Bihan 2019, 519).

In 2024, a new measure was introduced (Article 36(2)(b) of Legislative Decree 29/2024). It requires that part of the allowance be used to hire a home care worker, in compliance with the national collective agreement signed by the most representative trade unions in the sector. However, like many of the measures adopted to implement the 2023 long-term care reform (see above), its scope is extremely limited. Only a small number of older people—those over 80, with very severe care needs and an income below euros 6,000—are eligible to benefit from it.

## 5. The Outsourcing of Care Services

Other methods elaborated by Italian legislator to provide low-cost solutions to care needs concern outsourced care services. As already pointed out, in Italy public care services—in particular, elder care—have been and are underdeveloped. Facing the decreasing availability of unpaid carers and rigid public expenditure constraints which prevent hiring new staff public administrations have extensively contracted out care services. This has caused several consequences. First, monetary transfers have increased: instead of developing public care services, the legislator has introduced monetary contributions to cover the cost of private care services. This has not been changed by the 2023 reform of the LTC (Gualandi 2025). Second, regional disparities already in existence have increased. Care services largely depend on public funds, and in particular on municipal funds.[22] Therefore, the availability and the quality of care services are more related to the wealth produced in a certain territory than to the care needs. In other terms, care services are fewest where poverty and vulnerability is higher. Inequalities in access to care services thus contribute to reproducing and aggravating inequalities between Italian Regions (Martinelli 2019, 45).

[21] In fact, controls on transnational posting of workers require the collaboration among different national public authorities. Italian labour inspections have recently discovered severe forms of labour exploitation caused by some cases of transnational posting of domestic workers (Osservatorio Nazionale Domina 2022, 90).

[22] In 2020, municipalities covered the 57.4% of the costs for social services (ISTAT 2023).

Due to the absence of a national legislation that clearly defines the minimum levels of services that must be guaranteed throughout the territory (*Livelli essenziali delle prestazioni sociali* LEPS for its acronym in Italian), each Region offers different services. Consequently, it is difficult to collect data on care services because they are different from Region to Region and the services themselves are named differently in each Region.[23]

In 2017, the legislature created a Social Protection and Inclusion Network to coordinate social interventions and services (Borelli 2020, 13). However, due to the huge regional differences, the annual plans adopted so far by this Network have not been able to define the LEPS to be guaranteed throughout the country. The Network has emphasised that LEPS cannot be achieved without stable, adequate funding which is currently not available. In fact, public funding for care services has been extremely fragmented and discontinuous.[24] This problem has been further accentuated by the National Recovery and Resilience Facility (NRRF) that expires in 2026 and, consequently, it cannot be used for structural costs, such as staff cost (Borelli 2023, 25). Currently, the NRRF has been used to build infrastructure such as kindergartens, small hospitals and care centres; however, the public administration can barely cover the cost for the personnel who will work in these facilities and it is highly probable that their management will be outsourced.

The 2023 reform of LTC planned to harmonise the rules on authorisation and accreditation of care services.[25] However, this part of the reform was not implemented. Therefore, these rules remain defined by each Region, further amplifying the territorial disparities. In many cases, the authorisation and accreditation schemes do not list fair working conditions and qualification requirements among the elements that must be respected to provide care services.

Furthermore, some Regions (such as Lombardia) have implemented open authorisation and accreditation schemes, i.e. have established minimum criteria that have to be fulfilled by private care service providers without selecting them. This strongly reflects a *consumer-oriented approach* aimed at satisfying the needs of users that, according to these Regions, can freely select care services that better fit their needs.[26] However, in many cases users' free choice exists only

[23] On problems related to data collection see: Bocchino and Padovani 2023; Network Non Autosufficienza 2020; Fosti, Notaricola, and Perobelli 2021; Turchini, Ferri, and Ranieri 2022.

[24] Some LEPS have been established by Article 1(797) of the Law 178/2020, Article 1(162–166) of the Law 234/2021 and Article 1(699–700) of the Law 199/2025.

[25] Authorisation lays down the minimum requirements that all operators wishing to provide a care service must comply with while accreditation is required to provide services on behalf of the public service (i.e. the cost of these services is partially reimbursed by the Region) (Albanese 2007, 208).

[26] It should be noted that, while in the European Nordic countries, "a representative of the municipality provides an assessment of the needs and the recipient can then choose between care provided by the municipality or a private company chosen among the certified companies" (Dahl, Eskelinen, and Hansen 2015, 288), a care need evaluation by a public author-

"on paper" because users can hardly assess their care needs and the services that can be chosen depend both on the services available (that are widely different from Region to Region) and the costs that the user can bear.

The authorisation and accreditation schemes present a huge advantage for the *DIY welfare*: they are not regulated by public procurement law. Therefore, the many rules established for public procurement procedures to protect workers' rights do not apply in these cases (Caruso 2017, 1128).

Public procurement law also does not apply to care services outsourced to non-profit entities. In fact, public administration may enter into agreements with non-profit care service providers according to specific rules aimed at promoting their role in the sector. This generates a paradox: care workers in for-profit care services are protected by regulations on working conditions in public procurement law, while working conditions for workers at non-profit entities are unregulated (Borelli 2023, 50).

Moreover, in Italy several national collective agreements exist for non-profit actors, some of which are signed by predator employer associations and unrepresentative trade unions[27] in order to lower labour costs. Besides, due to the ultra-fragmentation of the employers' associations in the field of social services, the main trade unions (CGIL, CISL and UIL) have signed several national collective agreements applicable to non-profit care providers (Gualandi 2025; Renzi 2025). National collective agreements for non-profit entities usually provide lower wages and benefits than the one for the public sector and, sometimes, cheaper than the one for for-profit actors.

Non-profit entities can also employ volunteers. Legislative Decree no. 117/2017 restricts the use of volunteers in for-profit enterprises, but volunteers play an important role in non-profit actors providing care services (Natoli and Turchini 2023, 30) and this produces a further competitive advantage for them.

Therefore, in Italy the role of non-profit actors is still very relevant in the care service sector and corporatization of care—i.e. the growing presence of for-profit companies and their business rationalities in care sector—is still underdeveloped compared to other countries (Farris and Marchetti 2017, 109).

## 6. Looking For a Care State Model

The short description of the *DIY welfare model* clearly points out that it has allowed the emancipation of Italian wealthy women by legally and illegally exploiting female migrants as domestic care workers or personnel employed in care services provided by private actors. Instead of decreasing inequalities, the

ity is still missing in Italy. The care service reform outlined in the National Reform and Resilience Plan aims at setting up a single access point where a personal care need evaluation is performed by an interdisciplinary equip.

[27] In Italy, several trade unions exist. Each trade union can freely decide which sector to represent and can sign collective agreements. Therefore, there are several collective agreements for a sector and each collective agreement can have a different scope.

*DIY welfare model* increases the differences among wealthy families that can afford high-quality care services and poor families that have to look for low-cost solutions. Solutions available vary from Region to Region and these territorial disparities risk to be further increased if the proposal presented by the Meloni Government aimed at enhancing Regional competences and reducing solidarity mechanisms among Regions will be approved.

In a pamphlet published in 2020, the Care Collective proposed to develop a *Care State*, i.e. a State that "ensures versatile, high-quality and cost-free care for anyone in need, at all stages of life" (Care Collective 2020, 74). The interconnection between paid and unpaid care, as well as the analysis on how the type of welfare impacts on care workers' conditions prove that, in order to make this idea concrete, a holistic approach that encompass recognition of care as "background condition of possibility" of our social order is needed (Fraser 2022). This includes the need to redistribute unpaid and paid care work among genders, to strengthen public welfare, and to ensure respect for the rights of migrant workers. Working time should be reduced and on-demand contracts forbidden (Nedelsky and Malleson 2023). Unpaid caregivers should be supported and men's participation in care work should be mandated through full paid parental leave and compulsory leave for men. Public welfare policies should expand into areas where welfare States have historically provided limited support, such as long-term care (Engster 2015, 29). Fiscal systems should be reconceived to limit capital movement, increase taxation on activities to be discouraged (e.g. on financial transactions) and restore progressive taxation (on this point see High-Level Group on the Future of Social Protection and of the Welfare State in the Eu 2023, 86). Migration law should be reformed in order to reduce migrants' vulnerability. Care workers must be recognised as essential workers and decent care worker conditions should be considered a key element of quality of care. More than anything else, voices of both paid and unpaid caregivers and care receivers should be supported in order to develop "a counter-discourse on care that challenges the dominant discourse that has historically devalued care and considered it as irrelevant as a political issue" (Casalini 2020b, 69).

Therefore, the role of trade unions defending care workers' rights should be strengthened, also exploiting the recognition of social services as a field of the European sectoral social dialogue. As pointed out by the social movement developed alongside the approval of the ILO Convention 189, the unionisation of care workers has been traditionally low. On one side, this is a consequence of the under-evaluation of care, not considered as a real work by many (male) trade unionists. On the other side, many care workers are migrants not aware of their rights, often not trusting on the trade unionism and scared of losing their job and their residence permit. Besides, the nature of the workplace (often, private house) of these workers prevents them from meeting and socialising.

It is therefore important to remember that "we live inside the successes of past struggles" (Wallman 2022, 13): many rights we currently benefit from, such as public health care and public schools, have resulted from long-harsh battles

fought by women, workers and trade unions in the past.[28] Without these battles, transformation of the *DIY welfare model* towards a *Care welfare model* would just be a good intention.

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[28] On the role of labour movement in the development of the Welfare State see Kuhle and Sander 2022, 75.

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CHAPTER 9

# Domestic Care Work in Italy: The Work of Family Carers Between Irregularity and Exploitation

William Chiaromonte, Giulia Frosecchi

## 1. Introduction[1]

This essay is devoted to the regulation of work performed in the care sector for the benefit of non-self-sufficient persons, within the family sphere and under the authority of a domestic employer, with reference to three dimensions that appear especially significant in the Italian experience, namely the extensive deregulation of the ordinary labour law framework, irregularity and labour exploitation.

The first part of the essay highlights some of the main critical aspects of the Italian regulation of domestic care work. It examines certain particularly complex issues, namely the employer's duty of safety and the regulation of working time, also considering recent national and European Union case law, as well as the rules governing termination of the employment contract (para. 1–3).

The second part of the essay, starting from the manner in which the welfare state approaches the care of non-self-sufficient persons, reconstructs the causes, consequences and possible remedies of the widespread irregularity that characterises the sector, on the one hand, and examines the phenomena of labour ex-

[1] Although the essay is the result of a shared reflection, para. 2–4 of this contribution were written by Giulia Frosecchi, and para. 5–7 by William Chiaromonte.

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ploitation of which family assistants are often victims, highlighting in particular the limits arising from the application of Article 603-bis of the Criminal Code, on the other (para. 4–6).

## 2. The Legal Framework Applicable to Domestic Care Work

The first part of this essay examines, without any claim of exhaustiveness, some of the most critical aspects of the regulation of the employment relationship of domestic workers engaged in assisting non-self-sufficient persons. As highlighted within the "CARE4CARE – We Care for Those Who Care" project,[2] Italy is one of the European legal systems in which the relevant regulatory framework lends itself to important critical reflections.[3]

On the basis of the legislative notion—albeit imprecise (Montanari 2007) and variable (Persiani 1961, 629)—and according to a teleological characterisation (Basenghi 2000, 72–82), in the Italian legal system a domestic worker is defined as a person who performs work aimed at ensuring the functioning of family life,[4] that is, at meeting the personal needs of the employer and his or her family,[5] or at satisfying the needs of forms of cohabitation other than the family in the conventional sense, but nevertheless referable to that notion for classificatory purposes.

Within the field of domestic work, this contribution focuses in particular on the issues relating to domestic workers assigned to care work, whose function is not limited to the general "satisfaction of the living needs of those residing in the household" (Persiani 1968, 826), but consists in fulfilling the specific and distinctive task of assisting, or taking care of, the non-self-sufficient person. In this contribution, the Italian term commonly used to refer to such workers (*badanti*) is deliberately avoided, following discussions with stakeholders had in the context of the research project, during which attention was drawn to the negative value judgment embedded in that terminology (thus also, *inter alia*, de Martino 2021).

[2] See: <https://www.care4care.net> (accessed February 25, 2026). For an introduction to the project, see Vallauri 2025.

[3] As is the case with Spain: see Rönnmar 2025, who, based on the findings emerging during the research, highlights this aspect by comparing the two legal systems with those of the other partner countries in the project (France, Germany, Spain, Sweden, Poland).

[4] Court of Cassation, 1 October 2005, no. 6824, in *Giustizia civile*, 2005, 4.

[5] "For a community to possess a 'family' nature, it is necessary that there be stability, continuity and permanence of the persons composing it under the same roof, the absence of a profit-making purpose, observance of a principle of mutual assistance such as is found in families based on blood ties, and the presence of affectionate solidarity among persons sharing such common board and lodging" (Court of Cassation, 31 March 1983, no. 2354, in *Giustizia civile massimario*, 1983, 3); on the distinction from the employer's professional activity, see Court of Cassation, 30 August 2018, no. 21446, in *Diritto e giustizia*, 2018. On this point, see Milianti 2022, 578–79.

Domestic personal assistants belong to the care sector,[6] whose centrality has already been recognised at supranational level, both in the European Care Strategy[7] and by the International Labour Organization.[8]

Therefore, to ground the reflections that follow, a conceptual shift is made, compared with the traditional and consolidated domestic legal classification of personal assistants within the broader category of domestic work—a classification also found in most of the (numerous) collective agreements applicable in this field. This shift is justified by emphasising the defining element common to all the tasks performed by these workers, namely *care*.[9]

The first part of this study is limited to employment relationships based on a regular contract of subordinate employment concluded with a domestic employer,[10] and excludes both those who provide their services occasionally and are remunerated through the family voucher scheme (see Borelli 2020, 213–26), and irregular workers.[11]

The regulation of domestic work governing care employment relationships is laid down by statute and by collective bargaining, where applicable. The principal legislative references are: the sparse provisions of Articles 2240-2246 of the Civil Code; the other provisions of the Civil Code governing subordinate employment, insofar as compatible;[12] Law no. 339 of 2 April 1958, within the limits to be discussed shortly; and the provisions of special legislation governing subordinate employment that do not exclude domestic workers from their scope of application.

While Articles 2240-2246 of the Civil Code apply generally to employment relationships concerning domestic services, the prescriptive scope of the 1958 Law is further limited and is characterised primarily by a constitutive element

6 In continuity with the CARE4CARE – We Care for Those Who Care project, which defines them as "workers, without any qualifications, who take care of elderly, sick, dependent persons and persons with disabilities" (Vallauri et al. 2025a).

7 See European Commission 2022; cf. Vallauri 2025; Mazzetti 2025. Among EU sources, the Council Recommendation of 8 December 2022 on access to affordable high-quality long-term care is also relevant, which defines a "domestic worker providing long-term care" as any person employed to perform domestic work who provides long-term care in the context of an employment relationship (point 3, letter h).

8 ILC.112/Resolution V of 14 June 2024 classifies domestic workers within the "care workforce", 2.

9 "Care" thus enters the legal notion of domestic work providing personal assistance; see Vallauri 2025.

10 On the supply of care work, see Borelli 2023.

11 Reference is made to para. 5–7 of this essay.

12 This refers to the view that considers Article 2239 of the Civil Code applicable also to domestic employment relationships: see Basenghi 2000, 24–31, although the author regards certain exclusions as justified by incompatibility with the type of work (see Article 2087 of the Civil Code). The thesis supporting the applicability to domestic employment of the reference made by Article 2239 of the Civil Code is confirmed by Constitutional Court, 15 March 1994, no. 86; contra Offeddu 1986, 658. For a concise reconstruction of the debate concerning the special nature of the relationship, see Timellini 2003, 570.

of the distinct legal category: the time worked for the same employer must not be less than four hours per day. It follows that those who perform work in a domestic context for less than four hours per day fall within the scope of the Civil Code provisions alone (and of Law no. 940 of 27 December 1953), whereas those exceeding that threshold are subject both to Law no. 339/1958 and to the Civil Code provisions, where supplementation of the regulatory framework remains necessary.

Regarding the applicability of special legislation governing subordinate employment, such legislation excludes domestic work from the scope of certain provisions, obliging the interpreter to reconstruct a complex regulatory puzzle. Further complicating the framework is the wording used in the provisions introducing such exclusions. While some adopt the generic expression "domestic worker" (or the equivalent "family worker", of European origin), such as Legislative Decree no. 66/2003, others explicitly exclude only employment relationships governed by Law no. 339/1958, notably Article 4 of Law no. 108/1990.

Adhering to an interpretation slavishly faithful to the literal wording of the statutory provisions would lead to identifying further intricate and almost byzantine distinctions between the different legal categories, with paradoxical outcomes, such as applying the rules limiting dismissal only to domestic employers who fall outside the scope of Law no. 339/1958, that is, to the employment relationships in which the worker is presumably less integrated into the family context. The legal scholarship immediately argued that this distinction was the result of an "embarrassing oversight", promptly overcome through interpretation, by extending the exclusion from the obligation to provide justification for unilateral termination to all domestic employment relationships (Basenghi 2000, 302).

Moreover, the distinction between the two categories, from a practical standpoint—such as identifying which employers are subject to the obligation to justify dismissal—clashes with the inadequacy of the temporal threshold of "four hours per day". This criterion fails to account for the wide range of working-time arrangements that may be established within domestic employment. For example, one may question whether three hours per day for six days per week exclude the application of Law no. 339/1958, while work performed for four hours per day for three days per week falls within its scope.

The principal driver behind the regulation of domestic work through special legislation was the absence of collective bargaining, which was prohibited in the sector by Article 2068 of the Civil Code until the judgment of the Constitutional Court of 9 April 1969, no. 68. Through an ingenious argumentative device, the Court overcame the paternalistic cultural prejudice that considered employment relationships performed within the strictly private walls of the home, under a regime of "devoted loyalty", to be incompatible with collective representation of interests.[13]

[13] Constitutional Court, 9 April 1969, no. 68, in *Il diritto del lavoro*, 1970, II, 58; see Basenghi (2000), 35–8.

The establishment of the first employers' association in the sector followed shortly thereafter. *Nuova Collaborazione* was founded in 1969 (and still exists today, federated within *Fidaldo*) and, in 1974, signed—together with the National Federation of the Italian Clergy—the first collective agreement regulating domestic employment with FILCAMS-CGIL, FISASCAT-CISL and UDATCA-UIL.[14]

Even prior to the establishment of a formal bargaining framework, part of the academic literature did not exclude the possibility that statutory regulation might be "supplemented or even replaced by a discipline laid down by collective autonomy and more favourable to the worker", but only once "the trade union organisation of the categories has been completed" (Persiani 1968, 828). Here lies the central difficulty: not so much in the existence of employers' and trade union organisations aiming to regulate domestic employment collectively—which today are numerous, as are the collective agreements that proliferate in the sector[15]—but rather in the difficulty of recognising sufficient representativeness in the signatory organisations. Representativeness should reflect a genuine collective synthesis of individual interests, albeit mediated, a task made particularly complex by the highly individualised nature of employment relationships in this sector.[16] Moreover, as has convincingly been observed, the criteria established in the 2014 Consolidated Act on Representation for measuring trade union representativeness are ill-suited to domestic work, a sector in which there are no unitary or company-level trade union representations, and therefore no electoral data (Borelli 2023, 890).

Finally, it is noteworthy that the website of the National Council for Economics and Labour does not report coverage data for any of the collective agreements applicable to the sector.[17]

Regarding statutory regulation, the collective agreements currently in force tend towards merging the two legal categories, rejecting the distinction based on hours worked. A certain degree of uniformity can be observed in defining their scope of application as encompassing all domestic employment relationships in which the worker is "engaged in ensuring the functioning of family life and of family-structured forms of cohabitation".

[14] See Nuova Collaborazione 2024. For a historical reconstruction, see Ioli 2010, 207.

[15] Borelli (2023, 890–91) identifies 23 collective agreements; Casano (2022, 51–3) identifies 15 applying exclusively to subordinate employment under domestic employers and an equivalent number variously referable to that category; the CARE4CARE Project selected 16: see Vallauri et al. 2025a. Recently, CNEL identified 30 collective agreements referable to the heading "domestic and care work" (CNEL 2025, 85).

[16] Doubts regarding representativeness were already raised in the early 1990s: see Bianchi D'Urso 1990.

[17] Indeed, as regards the coverage rate of collective bargaining, CNEL itself notes that "critical sectors in relation to adequate wages, such as agricultural work and domestic work, remain uncovered in terms of information flows" (CNEL 2023, 17).

For the purposes of this contribution, primary reference will be made to the provisions of the *Fidaldo-Domina National Collective Agreement*, as it is signed by the trade unions commonly regarded as comparatively most representative, namely those affiliated with CGIL, CISL and UIL (hereinafter: the *Fidaldo NCBA*).[18]

## 3. The Subtractive Legislative Technique and the Role of Collective Bargaining

The technique through which domestic work has historically been regulated is frequently analysed by emphasising its "subtractive" force,[19] by reason of the numerous provisions governing subordinate employment from which domestic workers or domestic employers are exempted. It is true, however, that domestic work enjoys (so to speak) a special regime—a degree of legislative attention not reserved for workers in other sectors (perhaps with the exception only of seafarers, professional athletes, railway workers and a few others). Thus, if one were not to take as the starting point the special legislation governing subordinate employment, but rather Law no. 339/1958 and the provisions of the Civil Code, the regulatory technique of domestic work would appear rather "additive", in the sense that the special laws governing subordinate employment add, insofar as compatible, regulatory provisions also to domestic work.

This observation does not serve to challenge the nonetheless persuasive view that domestic work is regulated through a subtractive technique—a thesis capable of drawing attention to the reduced protection afforded to the workers concerned[20]—but rather to highlight the extremely sparse nature of the regulatory framework, which, at the time of its enactment, was embedded in an economic, cultural and social fabric, as well as in a labour market,[21] markedly different from that of today.

It suffices to consider the terminology that composes the illustrative list of domestic workers with "clerical functions" and that of "manual workers, specialised or otherwise", adopted by Law no. 339/1958.

It must also be added that, in articulating a special regime, the Law accorded the same legal consideration to those who take care of horses, those who wash laundry, and those who—even without a diploma—care for children. The conceptual flaw of superimposing roles that are not comparable, due to heterogeneity of competences and tasks, allegedly justified in the 1958 Law by the homogeneity of the employer, is even more evident today, when domestic workers no longer constitute

[18] For an overall critical reading, see Borelli 2020, 177 ff.

[19] Basenghi 2000; 2010; more recently reiterated by de Martino 2021, to which reference is made for an examination of the regulation of the sector during the COVID-19 period, and by Borelli 2023.

[20] The European Care Strategy highlights the risk that, for live-in carers, working conditions may even be "exploitative" (European Commission 2022).

[21] This is the analytical approach adopted in the volume edited by Casano 2022, which focuses on the capacity of collective bargaining to contribute to the construction of a care labour market; for example, Casano 2022, 44.

a "insignificant minority",[22] and domestic personal care has become one of the cornerstones of contemporary societies.[23] In this respect, the regulation of domestic work, in attempting to specialise the discipline, ultimately errs through excessive generality, insofar as it fails to distinguish between the performance of tasks serving the household or fully self-sufficient family members and the performance of care tasks for persons who are partially, if not entirely, non-self-sufficient. We are therefore confronted with a special regime applicable to a group of subordinate workers that is formally a species, but in practice functions as a genus, within which a distinct subcategory must be identified—namely domestic care workers. These are workers who, although operating within a domestic environment, perform specific tasks that should be distinguished, also at the level of legal classification, from those performed by workers commonly referred to as housekeepers (*colf*).

Collective bargaining, evolving over time, offers a more up-to-date representation, but departs only partially from the legislative framework. In many cases, it continues to treat all professional roles employed by a domestic employer as conceptually unified, while differentiating them through grading classifications.

The construction of professional profiles in the numerous collective agreements applicable to the sector (or sectors, considering the multiplicity of agreements directly referable to domestic care workers) is heterogeneous.[24] First, it should be noted that workers performing, without autonomy, the less complex tasks of maintaining or caring for the household or animals are placed at a different classification level from those performing relational tasks involving members of the family. Unlike the legislative framework, however, the presence of roles specifically devoted to assisting non-self-sufficient persons[25] is a constant feature across all collective agreements governing domestic work. These agreements generally provide for a higher classification level—with significant wage differentials (under the *Fidaldo NCBA* amounting to almost 300 euros)—for workers able to demonstrate specific training through possession of a recognised diploma.[26] Nonetheless, collective bargaining does not establish a clear

[22] Romagnoli 1990, 520, commenting on the exclusion of domestic employers from the obligation to justify dismissal provided for by Law no. 108/1990 (my translation).

[23] The Domina Report 2024 refers to approximately 1.6 million legally registered domestic workers; both the latest Eurostat data (2023) and the Domina Report 2024 indicate that around 50% of domestic workers legally employed in Italy are care workers. See also De Simone 2019, 658.

[24] In addition to the *Fidaldo NCBA*, some of the collective agreements selected within the CARE4CARE project were consulted, including the FMPI-CONFINTESA; CONFAPI-UNSIL; and ESAARCO-UGL collective agreements.

[25] The definition of a "non-self-sufficient" person for classification purposes may be derived from the *Fidaldo NCBA* (and similarly from the other agreements), where it is understood as a person who is not able to perform the most important activities relating to personal care and social life (Article 10, minutes note).

[26] The issue of remuneration is not addressed in this contribution for reasons of space. It should nevertheless be recalled that Article 36 of the Constitution applies also to this sector, as expressly established by Court of Cassation, 23 October 1985, no. 5211, in *Giustizia civile*, 1985, 10 ff.

separation in classification between domestic care workers and other domestic employees. For example, under the *Fidaldo NCBA*, a trained personal care assistant is classified at the same level as a "household manager" and a "trained family educator".[27]

Taking the statutory framework as the principal reference point and resorting to the *Fidaldo NCBA* only residually, the following paragraphs will briefly examine the (non-)regulation of two of the many institutions affected by the subtractive technique: the duty of health and safety protection and certain aspects of working time. These have been selected because of their capacity to illustrate clearly both the reduced level of protection afforded to domestic workers and the consolidated legislative and bargaining approach to regulating the sector, still rooted in a distant cultural legacy that can no longer be perpetuated.

### 3.1 Health and Safety Obligations in Domestic Employment

The duty to ensure health and safety within domestic employment relationships is characterised by the absence of an articulated and structured protective framework,[28] although it would be inconceivable to admit the outright exclusion of the domestic environment from the scope of this institution.[29]

A fortiori, there are no provisions expressing specific legislative—or indeed collectively bargained—attention to the risks deriving from the tasks performed by domestic workers who assist non-self-sufficient persons (De Vita 2009, 8; Angelini and Pascucci 2010, 233–34).

At the level of Civil Code protection, a recent judgment of the Court of Cassation has dispelled any remaining doubts regarding the applicability of Article 2087 of the Civil Code to domestic employment relationships.[30] Without engaging, in truth, with the related academic debate,[31] the Supreme Court affirmed the "decisive significance within the protective framework" of Article 2087 also in a case concerning an accident occurring in a domestic employment context, with the well-known consequences, not only as regards the contractual nature

[27] For a reading of the articulation of professional profiles in care work, see also Negri 2022 and Guerra and Negri 2022.

[28] Legislative Decree no. 81/2008—as previously Legislative Decree no. 626/1994 and Framework Directive EEC 391/1998—excludes from the definition of "worker" for the purposes of its application those "engaged in domestic and family services" (Article 2(1)(a)).

[29] Regarding the peculiarity of this "working environment", see Basenghi 2000, 239, and Angelini and Pascucci 2010, 223 ff., who clearly describe its hazardousness.

[30] Court of Cassation, 24 August 2023, no. 25217, in *Diritto delle relazioni industriali*, note by Tagliabue 2024.

[31] In legal scholarship, the applicability of Article 2087 of the Civil Code to domestic employment relationships has long been debated: Timellini 2003a, 581, firmly rejected it; Basenghi 2000, 240, denied its formal applicability, albeit with certain openings (241 ff.); Romei 1997, 74, and Angelini and Pascucci 2010, 240, supported its applicability subject to a compatibility assessment; Adapt 2009, 10; the same conclusion may also be reached on the basis of the analysis conducted by Albi 2008, 174.

of the safety obligation, but also with regard to the burden of proof: the domestic employer is likewise required to "prove that the damage was due to a cause not attributable to him or her, that is, that he or she fulfilled the safety obligation by adopting all measures necessary to prevent the harm".[32]

The judgment confirms that, regardless of the succession of special regulatory regimes, Article 2087 retains its function as a "closing provision of the entire system" (for all, Romei 1997, 63). From this derive both a "specific preventive obligation" (Timellini 2003b, 806) applicable also within domestic (including domestic care) employment relationships, and the applicability of the principle of "maximum technologically feasible safety", understood as an obligation of means and not of result, continuously adapting to the evolution of circumstances, according to which "it is not possible to eliminate risks entirely, but every effort must be made to eliminate them" (Del Punta 1999, 153; see also Romei 1997, 65 ff.). The relevance of this principle to the sector under examination is further supported by the same judgment of the Court of Cassation, which establishes the employer's liability—in that case a domestic employer—

> not only in the event of violation of known technical or experiential rules, but also for failure to adopt all measures and precautions capable of safeguarding the worker's physical and psychological integrity in relation to the specific situation of risk (Court of Cassation, 24 August 2023, no. 25217).

In addition to constitutional principles, Article 6 of Law no. 339/1958 supplements this framework by prescribing two obligations, partially overlapping in content. The first applies to employers of live-in domestic workers and requires them to provide "an environment not detrimental to the worker's physical and moral integrity, as well as healthy and adequate nutrition". The second, broader in scope, as it protects all domestic workers falling within Law no. 339/1958, consists in a general duty to safeguard the worker's health (though not expressly safety), "particularly where sources of infection are present within the family".[33] The special statute thus identifies a distinct health risk factor within the domestic environment—namely the presence of infectious sources—which is particularly sensitive in the case of workers engaged in assisting non-self-sufficient persons, thereby requiring the employer to adopt specific preventive measures.

Domestic care workers entitled to board and lodging would therefore be entitled to protection under both of the aforementioned profiles, although the obligation to provide an environment not detrimental to physical and moral integrity—essentially mirroring the wording of Article 2087 of the Civil Code—

[32] However, in the view of the present authors, reference to Legislative Decree no. 81/2008 is merely incidental and cannot be interpreted as extending the applicability of the decree to domestic workers, as such an interpretation would be *contra legem*; *contra* Tagliabue 2024.

[33] The issue of heightened infection risk in domestic employment was particularly debated during the COVID-19 pandemic; on this point, see de Martino (2021) and the bibliography cited therein.

would in itself be sufficient to encompass the full spectrum of traditional health and safety protections afforded to workers.

However, it must be emphasised that the exclusion of Article 2087 of the Civil Code, advocated in part of the academic literature, would raise significant critical issues for all the employment relationships under consideration.

First, since Article 6 of Law no. 339/1958 applies only to domestic workers employed for at least four hours per day, its exclusive application would leave a segment of workers—not easily identifiable in practice—without protection.

Secondly, excluding Article 2087 would result in the unacceptable removal of the principle of "maximum technologically feasible safety".

Even if one were to criticise, at a systemic level, the use of that jurisprudential formula, the safety obligation laid down in Article 2087 is circumscribed by a standard of reasonableness anchored in the requirement to act with diligence appropriate to the "nature of the activity carried out" (Article 1176 of the Civil Code),[34] which limits its scope to what is fairly and reasonably expected. It would therefore appear unreasonable to deny its applicability to domestic employers.[35]

Finally, it may be questioned whether the protection of health alone, as provided by Article 6 for domestic workers not entitled to board and lodging, is sufficient to establish a contractual obligation comparable to that arising under Article 2087—an obligation that extends to both physical and moral integrity and carries significant implications regarding the burden of proof—and whether such protection should, in any event, be interpreted in a manner that excludes a broader duty of safety on the part of the employer, at least with regard to non-live-in workers who are excluded from the more specific protection under Article 6 of Law no. 339/1958.

### 3.1.1 The Limited Contribution of Collective Bargaining

Having established the necessary applicability of both the Civil Code provision and the special statute, in the absence of a regulatory framework—even a "minimal" one (Angelini and Pascucci 2010, 24)—concerning prevention and protection in the domestic employment context, significant critical issues remain about the concrete measures to be implemented. This is even more so given that collective bargaining has not assumed the role of elaborating a structured discipline in this field.

[34] Albi 2008, 212, is among the most critical voices regarding the use of the "maximum technologically feasible safety" standard.

[35] Avoiding the ideologically hyper-protective rhetoric towards the employer and his or her limited economic means, as appears to be suggested by Timellini 2003a, 581, and equally avoiding an over-expansive reading of this principle that would render it impracticable in the domestic sphere, thereby requiring the adoption of a "static perspective of the safety obligation" (Basenghi 2000, 241–42).

The provisions of the collective agreement could potentially serve as a useful benchmark for assessing compliance with Article 2087 of the Civil Code, insofar as they might give substantive content to the principle of "maximum technologically feasible safety" within the domestic environment, including in relation to the specific needs of workers assisting non-self-sufficient persons. Nevertheless, these expectations are largely disappointed.

Article 28 of the *Fidaldo NCBA*, after establishing a general right of workers to a "safe and healthy working environment", provides that, to achieve this objective, employers must install "an appropriate residual current circuit breaker, the so-called life-saving device", in the electrical system. This constitutes the only concrete preventive measure elaborated within the bargaining framework.

Only one further obligation incumbent upon the employer is added to what seen above, which is to be fulfilled at the time of assignment of duties or upon subsequent modification thereof. It consists of a rather modest informational duty concerning

> any risks existing in the working environment, including those relating to the use of equipment, including telematic and robotic tools, and exposure to particular chemical, physical and biological agents.

The absence of further references to preventive obligations is striking. Were it not for the legislative framework and the aforementioned Supreme Court ruling—which clearly continues to apply even where the collective agreement is in force—one might fear that proper compliance with such informational duties could give rise to a disproportionate expectation that the worker autonomously organise his or her own preventive protection.

This concern might be mitigated only if the clause "on the basis of applicable legislation", appended to the contractual recognition of the right to a safe and healthy working environment, were optimistically interpreted as an attempt to suggest the extension, insofar as compatible, of at least some of the provisions of Legislative Decree no. 81/2008 to domestic workers.

The intention of partially reintegrating health and safety protection in the domestic sphere into the broader regulatory system seeks to overcome the unjustified underestimation of the element that assimilates domestic workers to other workers: namely, the performance of work for the benefit of another (Angelini and Pascucci 2010, 241).

This need is even more compelling in the case of domestic care workers whose tasks are comparable to those performed by socio-healthcare assistants employed in residential care facilities,[36] where Legislative Decree no. 81/2008 unquestionably applies.[37]

[36] For reflections on certain aspects of the regulation of socio-healthcare assistants (OSS and OSA) employed in residential care facilities (RSA), see Renzi 2025.

[37] Angelini and Pascucci 2010, 233–34, referring to tasks similar to those performed by nursing staff.

### 3.2 Issues Concerning Working Time

With regard to working time, in light of the exclusion of domestic workers—pursuant to Article 17(5) of Legislative Decree no. 66/2003—from the scope of application of the provisions concerning "normal working hours" (Article 3), "maximum duration of working time" (Article 4), "overtime work" (Article 5), "daily rest" (Article 7), the "break regime" (Article 8), and the "organisation and duration of night work" (Articles 12 and 13), as well as the implicit repeal, by the same decree, of Articles 7, 8, 9 and 10 of Law no. 339/1958,[38] workers providing personal assistance within the family sphere are left only with the protections provided by the remaining provisions of Legislative Decree no. 66/2003, by Article 2243 of the Civil Code, and by the applicable collective agreement.[39]

Given the minimal content of the Civil Code provision, which "introduces a general right to weekly rest (Basenghi 2000, 274), in accordance with custom, and to annual leave", the collective agreement—notwithstanding the critical issues already noted in terms of its diffusion and effective representativeness—becomes decisive, functioning as the sole normative source governing daily and weekly rest, maximum working time (set at 54 hours under the *Fidaldo NCBA*) and overtime work.

The almost complete legislative deregulation of working time in domestic employment cannot be justified by reference to the specificity of the employer or of the environment in which the work is performed, namely the private household, nor even by invoking the "marked and atypical emotional gradient" that may characterise such relationships (Basenghi 2000, 271). On the contrary, if one were to justify the previously noted dilution of health and safety obligations on such grounds, it would be necessary, as a counterbalance, to safeguard the worker's physical and moral integrity at least through a careful and balanced normative composition of working time.

As from 19 December 2024,[40] even the argument based on European legislation ceases to provide a valid pretext, insofar as the directive allows derogations for "family worker".[41] According to the interpretation of the Court of Justice, this exception cannot be used indiscriminately to support the legitimacy of a broad exclusion of domestic workers from working time protections.[42] In the Loredas judgment, the Luxembourg judges clarified that the margin of discretion granted to Member States under Directive 2003/88 cannot result in "depriving

[38] Basenghi 2010, 215; 2000, 274, emphasising that the provisions already "shone for modesty of content".

[39] See Articles 13, 14 and 15 of the *Fidaldo NCBA*.

[40] CJEU, 19 December 2024, Case C-531/2023, *Loredas*.

[41] Article 17(1)(b) of Directive 93/104/EC.

[42] It should be recalled that ILO Convention no. 189/2011 also requires Member States to ensure equal treatment (including in relation to working time) between domestic workers and other subordinate workers employed in productive or service sectors (Article 10).

of substance the rights enshrined in Article 31(2) of the Charter, in Articles 3 and 5, and in Article 6(b) of the Directive" (CJEU, *Loredas*, para. 35), with the evident consequence that, in order to ensure the effectiveness of the Directive, domestic workers must also benefit from minimum daily and weekly rest periods and from the maximum limit on average weekly working time provided by the Directive (CJEU, *Loredas*, para. 38).

The specific issue addressed in Loredas concerns the measurement of working time, understood as a necessary precondition for enabling workers to challenge violations of their rights, and a particularly sensitive issue in contexts of live-in assistance to non-self-sufficient persons.[43] To such an extent that collective bargaining itself acknowledges—and legitimises—an anomaly in the temporal commitment characteristic of such employment relationships. The *Fidaldo NCBA* provides that "in case of emergency, work performed during night-time and daytime rest periods shall be regarded as ordinary", if it is "absolutely occasional and unforeseeable". From a reciprocal perspective, the additional work so performed does not give rise to increased remuneration, but "only to an extension of the rest period". Only additional hours agreed at least one day in advance qualify as overtime and attract the corresponding premium. Domestic care workers assist individuals who structurally require interventions that are difficult to schedule and therefore inherently unpredictable. At the same time, the further requirement of "occasionality", expressed without any temporal reference parameters, risks losing any real deterrent effect against systematic recourse to this anomalous form of work, which might be described as ultra-ordinary.

The conclusions reached in Loredas, developed in continuity with the Deutsche Bank judgment,[44] according to which effective enforcement of working time rights requires the establishment of "a system enabling the duration of time worked each day by each worker to be measured objectively and reliably, and enabling the number of hours worked beyond normal working time to be determined" (CJEU, *Loredas*, para. 38), call into question the legitimacy of Article 39 of Decree-Law no. 112/2008 (converted into Law no. 133/2008). That provision exempts domestic employers—unlike other private employers—from the obligation to establish and maintain a unified labour register in which all subordinate workers are recorded and in which, for each worker, the daily number of hours worked, overtime, absences (including unpaid absences), holidays and rest periods must be registered.[45]

Concluding this brief reflection on working time, at least one (perhaps unintended) merit must be acknowledged in the 1958 statute. In accordance with Article 9(4) of Legislative Decree no. 66/2003, which preserves "special pro-

[43] For a critical reflection, see Borelli 2021, 290.

[44] CJEU, 31 January 2019, Case C-55/18, *Deutsche Bank*, annotated by Gentile 2019; see also Giampà 2022.

[45] Although, following *Deutsche Bank*, the provision would already be questionable, since it does not provide for an obligation to record workers' start and end times: Gentile 2019, 616; Leccese 2022, 8 ff.

visions allowing weekly rest on a day other than Sunday", the statute requires the employer to "grant the worker the time necessary to fulfil the essential duties of his or her religion" (Article 6). This mandatory provision of substantive protection pre-empts—at least within domestic employment—the traditional dilemma concerning religious freedom in the workplace, typically addressed through anti-discrimination law, by promoting a form of inclusive neutrality within the domestic sphere.[46]

However, it would be illusory to argue that this provision contradicts the many anachronistic elements of the statute in which it is embedded. At the time of its enactment, it was perfectly consistent with a legislative technique that recognised only minimal protections for domestic workers in a scarcely multicultural society in which Catholic worship predominated. The paradoxical anachronism of this apparently advanced protection is unfortunately confirmed by Article 13(5) of the *Fidaldo NCBA* ("Weekly Rest"), which, in the case of a worker professing a religion that observes a day of rest other than Sunday, invites the parties to agree on an alternative rest day, but ultimately provides that, in the absence of agreement, Sunday shall prevail.

### 4. Overcoming the "Paternalistic" Subtraction through a "Reasonable" Recalibration

The analysis of the special regulatory regime governing domestic employment relationships, and of its markedly derogatory character, developed in the first part of this contribution, has been confined to certain elements of two institutions considered particularly representative, both because of the high value of the legal interests only partially protected and because of the systematic manner in which the legislature has applied the subtractive technique, with the partial endorsement of collective bargaining.

Many other institutions and aspects would have lent themselves to examination. Their exclusion has been motivated exclusively by reasons of space, which required a rigorous and limited selection.

Among the other institutions whose regulation within domestic employment presents distinctive critical issues, foremost is the employer's unrestricted right of termination. It is well known and widely acknowledged that domestic employment remains one of the few residual instances of dismissal at will, because of the express exclusion of domestic employers, under Article 4 of Law no. 108/1990, from the obligation to specify the reasons for dismissal, with the resulting lacunae in the system of remedies for unlawful termination (De Simone 2007, 568; 2019, 659). Even the European Committee of Social Rights, in its conclusions of 2003, 2007 and 2008, highlighted the violation of the obligation arising under Article 24 of the European Social Charter to provide "adequate compensation or other appropriate relief" for workers dismissed without valid reason, observ-

[46] On this point, inter alia, Voza 2024; Lo Faro 2024; Frosecchi 2024.

ing that "the lack of protection against dismissal for domestic employees went beyond the provisions of the Appendix to Article 24".[47]

The employer's freedom to terminate at will constitutes the principal critical feature of the sector's regulatory system. It undermines the effectiveness of many other protective institutions, since the safeguards they provide "may in practice be sterilised by the employer's freedom to terminate",[48] ultimately generating a misleading equivalence between open-ended contracts and employment stability.[49]

Remaining within the sphere of termination, from the worker's perspective doubts of legitimacy arise primarily in relation to the provision excluding domestic workers from the obligation to submit resignations exclusively through the telematic procedure established by Article 26(7) of Legislative Decree no. 151/2015. The exclusion of domestic workers from this protective mechanism is consistent with the tendency to prevent public oversight from penetrating the domestic employment relationship, due to its close connection with private family life. However, this approach marginalises both the structural elements of subordination and the inherent contractual weakness of the worker—precisely the rationale underlying the telematic resignation system. Similarly, labour inspection activity is constrained by the coincidence between workplace and private domicile (De Simone 2010, 383).

Considering the foregoing, the possibility—suggested in *Loredas*—that a special regulatory provision, less favourable than the general regime and applicable exclusively to a sector characterised by an overwhelmingly female workforce,[50] may amount to indirect sex discrimination invites serious reflection on the domestic legal framework governing domestic employment.[51] This is even more compelling in view of Italy's ratification of International Labour Organization Convention no. 189 on domestic workers, whose provisions insist upon the equalisation of working conditions between domestic workers and workers employed in other productive or service sectors.[52]

[47] Most recently, European Committee of Social Rights (2008); on this point, De Simone (2010), 395.

[48] With regard to termination, it should also be recalled that the statute excludes domestic workers from the prohibition of dismissal under Article 54 of Legislative Decree no. 151/2001 (maternity protection), although protection is extended by the *Fidaldo NCBA* (Article 25), thus demonstrating the at least potential expansive force of collective bargaining in the sector; for further discussion, also in relation to possible violations of ILO Convention no. 189, see Borelli (2020), 176 ff.

[49] Basenghi 2010, 214, with reference to Article 2103 of the Civil Code.

[50] Article 13 of Law no. 689/1981; see Chiaromonte (2025). This legislative choice was criticised by the ILO Committee of Experts on the Application of Conventions and Recommendations; see ILO, *Labour inspection*, Report III (Part 1B), ILC, 95th Session (Geneva, June 2006), para. 264.

[51] In the case at issue, concerning Spain, the percentage of women amounted to 95%: CJEU, *Loredas*, para. 23.

[52] CJEU, *Loredas*, para. 56–9; previously CJEU, 24 February 2022, Case C-389/20, *TGSS*; see Chieregato 2022.

Specifically, to avoid the risk of systemic indirect discrimination—or of a proliferation of indirect discriminatory effects affecting a substantial portion of the rules governing domestic care work—it is appropriate to consider a reasonable recalibration of the regulatory framework. Such recalibration should consider the peculiarities of the relationship and the consequent need for a special regime but must definitively abandon the paternalistic approach that has long characterised the sector.

Just as the liberalisation of collective bargaining represented a decisive moment in which the legal system actively promoted social change, contributing to overcoming entrenched cultural resistance to unionisation in the sector, the time has now come to abandon the marginalisation of domestic employment regulation[53] and to embark upon a second phase of modernisation. This reform process[54] should also recognise the specific nature of domestic care work and its distinctive protective needs.[55]

## 5. Contextual Data

The second part of this contribution examines two distinctive dimensions of domestic work performed in the care sector for the benefit of non-self-sufficient persons which, in the Italian experience, appear particularly significant. This is, indeed, a sector strongly characterised, on the one hand, by irregularity and, on the other, by the frequent presence of forms of labour exploitation—both lawful and unlawful.[56]

Following once again the methodological approach adopted in the CARE4CARE research project, the analysis will be conducted exclusively regarding paid domestic care work, thus focusing on care workers rather than caregivers (those who provide care on an unpaid basis[57]), while acknowledging the close interconnections between paid and unpaid care work (Borelli 2023, 883).

[53] The ratification of Convention no. 189 by so-called developed countries cannot be taken for granted: it is noteworthy that two States with high standards of protection, such as Poland and, even more strikingly, France, have not ratified it. On this point, see Rönnmar 2025.

[54] Metaphorically described as the "Cinderella of subordinate employment" (De Simone 2019, 657).

[55] For a critical analysis of the incapacity of public welfare to respond adequately to families' needs, see Borelli 2020, especially 11 ff.; even Law no. 33/2023 (the so-called delegation law on non-self-sufficiency) has not been welcomed enthusiastically in legal scholarship; for a first critical analysis, see Pioggia 2023.

[56] The Policy Paper developed within the CARE4CARE project (see CARE4CARE Consortium 2025, Kocher 2026) emphasises that "Undeclared work, including 'bogus' self-employment, is present in care work in many countries within the EU, especially in live-in-care, with risks not only of exploitation and substandard working conditions, but also of unfair competition against institutions that offer regular employment" (p. 4). With regard to the Italian situation, see Vallauri et al. 2025a; 2025b. For a comparative perspective, see Rönnmar 2025; Camas Roda et al. 2025.

[57] On the distinction between paid care work and unpaid care work, see ILO 2018a. With regard to the social protection of informal caregivers, who aid in the absence of a contractual

In particular, the discussion will concern not so much work performed under a regular contract of subordinate employment, but rather work performed irregularly, in the awareness that the latter scenario is the one that most frequently gives rise to phenomena of labour exploitation.

In the following pages, reference will be made to family assistants. This is the term that, also in line with the leading sectoral collective agreement (*Fidaldo NCBA*, Article 1.), has been chosen to avoid the commonly used expression of *badanti*, which carries an implicit demeaning judgment both towards those who provide care and those who receive it.[58]

The analysis will focus exclusively on situations in which the regulatory framework applicable to family assistants is violated, along a continuum ranging from partially irregular work (so-called grey work), through undeclared work (so-called black work), to the most serious forms of exploitative labour.

As will become clear, the widespread incidence of undeclared work in the domestic sector produces significant repercussions, first and foremost for workers, primarily in terms of reduced protections and guarantees, but also for employers and for the economic system, generating greater instability and loss of tax and social security revenue (Osservatorio Nazionale Domina 2024, 80). Although the second part of this contribution concentrates exclusively on the vulnerability of family assistants, an autonomous reflection would also be warranted on the analogous vulnerability often experienced by employing families, who—particularly in view of the special bond that may develop with the worker entrusted with the care of especially fragile individuals—see the traditional position of dominance characterising the employer in subordinate employment relationships attenuated.

Before addressing irregularity and exploitation in greater depth, it is useful to consider the most recent data concerning domestic work in Italy.

In 2024, domestic workers contributing to the National Social Security Institute (INPS) numbered 817,403, marking a decline for the third consecutive year following the significant increases recorded in the 2020-2021 biennium. Those increases were attributable, on the one hand, to the regularisation of employment relationships aimed at obtaining the self-certification required to travel to work during the lockdown period and, on the other, to the latest regularisation procedure for foreign workers introduced by Decree-Law no. 34/2020 (to which reference will be made below) (INPS 2025, 1). Notwithstanding this decline—which suggests not so much a decrease in demand from families as a possible intensification of irregular employment—and confirming the prospective relevance of the sector, it is estimated that care work in Italy, within

bond, see D'Onghia 2024a. The gender dimension of care work within the family sphere is explored by Zilli 2022.

[58] Sciurba 2015, 79. In the same sense, de Martino 2021, 57, recalling that Ambrosini 2013, 96, points out that in the past the term referred to those who supervised livestock.

which domestic work plays an essential role, could generate approximately 1.4 million new jobs by 2030.[59]

The total number of domestic workers is divided almost equally between family assistants (50.5%) and household workers (49.5%) (INPS 2025, 6). It is noteworthy that, for the first time in 2024, family assistants slightly outnumbered household workers.

As anticipated, gender and migration status are defining features of the workforce in this sector.

Women account for 88.9% of domestic workers (INPS 2025, 2).

Regarding nationality, foreign workers represent 68.6% of the total, the majority originating from Eastern Europe (34.8%).[60] It is worth recalling that domestic work has traditionally represented one of the principal "entry occupations" into the labour market for newly arrived migrant women in Italy, contributing to the social and economic sustainability of migration flows towards the country (Lutz 2016). At the same time, domestic work tends to function as an occupational trap for foreign women workers, especially following the transition from short-term or circular migration patterns to more stable forms of settlement. Once employment in the sector has been secured, it is extremely difficult for these workers to escape this form of occupational segregation and obtain employment in other sectors or in more qualified roles, also in view of the low turnover rate characterising domestic work (Noviello and Parente 2024, 65).

Regarding age, domestic workers are generally older than workers in other sectors. Workers aged 60 or over account for 23.9% of the total, while those aged between 55 and 59 account for 18.1%. Only 1.5% are under the age of 25. With specific reference to family assistants, the average age in 2023 was 52.1 years, and 64.9% were at least 50 years old (Osservatorio Nazionale Domina 2024, 60). These data not only indicate a relatively advanced workforce, but also reveal a progressive ageing trend, with significant implications in terms of imminent exit from the labour market and insufficient generational replacement to meet families' needs, representing one of the most critical challenges facing them (Fondazione Studi dei Consulenti del Lavoro 2023, 11).

Regarding working time, almost 45% of family assistants work more than 40 hours per week, with a strong concentration at the contractual maximum of 54 hours established by collective bargaining (*Fidaldo NCBA*, Article 14). Only 6.3% work fewer than 10 hours per week (Osservatorio Nazionale Domina 2024, 63).

[59] ILO 2018b, 4. With specific reference to family assistants, it is estimated that in Italy the labour demand in the personal services sector for the three-year period 2026–2028 will amount to 938,600 (2026), 949,100 (2027) and 957,600 persons 2028; see Centro Studi e Ricerche Idos 2025.

[60] INPS 2025, 3. This is followed by workers holding Italian citizenship (31.4%, a percentage that obviously also includes those who subsequently acquired Italian citizenship), those from South America (8.5%) and those arriving from East Asia (5.8%).

Closely linked to working time is the issue of remuneration. The sector is characterised not only by low wages—23.4% of family assistants earn an average annual income between 6,000 euros and 10,000 euros; 36% earn more than 10,000 euros; only 20.8% exceed 13,000 euros—despite often being employed full-time and notwithstanding considerable employment discontinuity, frequently linked to the lifespan of care recipients (Fondazione Studi dei Consulenti del Lavoro 2023, 15)—but also by the peculiarity that it is one of the few sectors in which women earn, on average, slightly more than men.

The proportion of workers earning more than 12,000 euros per year is higher among women (21.5%) than among men (19.3%), whereas men are more concentrated in the lowest income bracket. This depends essentially on the fact that women more frequently occupy longer-term roles involving greater responsibility, such as caring for elderly and non-self-sufficient persons, whereas men are more often employed in reduced-hour tasks such as cleaning or gardening (Osservatorio Nazionale Domina 2024, 92).

The issue of low remuneration is closely connected to families' capacity to bear the cost of care. Most domestic employers are at least 60 years old (70%), and 37% are over 80. Their principal source of income is therefore pension benefits. Many elderly persons are unable to meet care needs solely through their pension, particularly considering rising costs. The majority can afford assistance for approximately five hours per week (55%), whereas only a small percentage can sustain assistance of 40 or 54 hours per week (7.7% and 6.69%) (Osservatorio Nazionale Domina 2024, 99).

The unequal economic capacities of those resorting to the market tend to crystallise pre-existing structural inequalities and, at the same time, to worsen the working conditions of care workers (Militello 2024, 360). Low wages and families' limited spending capacity contribute to placing care work—even where formally regular—among the poorest segments of the labour market (Militello 2024, 357).

The figures cited thus far concern regular employment relationships. However, domestic work is the sector with the highest density of irregular employment compared to the average across all economic activities.[61] In 2022, against an average irregularity rate of 9.7%, undeclared work in the domestic sector reached 47.1% (Osservatorio Nazionale Domina 2024, 77). Considering that approximately 1.7 million individuals are registered with the National Social Security Institute as either domestic workers or employers, applying the irregularity rate suggests that more than 3.3 million persons are involved in the sector irregularly. In other words, in Italy one out of every two domestic employment relationships is wholly or partially irregular, notwithstanding the extensive leg-

[61] The concept of "irregularity", which in this case refers to the employment contract, may also concern the worker's residence status; for this reason, in the domestic work sector irregularity assumes a dual dimension.

islative derogations from the general protective regime of subordinate employment (de Martino 2021, 59).

It is therefore impossible to analyse domestic work—and especially the work performed by family assistants—without first undertaking a reconstruction of the causes, consequences and possible remedies of its widespread irregularity, which often constitutes fertile ground for the development of exploitative practices. These causes are deeply rooted in the way the Italian welfare state has historically approached, and continues to approach, the care of non-self-sufficient persons.

## 6. Irregularity: Causes, Consequences and Possible Remedies

For many years, the familistic welfare model that characterised Italy allowed the State to disengage largely from responsibility for the care of non-self-sufficient persons, transferring this burden onto families—more precisely, onto women's unpaid labour.[62]

The crisis of this model—caused, *inter alia*, by the growing need for support in care work within families, itself driven by demographic ageing and transformations in the country's social structure, including increased female labour market participation and changes in family organisation[63]—together with the progressive reduction of public expenditure on welfare services and the consequent impetus towards the privatisation of care provision, has given rise to what has been described as do-it-yourself welfare.[64]

The increase in demand for care services has prompted reform of long-term care systems throughout the European Union, also considering the European Care Strategy.[65] In Italy, this process—accelerated by the pandemic and supported by the National Recovery and Resilience Plan (PNRR), which allocates significant resources to elderly and disability care—has been initiated.[66] However, the long-awaited comprehensive reform concerning non-self-sufficiency has, for the time being, taken only initial steps. Within this framework, families remain essentially responsible for addressing care needs, partly by bearing the burden directly[67] and partly by purchasing services on the market.

Where the latter route is chosen, the only financially sustainable solutions are those that make it possible to secure care services—even with the assistance of limited cash transfers provided by the State—at a cost compatible with fam-

[62] Saraceno 2003. For an overview of the evolution of the national welfare state, see, among many others, Giorgi and Pavan 2021.

[63] Noviello and Parente 2024, 63. See also Borelli 2020, especially 24 ff.

[64] Most recently, Borelli 2023, 885. See also Sarti 2016.

[65] On the European Care Strategy, presented by the European Commission in September 2022, see Mazzetti 2025.

[66] Reference is made to Delegation Law no. 33/2023 (on which see Gori 2023) and to Legislative Decree no. 29/2024. For a labour law reading of these two measures, see Gualandi 2025.

[67] On informal care work, see again D'Onghia 2024a.

ily budgets. For this to be feasible, the cost of care work must remain lower than the income that individuals can earn in the labour market by reallocating the time freed from care responsibilities.

The gradual displacement of care work from its "natural" location within the family has therefore made it necessary to externalise a service that, based on the erroneous assumption that it requires no particular competences[68] and that must be provided at competitive costs for the reasons just mentioned, is increasingly entrusted to vulnerable subjects within the labour market (Pavlou 2021, on which see Papa 2023).

The need to contain—legally, primarily through the subtractive legislative technique already referred to, and illegally, through widespread recourse to irregular employment—the cost of care work under this configuration has further contributed to its devaluation (Vallauri 2025). It has favoured reliance on paid family assistants, often of foreign origin. In this way, the traditional model of family-based care has progressively been replaced—through global care chains—by a model based on the "migrant in the family" (Borelli 2023, 886).

For all these reasons, family assistants represent not only an essential response to the growing demand for care in situations of non-self-sufficiency, but also—owing to the compression of their rights, tolerated by the public apparatus in order to preserve social equilibrium (de Martino 2021, 60–1)—the most economically convenient instrument for compensating for the shortcomings of the welfare state,[69] especially where work is performed irregularly.

These brief observations capture only some of the factors underlying the widespread diffusion of irregular employment in the domestic sector. In addition to deficiencies in the welfare state, political and institutional inertia in managing non-self-sufficiency policies, and the relative indifference of the administrative apparatus towards regularity in the sector (de Martino 2021, 61), other elements also contribute to the persistence of irregular employment relationships.

A study by Maurizio Ambrosini identified several factors that remain highly relevant (Ambrosini 2013, 48).

First, family assistants perform their work within a workplace that is difficult to monitor. Even the Labour Inspectorate's powers are effectively curtailed at the threshold of the private home. Inspection activities—generally initiated upon complaint by workers, who are often reluctant to report abuses, particularly where they are irregular migrants, given that the offence of unlawful entry and stay in the national territory remains in force—are almost impossible to conduct without infringing the constitutional protection of the inviolability

[68] There is a widespread belief that care work does not require specific training and that the principal channel of learning consists in direct experience. As is easily understood, this is an overly simplistic reading of the phenomenon, which neglects the importance of investment in training and professionalisation.

[69] It represents the "most economical and most widespread response of home-based care", according to Borelli (2023), 903.

of the home.[70] In practice, this substantially exempts domestic employers from public controls and related sanctions.[71]

Secondly, domestic employers are typically unstructured and weakly formalised. The domestic employer is not generally an entrepreneur pursuing profit, but a private individual seeking to meet an urgent and sometimes sudden care need (which may itself prevent compliance with the lengthy and cumbersome procedure for hiring foreign workers, discussed below). Moreover, both employers and workers often lack adequate knowledge of the applicable legal framework and of the administrative obligations it entails (Osservatorio Nazionale Domina 2024, 79–80).

Thirdly, final consumers frequently have an interest in reducing the cost of the service purchased. As noted above, families' economic resources rarely allow them to employ a full-time family assistant while fully complying with the statutory and collectively agreed economic and normative treatment.

The economic sustainability of care costs constitutes a particularly pressing issue for Italian families, especially for those requiring the support of a family assistant to care for their relatives, who are therefore often driven to resort to undeclared work. The issue is certainly not resolved by the cash transfers underpinning social policies for non-self-sufficiency, which essentially consist of—aside from recent experimental measures—the attendance allowance (*indennità di accompagnamento*) provided under Law no. 18/1980. This allowance, which absorbs approximately 45% of total expenditure on non-self-sufficiency care,[72] remains wholly insufficient to cover the cost of employing a full-time family assistant (in 2025 its monthly amount stands at 542.02 euros). Moreover, it is not selective about income or family structure, is not calibrated according to the severity of need, and is not subject to monitoring regarding the use of transferred resources.

Finally, there is often a convergence of interests between employer and worker in maintaining employment within the sphere of informality, particularly in cases involving:

[70] Article 8 of Presidential Decree no. 520/1955 provides that "Labour inspectors […] are authorised to visit, in every part and at any time of day or night, workshops, factories, construction sites and workplaces, insofar as they are subject to their supervision, as well as dormitories and refectories annexed to establishments; nevertheless, they must refrain from visiting premises annexed to workplaces that are not directly or indirectly connected with the running of the undertaking, unless they have reasonable grounds to suspect that such premises are used to commit or conceal violations of the law" (emphasis added). Borelli (2023), 894, underlines the tension between this provision and Article 17(3) of ILO Convention no. 189, which, in relation to inspection measures, requires States to "specify the conditions under which access to household premises may be authorised, having due regard to privacy".

[71] Undeclared domestic work was excluded by Law no. 183/2010 from the application of the so-called "maxi-sanction" provided for by Article 36-bis(7) of Law no. 248/2006.

[72] Audino, Mazzaferro and Morciano 2024, who recall that in 2023, according to INPS estimates, the total number of attendance allowances amounted to 2.2 million benefits, with an expenditure of 13.3 billion euros: "it is entirely evident that without intervention on this benefit any reforming aspiration would be frustrated".

- Migrant workers lacking a valid residence permit, who can only work irregularly, given that Italian law does not provide an ordinary legal mechanism enabling irregular migrants already engaged in irregular employment to regularise their status through employment, unlike what occurs, for example, in France or Spain.[73]
- Workers engaged in short- or medium-term migration projects who may have limited interest in social security regularity, particularly where they must repay migration debts or support families in their country of origin through remittances.
- Workers originating from countries that have not concluded bilateral social security agreements with Italy, thereby preventing the aggregation of contribution periods for pension purposes where the period completed in one country does not meet minimum requirements.[74]

More than a decade after they were first identified, these push factors remain substantially unchanged. Recent research confirms that the high incidence of irregularity is closely connected to the intrinsic nature of domestic work, to the characteristics of employers and workplaces, and to the predominance of migrant workers in the sector (Fondazione Studi dei Consulenti del Lavoro 2023, 7).

Turning to possible remedies,[75] it is worth recalling that, within the framework of the National Recovery and Resilience Plan, a National Plan for Combating Undeclared Work 2022-2025 has been adopted. The Plan aims to address irregularity across economic sectors, including domestic work, through rationalisation of sanctions and strengthening of intermediation services. However, this instrument intervenes only marginally on the structural causes described above, which may be interpreted as a further sign of broad tolerance towards illegality in the sector (Borelli 2021, 294). Recent studies have suggested additional measures that might encourage families to regularise domestic employment relationships, such as full tax deductibility of expenses incurred for employing family assistants or total contribution exemptions for employers, while simplification of hiring procedures and targeted family allowances appear less decisive (Fondazione Studi dei Consulenti del Lavoro 2023, 48–50).

[73] Chiaromonte 2023a, 712. For a comparative perspective, see Locchi 2021. On the desirability of introducing solutions such as those mentioned, as well as simplifying procedures to facilitate migrants' access to the labour market, see also the above-mentioned CARE4CARE Policy Paper, 21.

[74] Chiaromonte and Ferrara 2020, 533. Additional deterrents to the establishment of regular employment relationships are represented by two statutory exceptions to the principle of equal treatment in social security matters: the special social security regime provided for seasonal migrant workers (Article 25(2) of the Consolidated Immigration Act) and the absence of reimbursement of contributions paid by migrant workers in the event of repatriation (Article 22(13) of the Consolidated Immigration Act); see Chiaromonte and Guariso 2019, 377 ff.

[75] For a comparative analysis, see Tomei 2011.

The economic burden borne by families would justify interventions aimed at reducing—or even eliminating—the cost differential between regular and irregular employment, potentially through enhanced fiscal and social contribution incentives (Noviello and Parente 2024, 69), although such measures would reduce public resources available for developing public care services (Borelli 2023, 888).

In this direction, the legislature has introduced, for the period from 1 April 2024 to 31 December 2025, a 100% exemption from employer social security contributions—up to an annual ceiling—for domestic employers over 80 years old receiving the attendance allowance and with a low-income indicator (Art. 29(5), Law Decree no. 19/2024, converted into Law 56/2024). More recently, a universal benefit has been established on an experimental basis, including a care allowance of 850 euros per month, to be used for remunerating care work performed by domestic workers employed under national collective agreements or for purchasing qualified social care services. The measure is addressed to elderly persons with very severe care needs and limited income (Art. 36, Legislative Decree no. 29/2024).

These measures, however, are limited both by their experimental character and by the modest financial resources allocated.

### 6.1 Critical Aspects of the Procedure for Hiring Foreign Workers

In addition to the structural factors outlined above, there are further normative elements that facilitate the diffusion of irregular employment in the domestic sector and that would require corrective legislative intervention. It has already been noted that domestic work has long been subjected to less favourable treatment compared with other sectors, a gap that has not been bridged even following Italy's ratification of International Labour Organization Convention no. 189 on decent work for domestic workers (Borelli 2020, especially 181 ff.).

For reasons of space, attention will be confined here to the critical aspects of the particularly complex and cumbersome procedure for hiring foreign workers laid down in the Consolidated Immigration Act, which has been identified as a legal technique for containing the cost of care work (Borelli 2023, 887). This system is founded upon two unrealistic assumptions, which reveal their limitations especially in the context of domestic care work: first, that the employer is able to foresee recruitment needs well in advance, given the lengthy administrative procedure; and second, that the employer may be willing to hire a worker whom he or she has never met, in the case of numerical recruitment.

The absence of effectively accessible legal entry mechanisms has rendered regular entry for work purposes virtually impossible. Combined with ineffective programming of admission quotas—which continue to provide an insufficient number of permits for domestic and care work[76]—this situation has encouraged

[76] And this notwithstanding the existence of quotas specifically reserved for them.

circumvention of the rules designed to match labour supply and demand, as well as the search for alternative entry channels, thereby increasing irregular arrivals, fuelling criminal organisations and expanding the undeclared labour market.

Without claiming exhaustiveness, the principal critical aspects include[77]:

- The predominant mechanism of named recruitment of workers still residing abroad.
- The impossibility of entering Italy for the purpose of seeking employment.
- The principle of preference for hiring workers already present in the national territory.
- The introduction of the residence contract for subordinate employment.

This framework has been aptly described as a model that renders lawful access to the labour market "virtually impossible"[78] and that tends to foster rather than prevent irregularity, producing a striking heterogenesis of ends (D'Onghia 2022, 54–5). These elements—which cannot be analysed in greater depth here—create a normative disincentive to hiring foreign workers and thus to concluding regular employment contracts with them.

In the absence of legislative reforms capable of addressing these shortcomings, the principal instrument used over time to remedy a regulatory structure that discourages regular employment of migrants has been the periodic adoption of regularisation procedures. In practice, behind the formal rationale of regulating new entries, such measures have primarily served to regularise the status of individuals already present irregularly in Italy (Chiaromonte and D'Onghia 2021).

It is no coincidence that, of the eight regularisation measures adopted since 1986, the 2009 measure was exclusively devoted to the emergence of workers employed in family assistance activities,[79] while the measures of 2002,[80] 2012[81] and 2020[82] specifically identified domestic workers among their primary beneficiaries. Regarding the 2020 regularisation, 85% of the nearly 208,000 applications concerned domestic employment relationships. Moreover, definitive data concerning the outcomes of those applications remain unavailable, given the prolonged administrative procedures, which, at the time of writing, have not yet been fully concluded.[83]

[77] For further analysis, see Chiaromonte 2023a, 717 ff.

[78] It should be recalled that Article 22(12) of the Consolidated Immigration Act criminally sanctions employers who employ foreign workers without a residence permit, whose permit has expired and for which renewal has not been requested within the statutory time limits, or whose permit has been revoked or annulled.

[79] Article 1-ter of Decree-Law no. 78/2009, converted with amendments into Law no. 102/2009.

[80] Article 33 of Law no. 189/2002.

[81] Article 5 of Legislative Decree no. 109/2012.

[82] Article 103 of Decree-Law no. 34/2020, converted with amendments into Law no. 77/2020.

[83] For updated monitoring, see Ero Straniero 2024.

Reliance on repeated regularisation measures fails to acknowledge that the structural demand for domestic workers and family assistants should be met through stable and accessible mechanisms for lawful entry (de Martino 2021, 65–6). Such mechanisms remain absent even in the most recent legislative interventions.[84]

## 7. The Exploitation of Care Work

Some final remarks must be devoted to the offences of unlawful intermediation and labour exploitation, as regulated by Article 603-bis of the Criminal Code. It frequently occurs that undeclared employment involving family assistants is characterised not only by the involvement of an irregular migrant, but also by unlawful labour intermediation and/or exploitative working conditions.

Alongside the general—and, so to speak, non-technical—notion of labour exploitation, which refers to the condition of those who benefit from work without adequately compensating it, taking advantage of their privileged position or of the worker's state of need, there exists the more specific notion adopted by the law and codified in Article 603-bis.

The provision identifies two distinct criminal conducts against the person: that of the intermediary, who recruits workers (often irregular migrants) in order to assign them to work for third parties under exploitative conditions while taking advantage of their state of need[85]; and that of the employer who uses, hires or employs workers — even without recourse to such intermediaries — subjecting them to exploitative conditions and taking advantage of their state of need.[86]

Labour exploitation is described through a series of "factual indicators" (Di Martino 2018, 1 ff.), that is, circumstances defining the typical contexts in which such phenomena occur in most cases.[87] Through this process of indexation—rather than strict definition—the most serious cases involving non-compliance with the core of labour law protection, whether statutory or collectively agreed (remuneration, working time, health and safety etc.),[88] are brought within

[84] Reference is made, most recently, to Decree-Law no. 20/2023, converted with amendments into Law no. 50/2023, to Decree-Law no. 145/2024, converted with amendments into Law no. 187/2024, and to Decree-Law no. 145/2025, converted with amendments into Law no. 179/2025; on these measures see Chiaromonte 2023b and D'Onghia and de Martino 2025.

[85] The "state of need" identifies a particular condition in which indigence and economic hardship render a person more inclined to accept extreme working conditions that would otherwise be rejected. The Court of Cassation considers that even the mere condition of irregular residence may be sufficient to fulfil the requirement of "state of need" (Criminal Chamber, Court of Cassation, Section IV, 9 March 2021, no. 10554).

[86] Among many, Garofalo 2024; with specific reference to the repression of migrant labour exploitation, see Chiaromonte 2023c.

[87] From this derives a notion of exploitation that is "rather ambiguous and strongly conditioned by the political-cultural orientation of the interpreter" (D'Onghia 2025, 55).

[88] Most recently, Donini 2025. As Sarti (2022, 67) observes, "Many of the conditions indicated as indicators of exploitation by Article 603-bis of the Criminal Code are [ … ] implicit in the current regulatory framework governing domestic work: part of the work is exploited, but legally".

the scope of the criminal provision, as evidenced by recent case law grappling with these indicators in the complex task of delimiting and interpreting them (D'Onghia and Laforgia 2021; Donini 2025).

The work of family assistants, performed within the private home—an environment that facilitates evasion of minimum protective standards—by individuals who are often vulnerable, gives rise to forms of "invisible exploitation" (Militello 2024, 360–61) that, in extreme cases, may fall within offences such as enslavement or human trafficking, and may also engage the prohibition of forced or compulsory labour under Article 4(2) of the European Convention on Human Rights.[89]

For reasons of space, the analysis here will be confined to cases in which exploitation of family assistants is unlawful because it meets the criminal threshold established by Article 603-bis. It will not examine, on the one hand, the various techniques developed within the Italian legal system to contain the cost of care work, which generate forms of lawful exploitation,[90] nor, on the other, the additional manifestations of irregularity that take the form of under-classification, under-reporting of hours, non-payment of overtime or night work, or failure to grant rest periods and holidays (Borelli 2021, 293; Picco 2022, 144 ff.).

Applying the indicators, the Court of Cassation has held that exploitation must be understood as a deterioration in the balance between the labour force expended by the worker and the working conditions ensured by the employer. Exploitation arises where those conditions systematically and repeatedly exceed the limits established by law to protect work performance, or where the worker's dignity is degraded precisely by the working situation imposed upon him or her—whether through disregard for the worker's physical and psychological well-being or by compelling acceptance of humiliating accommodation conditions.[91]

This is a definition with significantly blurred contours, focusing above all on the systematic nature of violations of rules protecting workers' integrity and dignity (Martelloni 2025, 110; see also Laforgia 2020).

The provision does not readily lend itself to application in the context of family assistants' work, first and foremost because the relationship between care provider and care recipient does not, in most cases, correspond to the typical paradigm of exploiter and exploited. The ultimate beneficiary of the service may himself or herself be a victim of an inadequate social protection system which, failing to provide sufficient public care services, leaves as the only alternative to the familialisation of care recourse to low-cost market provision (Militello 2024, 359).

[89] This notion revolves around coercion in the performance of work, an element which, conversely, is not necessarily characteristic of labour exploitation. Not every form of exploited labour or work performed in conditions of hardship or degradation may be defined as forced labour in the strict sense; see D'Onghia 2025, 62.

[90] Borelli 2021, 287, referring, inter alia, to the aforementioned subtractive legislative technique, to the proliferation of sectoral collective agreements, to immigration legislation, and to the difficulty of trade union organisation in the sector. See also Picco 2022, especially 142 ff.

[91] Criminal Chamber, Court of Cassation, Section IV, 16 May 2022, no. 19143.

The few cases in which labour exploitation in the domestic sphere has been judicially established concern the first of the two criminal conducts described above, particularly the unlawful supply of irregular domestic workers by labour providers who exploit both the worker's and the employing family's state of need.[92] The role played by private intermediation and labour supply agencies in the domestic sector—a phenomenon of considerable relevance that cannot be examined in depth here—demonstrates that such entities may contribute to exploitation, taking advantage of the difficulty many families experience in conceiving of themselves as employers and in managing employment relationships.[93]

Moreover, although the concurrence of all exploitation indicators is not legally required for the offence to be established, in practice criminal liability is rarely found based on a single indicator. Most judicial decisions recognising exploitation describe situations of extreme gravity in which all the indicators are present simultaneously (Donini 2025, 84), further limiting the practical applicability of the provision in the context of family assistants.

As a result, the criminal norm ends up sanctioning only the most evident forms of exploitation, leaving outside its scope a wide range of situations that, while involving the imposition of working conditions contrary to mandatory labour law, do not reach the threshold of criminal punishability. Where the exploited worker is an irregular migrant who has reported the offence and cooperated in criminal proceedings, failure to establish the offence may preclude the granting of a residence permit for victims of unlawful intermediation and labour exploitation (Art. 18, Legislative Decree no. 286/1998; Chiaromonte 2025, 20).

This circumstance is especially significant in the context of family assistants, given that the majority of "non-technical" exploitative situations—widely tolerated because the care system itself depends upon them—consist of lawful forms of exploitation and are therefore not criminally relevant. In such a framework, a purely repressive approach, focusing exclusively on criminally relevant cases and intervening only after exploitation has occurred, appears inadequate (Militello 2024, 363).

The marginalisation of the criminal provision's operational scope, functional to preserving non-criminal forms of exploitation and thus the stability of the system described above, produces evident distortive effects: anti-exploitation policies, by concentrating primarily on isolated and spectacular cases, undermine their capacity to prevent and correct ordinary abuses deriving from the routine functioning of the socio-economic system (Borelli 2021, 296).

Even setting aside the limited practical relevance of Article 603-bis in this context, it remains clear that a purely punitive approach, treating exploitation

[92] Criminal Chamber, Court of Cassation, Section IV, 9 October 2019, no. 49781, which held that the mere irregular presence of a foreign national, accompanied by a situation of hardship and need to access employment, does not in itself suffice to constitute the offence under Article 603-bis of the Criminal Code, which instead requires exploitation characterised by indicators reflecting a situation of evident prejudice and significant subjection of the worker.

[93] For further analysis, see Amorosi, Borelli and Sarti 2024.

as a pathological private relationship to be cured exclusively through criminal law, without offering effective protection to exploited workers, is insufficient (D'Onghia 2025, 68). While criminal law may play an important role in identifying exploitation in sectors where labour protections are particularly fragile, the criminal offence itself cannot guarantee effective protection to those who suffer exploitation (D'Onghia 2024b, 33).

The penal response, intervening *ex post*, should therefore be complemented—as an ultimate *ratio*—by preventive measures capable of addressing the structural causes of exploitation. Labour law must reclaim its traditional function of protecting workers through a consciously unequal approach, rethinking the system for combating labour exploitation from a perspective capable of encompassing the multiple dimensions—including gender-specific aspects—of exploitation (D'Onghia 2024b, 34).

An excessive emphasis on the penal dimension risks marginalising the labour law perspective and creating a gap in the typical protections afforded by labour law. A renewed synergy between the two fields is necessary. A multidimensional approach to exploitation would restore centrality to labour law (Calafà 2021; Chiaromonte 2025), whose teleological reference point has always been the dignity of the worker (D'Onghia 2025, 70).

Admittedly, once one moves beyond the boundaries of criminal law, it is not easy—in the absence of explicit positive legal references—to define exploitation or determine when it arises, especially if one considers that labour law itself may formalise and legitimise forms of "physiological" exploitation that do not, according to prevailing views, infringe human dignity or freedom (Lassandari 2024, 37).

Despite these definitional difficulties, from a *de lege ferenda* perspective it may be appropriate to develop a broader and more comprehensive notion of exploitation.[94] Such an approach would partially relocate the issue within the domain of labour law, provide interpreters and supervisory authorities with a useful conceptual tool, and strengthen preventive legal instruments, re-establishing the prevention–repression dualism traditionally favoured by labour law, for example in the field of health and safety.

In this way, it would become easier to interpret exploitative phenomena in their concrete and systemic dimension, looking beyond the formal appearance of consent to the actual time worked and remuneration received, to the environmental and personal conditions of workers, and to the harmful effects on their physical and psychological integrity—all factors that, in reality, render the exchange between worker and employer far from free (D'Onghia 2025, 74). Such an approach would be particularly valuable in sectors characterised by a high degree of worker vulnerability and by a continuous process of erosion of labour rights, such as domestic care work (D'Onghia 2025).

[94] D'Onghia and Laforgia 2021, 251. In legal scholarship, there are also voices that do not consider it indispensable to fill this gap in the labour law system: Barbieri 2019.

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CHAPTER 10

# Reconstructing the Legal Architecture of the Care Sector: EU Governance, Social Dialogue, and Italian Collective Bargaining

Michele Mazzetti, Samuele Renzi

## 1. Introduction and Methodological Approach[1]

The care sector constitutes a cornerstone of social cohesion, the sustainability of welfare systems, and the promotion of gender equality. Care is a universal human need experienced both as a recipient and as a provider: it directly affects personal well-being, the autonomy of citizens, and labour productivity (International Labour Office 2018, 6). Nevertheless, the legal and conceptual definition of care remains a matter of debate.[2] Within European policy frameworks and academic literature, care is broadly understood as the range of services and activities aimed at safeguarding the physical, psychological, and emotional well-being of individuals requiring support throughout the life course, encompassing early childhood education, long-term care, and integrated health and social care services (Duffy 2011; Jochimsen 2003; Razavi 2013).

[1] This Chapter was prepared within the framework of the research project CARE4CARE – We Care for Those Who Care, funded by the European Union under the Horizon Europe Research and Innovation programme (Grant Agreement no. 101094603). This Chapter represents a shared reflection. However, it should be noted that Sections 1, 2, 3, 4, and 9 were authored by Dr. Mazzetti, whereas Sections 5, 6, 7, and 8 result from the work of Dr. Renzi.

[2] Seltzer 1992; Kahana et al. 1994; Daly 2001; Silverstein and Giarrusso 2010, 1047–50; Razavi 2013; Thorning and Dixon 2016; Eurofound 2020.

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From a European Union (EU) perspective, care is recognised as a strategic sector, yet its conceptualisation remains fragmented. The European Care Strategy (2022) and the Council Recommendation 2022/C 476/01 emphasises the need to ensure accessible, high-quality, and sustainable care services while promoting decent working conditions for both formal and informal caregivers, work-life balance, and professional upskilling opportunities. Soft law instruments, including Principles 17 and 18 of the European Pillar of Social Rights (2017) and the Hulpe Declaration (2024), although non-binding, exert significant normative influence by shaping the development and implementation of national policies in the care sector. The EU framework positions care as a strategic component of social inclusion, gender equality, and economic development with particular emphasis on vulnerable workers, such as migrants and domestic staff (European Commission 2022b).

Concurrently, the national dimension illustrates how European normative frameworks are operationalised within domestic legal and industrial relations systems. In Italy, the healthcare system has historically prioritised the "care for illness" over the "care for the person", resulting in the systematic undervaluation of roles dedicated to assisting non-self-sufficient individuals. The quality of services and the recognition of professional competencies are closely linked to labour regulation: collective bargaining, while central, frequently fails to guarantee equitable remuneration and adequate protections, at times permitting regulatory and wage disparities. This highlights a critical intersection between European directives, national legislation, and industrial relations in shaping the conditions of care work.

This contribution adopts a legal methodological approach to integrate EU and national perspectives. The first part analyses EU instruments (1998–2025)[3]—including directives, regulations, opinions, policy documents, and studies—to reconstruct the legal conceptualisation of care and assess the implications of adopting either a unitary or fragmented framework. The second part examines Italian collective bargaining practices, focusing on remuneration structures, working conditions, and protective mechanisms for care workers in health and social-care contexts.

The primary aim of this contribution is twofold. Firstly, it seeks to elucidate the principal characteristics, regulatory challenges, and policy instruments governing the care sector at the EU level. Secondly, it aims to demonstrate how EU general principles and recommendations are translated into concrete protections and employment conditions for care workers in Italy. By linking EU legal instruments, policy initiatives, and national industrial relations practices, this

[3] The reference period was identified through a historical analysis reconstructing the emergence of the concept of the *care sector* within the framework of the European Union's secondary legislation. The focus was deliberately not placed on primary law, which—while containing certain embryonic principles relevant to care and assistance—has not generated tangible legal or policy effects.

study provides an integrated, legally grounded perspective on care as a multidimensional social, economic, and normative phenomenon.

## 2. The EU's Emerging Legal and Policy Framework on Care

The EU legal framework on care is complex and multilayered. It is shaped by the interplay between soft-law and hard-law instruments, which, in line with the Union's usual regulatory approach, tend to complement and reinforce one another. In terms of EU competences, its normative basis does not rest on a single Treaty provision, but rather emerges from the combined reading of Articles 151–155 TFEU on social policy, Article 168 TFEU on public health, and Article 19 TFEU on non-discrimination. Taken in isolation, none of these provisions confer an autonomous or exclusive competence upon the Union in the field of "care". However, when applied together—subject to the constraints of the relevant legislative procedures and the overarching principle of conferral—they permit meaningful intervention in this area, thereby laying the foundation for the integrated conception of care later articulated in Union strategies and recommendations.

The first explicit institutional reference to "care" as a coherent set of services can be found in the 1998 Interim Report on the Implementation of the Medium-Term Community Action Programme on Equal Opportunities for Men and Women (1996–2000). Based on a 1997 study of the reconciliation of professional and family life, the report examined issues relating to service quality, flexible working arrangements and the particular labour-market risks faced by women (Commission of the European Communities 1998, 13). Even at this early stage, elements that would become central to the subsequent conceptualisation of the care sector were evident: the role of services in enabling work–life balance, the structural undervaluation of care, and the gendered distribution of caring responsibilities.

EU equality legislation has played a particularly important role in improving the protection of care workers. Directives 2000/43/EC and 2000/78/EC introduced binding obligations to combat discrimination based on racial or ethnic origin, religion or belief, disability, age and sexual orientation. These directives demonstrate the Union's early recognition of the structural vulnerabilities disproportionately affecting care workers, particularly women and migrant workers, and anticipate the functional definition of care embedded in subsequent policy initiatives (Camas Roda et al. 2024).

In 2004, the Commission further broadened the scope of EU action with two key policy documents: "e-Health: Making Healthcare Better for European Citizens" and the "First Annual Report on Migration and Integration" (European Commission 2004a; 2004b). Read together, these documents suggest a conceptual shift: healthcare is no longer considered an isolated specialist field, but rather an integral part of a wider "care" ecosystem. This cross-sectoral understanding directly foreshadows the operational definition that was later consolidated in the 2022 European Care Strategy.

Subsequent texts, including the 2007 Report on Gender Equality, highlighted the disproportionate burden of unpaid and paid care borne by women (Europe-

an Commission 2007). The European Economic and Social Committee's 2008 exploratory opinion on universal access to long-term care anticipated many of the principles later incorporated into the Care Strategy, including universal accessibility, sustainable financing, structured provision, and the professionalisation of care work. This trajectory illustrates the gradual institutionalisation of the care sector as a policy field in which service provision and labour rights are increasingly intertwined (European Economic and Social Committee 2008).

Notwithstanding this growing recognition, EU intervention remained limited until the 2010s. Directive 2011/24/EU on patients' rights in cross-border healthcare did not establish a comprehensive definition of the care sector, nor did it directly address care work or the rights of care workers, referring instead to existing labour legislation governing issues such as health and safety. References to care work between 2011 and 2015 were limited (European Parliament 2014).

A decisive turning point occurred with the proclamation of the European Pillar of Social Rights (EPSR) in 2017. Although non-binding, the EPSR has proved highly influential in shaping legislative initiatives, policy coordination, and funding priorities through mechanisms such as the European Semester. Out of its twenty principles, three are directly pertinent: Principle 9 on gender-balanced distribution of care responsibilities; Principle 11 on access to affordable, high-quality early childhood education and care; and Principle 18 on access to affordable, high-quality long-term care. These provisions explicitly connect care to gender equality, social rights, and a life-course approach, and they form the normative backbone for the EU's subsequent strategic developments (European Commission 2017).

The COVID-19 pandemic further intensified the focus on care within EU policymaking. Throughout 2020, the Commission and Council mobilised financial resources, facilitated the cross-border deployment of healthcare professionals and reinforced long-term care provision (European Commission 2020b). The Joint Employment Report of November 2020 emphasised, from a gender-sensitive perspective, the increased precariousness experienced by women and the specific vulnerabilities of the predominantly female care workforce (European Commission 2020a, 7). This period crystallised a functional concept of the "care sector", embedding within it the intersecting dimensions of service provision, labour protection, financing and gender equality, elements that anchor the legal and discursive analyses undertaken in this article (European Commission 2020a, 18).

The 2021 opinion of the Committee of the Regions, *Future Plan for Care Workers and Care Services*, advanced a functional definition of the care sector built upon four pillars: the target population (children, older persons, persons with disabilities); modes of provision (formal and informal); the actors involved (professional workers and family carers); and the socio-economic relevance of care as a strategic lever for cohesion and territorial development. To this end, the Committee calls for adequate public investment and an integrated policy approach linking the health system, social services and inclusion policies. The care sector encompasses formal and informal services offered in domestic and

community settings. These services range from daily assistance to promoting social participation. They are an indispensable pillar of social cohesion and local economic development (European Committee of the Regions 2021).

A decisive turning point occurred in 2022, when the European Commission and the co-legislators adopted a suite of measures designed to strengthen and consolidate the Union's approach to the care sector. Building upon the policy orientations articulated in the European Care Strategy, two key instruments were issued on 8 December 2022: the Council Recommendation on access to affordable, high-quality long-term care (2022/C 476/01) and the Council Recommendation on early childhood education and care, which revised the Barcelona targets for 2030 (2022/C 484/01). Although formally non-binding, these instruments have contributed to the emergence of a coherent regulatory and programme framework that promotes an integrated system of care services oriented towards the physical, psychological and emotional well-being of individuals across the life course.

None of these three instruments furnishes an explicit definition of the *care sector*. Yet the expression appears no fewer than thirty-six times in the European Care Strategy, underscoring its centrality within the Union's renewed social-policy agenda. Despite this definitional reserve, a close reading of the Strategy's semantic architecture permits the extraction of an operational and functional understanding of the sector (European Commission 2022a, 3, 9–16, 18, 20, 23).

The notion of the care sector rests on a dual dimension: its essential value to society—*vital*, in the language of the Strategy—and the structural challenges that persistently undermine its stability. The sector is simultaneously portrayed as an area of significant opportunity (*opportunities*; *improving*) and marked vulnerability, testing its *resilience*. It remains characterised by a high incidence of part-time and involuntary part-time work, low pay, and difficult working conditions, reflecting a longstanding pattern of gender segregation. Moreover, the care sector occupies a distinctive position at the juncture of health and welfare, encompassing both formal and informal care. Its collective and institutional dimensions are illuminated through repeated references to social dialogue and social involvement, which accentuate the role of public policy and collective bargaining in addressing entrenched structural shortcomings.

Transposed into legal terms, the *care sector* may accordingly be defined as the ensemble of formal and informal activities directed towards providing assistance and support to individuals who are non-self-sufficient, disabled, elderly or otherwise in need. This includes healthcare and social care delivered in professional, community and family settings. The sector is marked by pervasive precariousness—low wages, involuntary part-time work, and complex working conditions—and by pronounced gender segregation. Functionally, it constitutes an integrated system of services that perform a strategic role in sustaining social cohesion, promoting inclusion, and supporting territorial development, particularly in rural and disadvantaged areas.

From 2024 onwards, the Union's strategy has centred on strengthening minimum training requirements for the nursing professions—through a delegated

directive aimed at harmonisation and mutual recognition—and on fostering reflection, via an opinion of the European Economic and Social Committee, on the industrial transformations reshaping the healthcare sector in an age of recurring crises (European Economic and Social Committee 2024). These initiatives represent an effort to consolidate the reflections and priorities articulated in the 2021–2022 policy cycle while monitoring national implementation of Recommendations 2022/C 476/01 and 2022/C 484/01.

Further political impetus has been provided by the *La Hulpe Declaration* (2024), which affirms the indispensable role of care services in underpinning the resilience and well-being of European societies. The Declaration issues a clear call to action: that care systems across the Union be strengthened without delay, and that care work—frequently undervalued and poorly remunerated—be recognised as a cornerstone of the European social model.

Taken together, these developments confirm that the European Union now operates with a fully-fledged, functional conception of the *care sector*. This comprises a continuum of activities, both formal and informal, aimed at supporting vulnerable individuals across the life course. It spans healthcare, daily assistance, and measures designed to promote social participation, delivered by professional health and social-care workers as well as unpaid family carers.

At the same time, Union institutions increasingly acknowledge the enduring structural weaknesses that afflict the sector: deep-seated gender segregation (with a predominance of women and migrant workers), widespread precariousness, low pay, involuntary part-time employment, and insufficient social protection. Yet they equally recognise the sector's strategic importance for social cohesion and economic development, particularly within rural and structurally disadvantaged regions. This dual awareness—of vulnerability and societal indispensability—underpins the evolving European approach to care and sets the stage for the national-level analysis developed in the subsequent sections of this article.

## 3. Social Dialogue at EU Level: Representation, Fragmentation and Structural Constraints

The EU adopts a largely unitary conceptual approach to the care sector, as evidenced by the functional definition articulated in its legal instruments. The central question of this section concerns the legal ramifications of this definition in the context of EU labour and social law, with European social dialogue serving as a key lens through which these effects can be assessed. Indeed, social dialogue operates as a privileged mechanism intertwining normative and industrial relations dynamics, permitting the identification of discrepancies between conceptual frameworks and applied practices (Nunin 2001; Milman-Sivan 2009; Bechter et al. 2017). Moreover, it provides insight into the extent to which EU soft law and sectoral definitions are effectively operationalised at the supranational level, thereby connecting the theoretical foundation to the practical realities explored in Sections 4 and 5.

Social dialogue is a core instrument through which the EU fosters social partner participation in the formulation and implementation of labour and social policies (Varsori 2006, 33; Del Frate 2021, 13–6). While its origins can be traced to the 1970s, a decisive turning point occurred on 31 January 1985 at the high-level meeting in the Château de Val Duchesse, Belgium, under the initiative of Commission President Jacques Delors. This event inaugurated the "Val Duchesse period" (1985–1993), characterised by structured concertation and joint opinions, resolutions, and declarations (Del Frate 2021, 16–9). The normative codification of social dialogue was later consolidated through the Single European Act (1986), introducing Article 118B of the EEC Treaty (now Articles 154–155 TFEU) and culminating in the 1991 Social Policy Agreement, subsequently integrated into the Maastricht and Amsterdam Treaties.[4]

Post-Lisbon, Articles 151–155 TFEU remain the principal legal basis. Article 151 establishes the EU objective of promoting dialogue between social partners, while Articles 154 and 155 regulate consultation procedures and the negotiation of agreements, either autonomously or through Council implementation. This arrangement confers a "quasi-constitutional" role to social dialogue, situated at the intersection of participatory democracy and multilevel governance, operationalised through Commission Decision 98/500/EC, which establishes sectoral committees, their representativeness criteria, and procedural rules (Eurofound 2009; Roccella et al. 2023, 509–13).

European social dialogue functions on two levels: cross-industry (engaging principal European employer and worker organisations across economic sectors) and sectoral (structured around forty-four officially recognised committees). In accordance with Decision 98/500/EC, sectoral committees are formed by the Commission on joint initiative of social partners representing multiple Member States, possessing negotiation capacity and sufficient organisational structures for continuous engagement.[5] Committees are parity-based and serve as forums for co-decision, contributing to sectoral policy development aligned with European social model principles (Obradovic 2005).

As a consultative mechanism, the European social dialogue assigns the European Commission a necessary but not decisive role. The establishment of a sectoral committee requires a joint proposal from the social partners, who hold the procedural initiative. Thus, the organisations representing employers and workers originally shape the structure of industrial relations at the supranational level, often reproducing structural models and bargaining categories borrowed from their respective domestic systems.

[4] Lyon-Caen and Lyon-Caen 1991, 298 ff.; Tizzano 1998; Fiorillo 2009; Roccella et al. 2023, 509–13.

[5] Artt. 1 e 4, Commission Decision of 20 May 1998 on the establishment of Sectoral Dialogue Committees promoting the Dialogue between the social partners at European level (notified under document number C(1998) 2334) (Text with EEA relevance).

However, collective actors go beyond transposing national paradigms. They contribute to agreements and regulatory instruments influencing domestic systems, thus advancing progressive Europeanisation of labour law and industrial relations. European social dialogue operates at the intersection of interests, between actors including employers' associations, trade unions, the European Commission and the Union's co-legislators. The result is an intricate institutional landscape, with law-making processes partially decentralised compared to traditional EU law-making.

Against this background, it is unsurprising that the sectoral committees do not mirror the unitary model of the care sector that appears to emerge from recent EU policy and legislative developments. Instead, they present a fragmented and segmented configuration. This structure is, on the one hand, incomplete, since there is as yet no committee expressly dedicated to domestic work and personal or household care services; and, on the other hand, highly fragmented, as matters pertaining to care work are distributed across multiple committees, each reflecting the functional segmentation typical of national systems.

The European Sectoral Social Dialogue Committee for Hospitals and Healthcare and the European Sectoral Social Dialogue Committee for Social Services are the sectoral committees relevant for analysing the care sector. The former, created in 2006, brings together the European Public Service Union (EPSU) and the European Hospital and Healthcare Employers' Association (HOSPEEM) (European Commission 2025a). The committee's remit includes matters such as working conditions, human resource management, training and the prevention of psychosocial risks. It covers staff employed in hospitals and wider healthcare services, including medical and dental practices.[6]

The European Sectoral Social Dialogue Committee for Social Services, established on 10 July 2023, brings together the European Federation of Public Service Unions (EPSU), UNI Europa, the European Confederation of Independent Trade Unions (CESI), the European Federation of Employers of Social Services (Social Employers) and the Council of European Municipalities and Regions (CEMR). The establishment of this committee is an important recognition of the specific nature of the social services sector, which is characterised by a multitude of stakeholders (public, private and third sector) and growing importance within welfare and personal care policies (European Commission 2025b; EPSU 2023). The committee's focus is on workers employed in residential nursing, social care, and socio-assistential services.[7]

[6] The provision establishing the committee refers, for the identification of the workers represented on this committee, to the NACE (Rev.2) code division 86 adapted by Regulation 1893/200/EC, which defines the statistical classification of economic activities NACE Revision 2.

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Live-in and non-live-in personal-care workers (and domestic workers more generally) remain outside the scope of any recognised sectoral committee. Nonetheless, the domestic-work sector has become the focus of emerging dynamics of social dialogue at EU level. Notable initiatives are being promoted by employers' organisations such as the European Federation for Family Employment and Home Care (EFFE), by trade unions such as the European Federation of Food, Agriculture and Tourism Trade Unions (EFFAT), and by international networks representing domestic workers. These initiatives all seek the formal recognition of a dedicated committee, in light of the growing importance of this sector for the sustainability of care systems (EFFE 2023; EFFAT 2022; Times 2022).

As none of the existing committees represent informal care service providers, their delineations are somewhat artificial in that they classify workers primarily on the basis of workplace—or rather, employer type—when greater emphasis should arguably be placed on the nature of the service provided in this field of activity. The result is a fragmented model that contrasts sharply with the functional definition underpinning EU strategies and the relevant soft law and legislative instruments.

This fragmentation is deeply rooted in national models, as demonstrated by the comparative analysis undertaken within the CARE4CARE Project.[8] Across all countries examined, social dialogue and industrial-relations frameworks are marked by a series of recurrent fault lines. These can be summarised as four structural divides: (i) formal versus informal work; (ii) public versus private employment; (iii) productive versus non-productive sectors; and (iv) home-based versus facility-based care. Each of these divides undermines coherence and hinders the emergence of a unified European approach.

The primary and most significant fault line is the divide between *formal and informal workers*. As consistently highlighted by the ILO, care work is particularly prone to informality due to its intimate, household-based and often unregulated nature (International Labour Office 2018, 10–12; Peterie and Broom 2024). This structural segmentation excludes informal workers from mechanisms of collective representation and bargaining, producing a form of institutional invisibility and regulatory marginalisation.

A second fault line arises from the separation between *public and private employment* in mixed care systems. Because services are delivered through diverse public, private and third-sector providers, bargaining processes are dispersed across multiple negotiating tables. This proliferation of actors—even within the same occupational profiles—fragments representation and prevents the development of coherent sector-wide standards, standing at odds with the more integrated model implicitly promoted by the EU.

A third divide stems from the traditional distinction between *productive and non-productive sectors*, grounded in a productivity-oriented socio-legal paradigm

[8] Daugareilh et al. 2024, 17; Kocher et al. 2024, 13–7; Vallauri et al. 2024, 4; Ludera-Ruszel and Kotarski 2024, 6–7,10; Camas Roda et al. 2024, 9–10, 12; Rönnmar and Votinius 2024, 7.

that still shapes labour law. Care activities not categorised as economically "productive" are consequently undervalued, despite their essential contribution to social well-being, community resilience and long-term economic sustainability (Dermine and Dumont 2022; Keating et al. 2025).

Finally, a fourth fault line concerns the differentiation between *home-based care* and *institutional care*. Work performed in private households tends to be relegated to a residual, less protected and often precarious status, even though it represents an increasingly central component of European long-term care systems.

These fault lines—rooted in domestic regulatory traditions—are reproduced at the supranational level, hindering the effective integration of the care sector within the European system of social dialogue. They thus pose a significant challenge to the coherence, inclusiveness and effectiveness of the Union's policy ambitions in the field of care.

## 4. From EU Governance to National Regulation: The Italian Case as a Laboratory of Tensions

The transition from the EU to the national level illustrates the structural interdependence between EU governance and domestic regulatory systems in the organisation of care. As the preceding sections have shown, the EU has gradually elaborated an increasingly sophisticated—though still fragmented—normative and policy architecture aimed at recognising care both as a fundamental social need and as a field of employment requiring coherent legal protection. Through the cumulative development of secondary legislation, soft law instruments and strategic policy documents, the EU has articulated a functional conception of the *care sector* encompassing health, social and long-term care, and placing significant emphasis on quality, accessibility, sustainability and decent working conditions. However, the effectiveness of this supranational framework ultimately depends on its interaction with domestic legal orders and the adaptive capacity of national industrial relations systems.

In this respect, the Italian experience provides a key example of the dialectic between supranational objectives and national regulatory realities. While the European Care Strategy and the 2022 Council Recommendations promote an integrated and life-course approach to care provision, the Italian regulatory landscape remains characterised by entrenched organisational and contractual divisions. The coexistence of multiple collective bargaining regimes, the asymmetrical distribution of competences between public and private providers, and the historically blurred boundaries between healthcare and social assistance have produced a fragmented and uneven regime of protection. These divisions mirror broader structural asymmetries concerning gender, contractual status and the persistent undervaluation of relational and non-medical care work. Many of the challenges identified at EU level—governance fragmentation, weak recognition of personal care roles, and the marginalisation of lower-qualified workers—thus reappear with intensity in the Italian context.

Within this framework, collective bargaining in Italy plays a key mediating role between EU policy orientations and national labour regulation. On the one

hand, National Collective Labour Agreements provide a vehicle through which principles such as fair remuneration, equality and professional recognition may be implemented in practice. On the other hand, the coexistence of multiple agreements governing comparable professional profiles—especially in the accredited private sector—reveals the limitations of EU governance, insofar as the absence of binding supranational standards allows contractual differentiation and contractual dumping to persist.

At the same time, Italy's accreditation system for private providers participating in the National Health Service (NHS) offers a potential regulatory leverage point. By linking accreditation to stringent labour-law requirements and to collective agreements concluded by the most representative social partners, this mechanism could contribute to translating EU objectives—quality, safety and adequate working conditions—into enforceable national standards.

The following section turns to the Italian case in more detail, analysing the dynamics of collective bargaining within the public and private healthcare sectors. Through this analysis, the extent to which the EU's normative and governance framework—rooted in principles of social justice, equality, and sustainability—has been internalised within national labour law and industrial relations can be assessed, and the degree to which enduring sectoral fragmentation continues to constrain the full realisation of those principles in practice can be determined.

## 5. Collective Bargaining in Healthcare and Social Care in Italy: Professional Profiles Examined

Within the facilities pertaining to the healthcare, social-healthcare, and social-assistance sectors, personal care services are predominantly delivered by two types of professional profiles: on the one hand, nurses, included within the sphere of health professionals, and on the other, socio-healthcare operators (*Operatore Socio-Sanitario* – OSS), who do not participate in clinical processes and are therefore exclusively engaged in "activities directed at the individual and their living environment".[9]

The nursing profession underwent a significant process of professionalisation from the mid-1990s onwards. Initially, Ministerial Decree 739/1994 enhanced the competences and direct responsibilities of nurses, establishing that the nurse participates in the identification of individual and community health needs, plans, manages, and evaluates nursing interventions, and ensures the correct administration of prescribed therapies. Subsequently, Law no. 42 of 26 February 1999 repealed the so-called nursing job description under Presidential Decree 225/1974 and deleted the textual references in Royal Decree 1265/1934 that qualified nurses merely as "auxiliary workers" (Bottari 2020, 171).

[9] Accordo Stato Regioni del 22 febbraio 2001, O.J. no. 91 of 19 April 2001.

While the evolution of the profession did not alter the nurse's responsibility for patient care,[10] the aforementioned interventions led to the gradual transfer of some basic care duties—formerly performed by general nurses—to other figures, introduced in a fragmented manner through collective agreements and local regulations. As early as the 1990 National Collective Labour Agreement (*Contratto Collettivo Nazionale di Lavoro* – CCNL) for the Public Healthcare Sector, alongside general and professional nurses, the roles of socio-health auxiliary and technical care operator (OTA) were provided for. Similarly, the Regions, in the absence of a unifying regulatory intervention, attempted to fill the gap by creating a wide range of differently named profiles, such as "technical socio-assistance operators", "basic healthcare operators", "socio-assistance auxiliaries" etc.

Fragmentation was eventually addressed through the State-Regions Agreement of 22 February 2001, which established the OSS profile and regulated its training pathway in a uniform manner. The OSS thus became the reference profile for basic personal care, operating both in healthcare and social settings, not merely in support of, but also in collaboration with healthcare personnel. Reflecting the gradual redefinition of the role, Law no. 3 of 11 January 2018 included OSSs in the socio-health professional sector, thus overcoming the previous configuration that assigned them a primarily technical role.

However, the regulatory evolution outlined above has not ensured full recognition for all workers engaged in care tasks (Vallauri et al. 2024). In the private sector, alongside OSSs, additional support profiles persist, notably the socio-assistance operator (*Operatore Socio-Assistenziale* – OSA). This figure is generally trained to provide basic personal care from a social perspective, although they may also operate in healthcare or socio-healthcare facilities. The OSA lacks a uniform definition or regulation in primary legislation and is mentioned only in certain regional regulations and collective agreements. Classification systems frequently continue to adopt diverse titles for support staff (e.g., "care assistant", "socio-assistance auxiliary", "socio-health auxiliary"), assigning duties comparable to those of OSSs but with inferior classification and remuneration.

These operators and related professional profiles struggle to advance in their careers and often suffer formal assignment to tasks different from those stipulated in their contracts.[11] Additionally, there is a chronic shortage of nursing personnel, a situation expected to worsen given the sector's ageing workforce (ISTAT 2021, 225). In response, the State-Regions Agreement of 3 October 2024 introduced a new intermediate qualification, provisionally called "nursing assistant", accessible to OSS holders undertaking additional training. Explicitly classified as a health-related operator under Art. 1(2), Law no. 43/2006, this figure will perform direct health-

[10] As required under Articles 3 and 4 of the Code of Professional Conduct for Nursing Professions.

[11] This critical issue also emerges in the case law. See, among many others: Court of Cassation, 18 April 2025, no. 10326; Court of Cassation, 25 July 2022, no. 23203; Court of Cassation, 11 July 2022, no. 21942; Court of Appeal of Rome, 8 November 2018, no. 4052.

care assistance and advanced organisational support under the direction and supervision of nurses, in collaboration with other operators and health professionals.

The legislator intends the nursing assistant profile to help overcome organisational inefficiencies and address the documented shortage of personnel, while also offering a career progression path for OSSs. While undoubtedly significant, this innovation targets a somewhat peripheral aspect and is unlikely to exert a substantial positive influence on the remuneration of nurses, OSSs, and analogous operators, as reflected in existing collective agreements.

## 6. National Collective Labour Agreements Across Public and Private Providers

Among the numerous characteristics of the healthcare system impacting care workers, the primary determinant of differences in treatment relates to the nature of the employer.

In the public sector—i.e., facilities directly managed by the NHS—the employment conditions of non-medical staff (nurses and OSSs, as well as technical-administrative personnel, officials etc.) are regulated by a single national collective labour agreement (CCNL) for the healthcare sector. Conversely, private clinics, nursing homes, care homes, and, more generally, private healthcare, socio-healthcare, and social-assistance institutions apply a broad range of collective agreements, often deriving heterogeneous provisions and significantly divergent levels of protection (Borelli 2020, 28–9). This is the case even when private facilities operate under accreditation with the NHS (Bottari 2020, 134), acting in its name and on its behalf, in accordance with Articles 8 *et seq.*, Legislative Decree 502/1992 (Bottari 2020; Ferrara 2025, 7–13).[12]

The considerable discretion enjoyed by accredited entities in selecting the applicable collective source is central, as it not only affects labour protections but may also compromise the equity of the healthcare system, producing competitive distortions. This issue will be examined in further detail, following a review of selected national collective agreements, chosen for their coverage rates or because they provide particularly clear evidence of the contractual dumping phenomenon identified in the introduction. The agreements selected are: (i) CCNL Public Healthcare Sector 2019–2021; (ii) CCNL Aris/AIOP 2016–2018; (iii) CCNL UNEBA Social-Health Sector 2023–2025; (iv) CCNL ANASTE 2020–2022; (v) CCNL ANPIT 2024–2027; (vi) CCNL Social Cooperatives 2023–2025.[13]

For brevity, this analysis focuses on clauses governing basic remuneration and certain provisions that, indirectly,[14] influence the adequacy and proportionality of salaries and career development opportunities, alongside working hours.

[12] The regulatory framework has been amended on several occasions, most notably by Legislative Decree no. 229/1999.

[13] For reasons of consistency with the scope of the project, decentralised collective bargaining was not examined; moreover, in the healthcare sector it typically occurs at organisational rather than territorial level.

[14] All remuneration figures are given in gross terms.

### 6.1 The National Collective Labour Agreement for the Public Healthcare Sector

The current CCNL for personnel in the public healthcare sector for the period 2019–2021 was signed on 2 November 2022, concluding negotiations that significantly redefined several contractual provisions.

Firstly, a new classification system for personnel, effective from 2023, replaced traditional categories (A, B, C etc.) with homogeneous professional areas: support staff; operators; assistants; health professionals and officials; and highly qualified personnel. Under this framework, OSSs are placed within the operators' area, comprising technical-executive health profiles with basic qualifications, while nurses (including paediatric and other healthcare graduates) fall within the health professionals and officials' area, reserved for technical and clinical roles involved in professional healthcare processes.

Regarding remuneration, the CCNL establishes uniform minimum salary tables for each area. OSSs receive a base salary of 20,105.34 euros for 12 months, supplemented by a thirteenth month, the patient care and health promotion allowance of 35.46 euros per 12 months, a professional qualification allowance of 9.55 euros per 13 months, professional pay differentials, and additional items that may accrue alongside base pay.[15] Nurses receive a minimum tabular salary of 23,298.93 euros for 12 months, with a thirteenth month, a nursing-specific allowance of 72.79 euros per 12 months, a specific professional allowance of 36.15 euros per 12 months, plus the additional items noted above. Expressed monthly, the minimum remuneration, considering tabular and recurrent additions, amounts to 1,721.25 euros (excluding the thirteenth month) for OSSs and 2,050.52 euros (excluding the thirteenth month) for nurses.

In terms of working time, Art. 43 of the CCNL establishes a 36-hour workweek, generally distributed over five or six days.

Finally, career progression opportunities—which may influence base salary growth beyond seniority or specific working conditions—are highly structured: economic advancement within and across professional areas occurs via competitive selection procedures, reflecting the principle of meritocracy (Buoso 2023, 212).

### 6.2 The National Collective Labour Agreement for ARIS/AIOP-affiliated Healthcare Providers

Among agreements in the private healthcare sector, the CCNL signed by ARIS and AIOP on the employer side, and by trade unions affiliated with the three major confederations, is widely applied, covering approximately 150,000 employees nationwide.[16] Following a prolonged contractual gap (about 14 years since the

[15] For example, the allowance granted for periods of contractual hiatus pending the renewal of the collective agreement.

[16] The data concerning the workers falling within the scope of this agreement—along with those cited below for the other agreements examined—have been drawn from the CNEL Archive for the year 2022, the most recent available.

previous agreement expired), the contract was renewed on 8 October 2020, referencing the economic and normative provisions of the 2016–2018 triennium.

Broadly, the contract mirrors the structure of the public healthcare CCNL, albeit with some notable differences. Professionally, the ARIS/AIOP CCNL maintains a categorisation system similar to the old public sector structure: nurses and non-medical healthcare professionals are in Category D, while OSSs are placed in Category B2.

Regarding remuneration, the CCNL sought to reduce the pay gap with the public sector. OSSs receive a tabular salary of 1,669.36 euros, and nurses 1,986.84 euros, both payable over 13 months.[17] Despite differences in composition—fewer fixed allowances but higher tabular minima—the private sector displays only a minor shortfall relative to public counterparts. Working hours align with the public CCNL at 36 hours per week.

Career advancement is addressed in Art. 48, providing a loosely defined system for intra-level promotion based on "acquisition of greater professionalism […] and/or specific knowledge allowing engagement in more qualified activities". The provision is generally lax, and its effects were suspended for most employees by the latest contract renewal. Only certain profiles, including OSSs, are exempt, with promotion from B2 to B3 after three years of service, accompanied by the corresponding salary increase.

### 6.3 The National Collective Labour Agreement for UNEBA Social and Health Services

Turning to the socio-healthcare and social-assistance sector, the UNEBA CCNL, signed by the relevant trade unions (CGIL, CISL, UIL), applies to approximately 135,000 workers. The latest renewal was on 24 January 2025 for 2023–2025.

Personnel classification follows a descending-level system: OSSs are at Level 4S, nurses at Level 3S. Base monthly remuneration, updated from 1 July 2025, is 1,517.86 euros for OSSs and 1,662.40 euros for nurses, with both receiving thirteenth and fourteenth-month payments.

Unlike prior contracts, UNEBA sets a 38-hour workweek, which inevitably impacts proportional remuneration adequacy. No mechanisms for career advancement towards higher, better-remunerated positions are explicitly provided.

### 6.4 The National Collective Labour Agreement Applied by ANASTE

Among the collective agreements most frequently applied in the private social-health and care sector, the National Collective Labour Agreement signed by Anaste together with several trade unions outside the three main confed-

[17] This value is calculated by adding the basic pay to the annual allowance of 428.66 euros provided for in Article 63. Although the provision requires the allowance to be spread over twelve monthly instalments, it has been divided into thirteen for the sake of consistency in calculation and comparison.

erations—such as SNALV, CONFSAL and CSE—covers over 10,000 workers nationwide. The most recent renewal, dated 27 December 2022, applies to the 2020–2022 contractual period.

The job classification system, broadly consistent with those described above, places OSSs at level 4 and nurses at level 6. The monthly basic wage amounts to 1,477.10 euros for OSS and 1,604.06 euros for nurses. Only the latter receive an additional professional allowance of 155.00 euros per month, though paid solely over twelve months. While the resulting figures may appear comparable to those under the Uneba agreement, the Anaste agreement provides only one annual bonus, namely the thirteenth month. The weekly working time is 38 hours.

The career structure allows only limited progression: OSSs may advance at most to level 5, and nurses to level 8, and only where they are assigned additional coordination or supervisory responsibilities over groups of workers or operational units.

### 6.5 The National Collective Labour Agreement Applied by ANPIT

A further collective agreement—less widespread but nonetheless worthy of examination given its wage levels markedly lower than those set by agreements concluded by the most representative unions—is the National Collective Labour Agreement signed by ANPIT, CIDEC, Confimprenditori, PMI Italia and others, together with CISAL, most recently renewed on 28 June 2024 for the period 1 July 2024–30 June 2027.

The classification system is relatively elaborate. With regard to nurses, it largely mirrors the structures already examined: they are placed in a single homogeneous area, level C1, with the possibility of progression to level B2 after thirty-six months' service. For OSSs, the agreement introduces a three-tier structure based on the autonomy of the care recipient. The OSSs are classified at level D2 when caring for self-sufficient individuals, at level D1 when assisting non-self-sufficient persons, and at level C2 where such assistance is provided "under conditions of unpredictability".

Considering the entry levels (D2 for OSSs and C1 for nurses), the monthly wage as of 1 January 2025 is 1,076.93 euros for OSS employed in care homes and 1,036.53 euros for those working in social and socio-health services. For nurses, the corresponding monthly wages are 1,400.02 euros and 1,347.49 euros. In addition to these basic rates, the agreement provides for a regional equalisation allowance, which in this case is substantial and materially affects overall remuneration, together with a specific duty allowance of 55.00 euros per month for OSSs and 70.00 euros per month for nurses. By way of illustration, the regional equalisation allowance amounts to 110.00 euros (OSSs D2) and 143.00 euros (nurses C1) in Lombardy; 93.00 euros and 120.90 euros respectively in Tuscany; and 40.00 euros and 52.00 euros in the southern and insular areas (Sicily, Puglia, Campania, Sardinia, Calabria, Basilicata and Molise).

The weekly working time under this agreement is 40 hours.

### 6.6 The National Collective Labour Agreement for Social Cooperatives

In the personal care and assistance market, a substantial proportion of providers operate as cooperative enterprises (Pioggia 2020, 173). Given the need to regulate the specific features of employment relationships involving worker-members, the sector traditionally relies on collective agreements distinct from those applied in other private healthcare, social-healthcare or social-assistance settings. Among these, the National Collective Labour Agreement for Social Cooperatives, signed by the employers' associations AGCI, Confcooperative and Legacoopsociali together with the unions affiliated to the three major confederations (CGIL, CISL, UIL), stands out for its extensive coverage, applying to over 370,000 workers. The most recent renewal was concluded on 26 January 2024 and covers the period 2023–2025.

Under this agreement, OSSs are classified at level C2, while nurses are placed at level D2, with no specific mechanisms designed to facilitate career progression. As of January 2025, the monthly wage amounts to 1,560.27 euros for OSSs and 1,694.91 euros for nurses. Only nurses receive an additional monthly professional allowance of 154.94 euros. The agreement provides for both a thirteenth-month payment and a fourteenth-month payment, the latter amounting to half of the monthly wage applicable in the month in which it is paid.

The weekly working time under the social cooperatives' agreement is 38 hours.

## 7. Outlining the Accreditation System within the Italian National Health Service

The comparative analysis reveals marked disparities across the selected collective agreements. To facilitate comparison, the extracted data are presented in two tables—one for OSSs and one for nurses—calculated on an annual gross basis.

Table 1 – OSS: Annual Gross Basic Remuneration and Weekly Hours.

| CCNL | Annual gross basic pay | Weekly hours |
|---|---:|---:|
| Comparto sanità | 22,376.25 euros | 36 |
| Aris/Aiop | 21,701.68 euros | 36 |
| Uneba | 21,250.04 euros | 38 |
| Anaste | 19,202.30 euros | 38 |
| Anpit | 14,715.09 / 14,189.89 euros | 40 |
| Cooperative sociali | 21,063.64 euros | 38 |

These figures clearly reveal the depth and breadth of wage differences between the CCNL for the public sector and those for the private sector aligned with it (in particular Aris/Aiop) and other private sector agreements not signed by the main trade union confederations (CGIL, CISL, and UIL).

Table 2 – Nurses: Annual Gross Basic Pay and Weekly Hours.

| CCNL | Annual gross basic pay | Weekly hours |
|---|---|---|
| Comparto sanità | 26,656.76 euros | 36 |
| Aris/Aiop | 25,828.92 euros | 36 |
| Uneba | 23,273.60 euros | 38 |
| Anaste | 22,867.78 euros | 38 |
| Anpit | 19,110.26 / 18,427.37 euros | 40 |
| Cooperative sociali | 24,895.50 euros | 38 |

Such disparities could be expected in a mixed market where public and private operators work side by side, given the distinct bargaining dynamics in the public sector and the absence of a legal obligation for private employers to replicate public sector terms and conditions. This argument would only be convincing if public authorities and private operators had no structural relationship at all, or if that relationship was limited to a simple authorisation process that was only aimed at verifying the basic suitability of the operator to provide sensitive health services (Caruso 2023, 16). In reality, though, private operators do not restrict themselves to authorisation.[18] Through the accreditation mechanism, they establish functional links with the NHS, effectively operating in its name and on its behalf (Ferrara 2025, 205–24).

Accreditation is a prerequisite for private healthcare providers to join the network of establishments that contribute to providing services and activities falling within the essential levels of care provided by the NHS, as set out in Article 8-bis of Legislative Decree 502/1992. Through a complex administrative process, the private healthcare provider must demonstrate that it meets and maintains minimum service quality requirements in terms of "organisational, structural and process" conditions (Pioggia 2020, 129). The general regulatory framework is established at national level, while Regions and the Autonomous Provinces are responsible for regulating and administering accreditation procedures in practice. Regional measures may also impose additional requirements beyond the nationally prescribed minimum standards, particularly to reflect local specificities and planning needs, for example, the adoption of tailored clinical protocols or the acquisition of technologies necessary for managing conditions prevalent in a specific territory.

[18] Reliable statistics on the proportion of authorised private facilities that are also accredited are difficult to obtain, particularly for residential and semi-residential centres. The *Annuario statistico del SSN* (Yearly statistics of the NHS) for 2023 (published in 2025) provides data only for private hospitals (i.e., *case di cura*), yet these figures clearly indicate the prevailing trend: private operators overwhelmingly seek accreditation. Regarding *case di cura*, the report shows that, out of a total of 550 facilities, as many as 485 (i.e., 88% of the total) hold accreditation to operate on behalf of the NHS.

These accreditation systems are designed to ensure that applicant institutions possess the characteristics required to guarantee high standards of care and assistance, such as adequate structural facilities, compliance with stringent safety and hygiene parameters, and the adoption of specific clinical protocols. Regional regulations set out a dense body of detailed prescriptions, predominantly technical and organisational in nature, that providers must satisfy to obtain accreditation and which are closely tied to the operational realities of healthcare provision.

Nevertheless, regional legislations (including those of the Autonomous Provinces of Trento and Bolzano) seldom attach significance to the working conditions of staff employed by accredited providers. Normally, accreditation is not made contingent upon compliance with minimum standards of remuneration or employment conditions, nor upon the application of collective agreements concluded by the most representative trade unions; requirements that, by contrast, are routinely imposed in the context of public procurement (Article 11, Legislative Decree no. 36/2023) (Tampieri 2024, 212 ff.).

## 8. Counteracting Contractual Dumping

Despite the close functional link between public authorities and private providers that deliver services on behalf of, and are funded by, the National Health Service (SSN), the current regulatory framework essentially lacks a genuine anti-dumping mechanism.

Recently, the Lazio Region attempted to make accreditation dependent on complying with certain labour law guarantees. In pursuit of the objective of ensuring "the quality of services provided and the correct relationship between labour costs and tariff levels", Article 9 of Lazio Regional Law no. 13/2018 stipulated that, in order to operate within the NHS, healthcare personnel dedicated to personal care services necessary to meet organisational standards must be employed under a national collective agreement signed by the most representative organisations in the healthcare sector. Although formulated as a quality improvement measure, this provision would indirectly but effectively have functioned as a safeguard against contractual dumping by preventing providers from lowering labour standards to reduce operating costs.

Inevitably, the provision touched upon the sensitive intersection between the State's exclusive competence in civil law and the Regions' shared competence in health protection. As expected, shortly after its adoption, several private healthcare providers initiated legal proceedings to challenge its legitimacy. Against this backdrop, the Council of State referred a question of constitutionality, suspecting a breach of Articles 3, 41 and 117 of the Constitution.

The Constitutional Court decision no. 113 of 9 May 2022 declared Article 9 unconstitutional due to its "rigid and inflexible" nature and "excessively intrusive limitation of entrepreneurial freedom". However, it offered valuable insight into the legal debate.

Having dismissed the competence-based objections, the Court established the existence of a link between labour protection and care quality. While re-

affirming that the primary social objective of health legislation, including authorisation and accreditation rules, is to protect health, the Court acknowledged (at para. 7.2) that labour protection "may also be pursued within the organisation of the regional health service". In other words, the legitimacy of measures aimed at improving working conditions within the health sector was not rejected.

It is therefore crucial to pinpoint the precise reason why the Court struck down Article 9. The provision imposed two distinct obligations: (i) all personnel had to be employed under a subordinate employment contract; and (ii) such contracts had to be governed by collective agreements signed by the most representative unions. A close reading of the judgment makes clear that the Court's objections were directed almost exclusively at the first of these requirements.

Applying a balancing test, the Court reiterated that where several constitutional values are in play, the legislation may not privilege one disproportionately at the expense of the others. Labour-protective objectives may legitimately inform health legislation, but they cannot give rise to unreasonable or excessive interference with economic freedom. In the Court's view, obliging all staff to be engaged solely under subordinate contracts was unduly rigid, as it prevented accredited providers from employing highly qualified professionals through self-employment arrangements or other legitimate forms of collaboration. Conversely, the Court expressed no constitutional reservations regarding the second obligation under Article 9 (i.e., the requirement to apply collective agreements concluded by the most representative unions). It follows that a mechanism of this kind does not, in principle, amount to an excessive constraint on entrepreneurial freedom under Article 41 of the Constitution (Benvenuti 2023).

If the imposition of such an obligation within accreditation processes is compatible with the Constitution, this scenario requires legislators to consider the consequences of approving the legislation. One of the most complex issues is identifying the applicable collective agreement.[19]

The literature agrees that collective agreements signed by the most representative trade unions offer a solid guarantee of decent working conditions. They could also protect the right to health, since higher wages and stricter regulatory standards contribute to better and safer care. Indeed, the use of collective agreements offering reduced safeguards, longer working hours and weaker normative conditions not only affects the legal and economic position of workers; it also risks degrading the overall quality of care. Lower standards often produce unsustainable workloads, high turnover and a diminution of professional expertise, particularly in residential settings, with obvious repercussions for the effectiveness and safety of the services provided (OECD and European Commission 2024).

[19] Bavaro 2022, 16; Ciucciovino 2022, 155; Garofalo 2022; Di Noia 2023; Piglialarmi and Poiani Landi 2024; Bellavista 2022.

Accredited providers should compete based on operational efficiency and clinical innovation. However, when competitive advantage is instead achieved by reducing labour costs, market conditions become distorted, with responsible providers coexisting alongside actors whose viability depends on the erosion of labour protections. This dynamic entrenches a structural misalignment between the public service mandate entrusted to accredited providers and the labour conditions under which it is carried out.

## 9. Concluding Remarks

This chapter has reconstructed the legal, institutional and policy landscape of the care sector through a two-level analysis: the emerging governance framework developed at EU level and its translation—often partial, uneven and contradictory—within the Italian system of collective bargaining and service provision. The findings reveal a persistent misalignment between the Union's increasingly functional and integrated conception of care and the fragmented regulatory and representational structures that continue to govern the sector both at EU and national levels.

The examination of EU governance demonstrated how, over the past two decades, care has progressed to a more central position of EU social and economic policy. Once addressed only indirectly through measures on work–life balance, gender equality or migrant labour, the care sector has gradually been recognised as a strategic component of the Union's social model, tied to demographic resilience, labour-market participation, territorial cohesion and the sustainability of welfare systems. Instruments such as the European Care Strategy and the 2022 Council Recommendations reflect an important step towards conceptual integration, promoting high-quality, accessible and sustainable care while emphasising improved working conditions, professional pathways and support for both formal and informal carers. However, this normative evolution has not culminated in a binding legal definition of the care sector, nor in enforceable standards capable of ensuring coherent regulatory regimes across Member States. The reliance on soft law limits the transformative capacity of the EU framework, leaving the realisation of its goals contingent upon domestic political will and institutional arrangements.

The analysis of European social dialogue further exposed this structural limitation. Despite the Union's endorsement of an integrated, life-long approach to care, the institutional architecture of social dialogue remains deeply fragmented. Sectoral committees replicate divisions that are historically embedded within national welfare systems—public versus private provision, medical versus non-medical care, formal versus informal work—thereby preventing the emergence of a unified representational space for care workers. This disarticulation weakens the visibility of the sector, hampers the development of common standards and restricts the capacity of social partners to influence EU policymaking in a coherent manner.

The Italian context offers an illustration of how these supranational constraints manifest in national labour markets, mostly regarding wage and work-

ing time aspects. Italy's long-standing privileging of clinical functions over personal assistance has resulted in the structural undervaluation of non-medical care roles, generating wage disparities, precarious employment and conditions conducive to contractual dumping. The coexistence of numerous National Collective Labour Agreements governing comparable professional profiles—particularly within the accredited private sector—amplifies fragmentation and creates inconsistent levels of protection. Workers performing the most relational, labour-intensive and socially indispensable tasks are those most exposed to the consequences of this contractual differentiation, mirroring broader European trends in the devaluation of care work.

Nevertheless, the Italian system also highlights regulatory opportunities that resonate with EU ambitions. The accreditation mechanism within the NHS offers a potentially effective means of establishing minimum labour standards and promoting upward convergence, insofar as it can be linked to collective agreements concluded by the most representative social partners. When applied with proportionality and reasonableness, accreditation requirements may limit the use of downward wage competition as a competitive strategy and ensure that contractual protections form an integral part of quality-of-care assessments. While regional initiatives, such as the Lazio Regional Law 13/2018, have attempted to introduce anti-dumping safeguards, their fragmented territorial scope underscores the need for national-level intervention capable of guaranteeing uniform protection across the country.

Taken together, the analysis demonstrates that the effectiveness of the care sector—both as a system of services and as a labour market—depends on a closer alignment between EU governance and national regulatory structures. At the EU level, the absence of a binding legal definition and the fragmentation of social dialogue continue to limit coherent policymaking. At the national level, collective bargaining must be capable of addressing entrenched inequalities and supporting the professional recognition of all care workers, including those operating at the margins of formal labour markets. Coherence between these levels is not simply desirable but essential if the strategic, social and gender-equality objectives attached to the modern care sector are to be fully realised in practice.

Ultimately, the chapter underscores that care work must be recognised not only as a social necessity but also as a legally protected profession. Achieving this requires both a stronger EU legal framework and domestic mechanisms capable of giving concrete effect to supranational principles. Only through such multilevel convergence can the dignity, rights and working conditions of care workers be safeguarded, and the broader societal value of care be translated into effective and enforceable law.

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CHAPTER 11

# Nursing under Pressure: Why Ensuring Adequate Staffing Levels is Crucial for Good Care and Employee Retention in German Hospitals

Ziga Podgornik Jakil

## 1. Introduction

> Well, the nursing shortage has come about because there is a shortage of skilled workers, and this has developed over the years, it hasn't fallen from the sky. It has been a process. This is precisely why there is the Hospital Movement, the nursing movement, which wants to ensure that working conditions are so good that people are motivated to work in nursing again.

These were the words of Dana Lützkendorf, an intensive care nurse turned union organizer and one of the main forces behind the Hospital Movement—a trade union initiative and alliance of workplace groups in hospitals across Germany, organized under the United Services Trade Union (*Vereinte Dienstleistungsgewerkschaft*, ver.di) that represents hospital nurses. I met Dana in September 2023 at ver.di's headquarters to talk to her about the origins, goals, and challenges of this movement and the working conditions faced by nurses in Germany. She emphasized that chronic staff shortages in hospitals had become the central issue of the movement's recent campaigns. At the end of our conversation, she suggested that I join the campaign, which was set to launch in the Private Hospital in a few months.[1]

[1] The name of the hospital where the primary research took place and the names of the nursing staff were anonymized to maintain confidentiality and protect the privacy of the participants.

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The campaign was part of the recent history of German nursing strikes, which can be traced back to the first successful industrial actions at the Charité, one of the largest public hospitals in Germany and Europe. In 2011, employees—particularly those from Charité's subsidiary companies who were excluded from the public sector collective agreement (*TVöD*)—organized a successful campaign for higher wages and inclusion into the TVöD. According to several nurses and strike organizers, this victory boosted the self-confidence of nursing staff and paved the way for pursuing the first in-company collective agreement for minimum staffing levels, which was implemented at Charité in 2016 (Lützkendorf 2022, 25, 28).

In contrast to traditional wage disputes, recent campaigns, including the one mentioned by Dana, cantered on the so-called *Collective Agreement "Relief"* (*Tarifvertrag "Entlastung", TV-E*). This company-level agreement primarily aims to establish legally binding, ward- and shift-specific minimum staffing levels based on nurse-to-patient ratios, negotiated between nursing staff and hospital management to improve working conditions. The TV-E has become one of the central demands of the Hospital Movement,[2] reflecting a shift in focus from pay to improving working conditions through better staffing levels.

Founded in Berlin in 2021, the Hospital Movement has since spread to hospitals in several other German cities. It frames its struggle as part of a broader pushback against the marketization of hospital care—a trend that intensified after the introduction of the Diagnosis Related Groups (DRG) system in 2004, a hospital financing model that reimburses a fixed amount for each treated diagnosis rather than the actual time the patient requires in the hospital. As a result, hospitals have been incentivized to cut costs, reduce services, and avoid hiring additional staff (Simon 2020). According to union organizers, these policies have hit nursing staff particularly hard, despite subsequent reforms to the DRG system and the introduction of the Nursing Staff Assessment Regulation (*Pflegepersonalbemessungsverordnung*) in 2024, which assesses staffing requirements in hospitals(Leber and Vogt 2020; Lützkendorf 2025).

Using qualitative research methods, including ethnography and structured interviews, this article seeks to demonstrate the crucial role of sufficient staffing in nursing and the urgent need for legal instruments to guarantee it. Understaffing not only creates poor working conditions for nurses but also endangers patients' lives. When nurses lack the time to practice in accordance with their professional identity, which is based on their ethical responsibility towards patients whose well-being is at stake and towards their colleagues whose workload is directly affected, they face heightened emotional strain and exhaustion. This dilemma is well captured in the statement, "We are saving you. Who is saving us?" Having time to care for patients is integral to what nurses define as *good care*.

[2] The term TV-E is used by union organizers as a general reference for this type of collective agreement, although its official name varies depending on the hospital and the specific agreement (see Footnote 13). Nevertheless, I will use TV-E throughout the text for the sake of clarity.

## 2. Methods and Fieldwork: Ethnography

This paper draws on qualitative research that I conducted at the Private Hospital between November 2023 and June 2024, with prior permission from ver.di. During this period, nurses employed there, together with campaign organizers from the Hospital Movement, ver.di, and the activist organization Organizi.ng, mobilized around the TV-E campaign. My research relied primarily on ethnographic fieldwork of the campaign, including participant observation of regular weekly meetings between nurses and organizers held in a community space near the hospital. Ethnography, as the study of others' social worlds through sustained, direct experience (Emerson et al. 1995), enabled me to build trust with nurses and union organizers and provided access to the everyday dynamics of the campaign—access that would have been difficult to achieve in the context of an industrial action where discretion was essential.

In addition to these meetings, I attended the TV-E campaign's kick-off event in the fall of 2023, accompanied organizers (particularly from Organizi.ng) to the hospital, where they helped nurses collect signatures and questionnaires on their wards, i.e., hospital departments where patients with similar medical needs are accommodated, and took part in several demonstrations. The latter included actions organized by the Hospital Movement, a union rally in front of Charité—Berlin University of Medicine on International Nurses Day (May 12, 2023), and a warning strike at the Private Hospital in June 2024.

During my fieldwork, I documented the exchanges between nurses and organizers and regularly held conversations with both groups, focusing on the dynamics of the campaign. I also conducted fifteen structured interviews with unionized and non-unionized nurses from different wards. These interviews explored the effects of understaffing on daily working conditions, how it shapes relations among colleagues, and how nurses themselves define good care.

To broaden the scope of my findings, I supplemented the ethnography with three focus groups conducted as part of my work on the CARE4CARE Project, which also funded this research. These took place in two other hospitals where the campaign was not taking place at the time of the research: two at Charité and one at Klinikum Frankfurt (Oder), a private clinic without the TV-E in smaller city near Berlin. Each focus group brought together between three and eight nurses in loosely structured conversations cantered on their everyday working conditions.

## 3. Care Crisis in German Hospitals

> The economization process began at the end of the 1990s, when many nursing schools in Germany closed, training positions were cut, and staff recruitment was effectively halted. This meant that many clinics imposed hiring freezes, leading to a gradual reduction in staffing levels, even as workloads continued to rise. But things really got bad with the introduction of the DRG System of flat-rate payments per case in hospital financing (Dana Lützkendorf, interview).

The economization mentioned by Dana Lützkendorf is related to the legislative reforms in the German healthcare system in the 1990s, which also targeted the financing of hospitals (Busse et al., 2006; Mohan 2019; Simon 2020, 92). These reforms, presented as a necessary response to rising national healthcare expenditures (Tiemann and Schreyögg 2012), placed hospitals under increasing pressure to cut costs, which also led to a reduction in nursing staff (Mohan 2018, 168; Simon 2014). This trend was further intensified by a wave of hospital privatizations since the 1990s (Heimeshoff et al. 2014), which also encompassed the Private Hospital.

A crucial part of these reforms was the *Diagnosis-Related Groups* (DRG) *system* (*DRG-Fallpauschalensystem*),[3] introduced in 2004 (Deutscher Bundestag 2017). It replaced the *retrospective and procedural reimbursement system* (*tagesgleiche Pflegesätze*) under which hospitals received reimbursement from the health insurance companies for the time the patient spent in hospital for treatment.[4] Under the DRG system, however, hospitals receive a fixed lump sum for each diagnosis, in other words, on the basis of the number and type of cases treated (Geissler et al. 2011, 10). The official argument for this shift was that the former system encouraged budget inefficiency, including through prolonged hospital stays and continued operation of unprofitable medical departments (Böcking et al. 2005, 129).

In this context, the DRG system was introduced to increase hospital profitability by reducing the length of stays and costs per treated patient, while boosting the number of patients and thus the revenue generated per diagnosis (Wilm et al. 2011, 28). However, the results have been ambivalent (Koné et al. 2019; Reifferscheid et al. 2015). Some argue that although hospital stays and waiting times for patients have been reduced in some cases, workloads and healthcare expenditures have risen (Koné et al. 2019, 11; Milstein and Schreyögg 2020, 28). Critics claim that this system created incentives for hospitals to prioritize profit over healthcare: discharging patients as quickly as possible to increase patient turnover, admitting patients with high-reimbursement diagnoses, and performing unnecessary procedures and treatments (Leber and Vogt 2020; Lützkendorf 2025; Reifferscheid et al. 2015, e130).[5] Moreover, many hospitals that have

[3] Diagnosis-related group-based payment is a lump sum reimbursement based on DRG codes, which divide patients into homogeneous groups. In 1983, DRG-based payment was first introduced for Medicare patients in the United States and later adapted in other countries, such as Australia, Canada, France, Germany etc. (Koné 2019, 2; see also Busse et al. 2006).

[4] German hospitals are financed according to the principle of duality, introduced with the Hospital Financing Act (KHG) in 1972 (Geissler et al. 2011, 244). Under this system, health insurance funds cover the operating costs of patient treatment, while investment costs for buildings and medical infrastructure are funded by the individual federal states (cf. Bundesministerium für Gesundheit 2026a). Healthcare workers are primarily paid through hospital operating budgets, which are financed primarily by health insurance funds.

[5] However, institutional actors such as the National Association of Statutory Health Insurance Funds (GKV- Spitzenverband Bund der Krankenkassen) (GKV-Spitzenverband 2014, 2015; GKV-SV 2018b), along with some scholars (Braun 2019; Busse et al. 2006),

not been profitable enough, especially in rural areas, have been threatened with closure (Pilny et al. 2025).

Among the largest critics of the hospital reforms and the DRG system have been the trade unions (Hans-Böckler-Stiftung 2020), such as ver.di, and nurses themselves. Both emphasize that these reforms have severely impacted nurses' working conditions, primarily through hiring freezes and staff reductions amid increasing workloads (Simon 2020, 178–79). In their opinion, the pressure to reduce hospital costs has been borne disproportionately by nursing staff (Leber and Vogt 2020, 115).

Raising pressures by the public and experts have achieved that nursing personnel costs were decoupled from DRG-based payments in 2020 and became financed via a hospital-specific nursing budget (*Pflegebudget*) (Schmedders 2023, 216). A few years later, the federal government in office from 2021 to 2025 undertook a broader reform of the DRG system (Lobenstein 2022). A new hybrid model of hospital funding was introduced that retains elements of the DRG system but supplements them with so-called readiness payments (*Vorhaltepauschalen*) to prevent the closure of essential but unprofitable hospitals.[6]

Critics argue, however, that the reform does not go far enough. They claim that it fails to alleviate the economic pressure hospitals face under the DRG logic, which continues to limit the additional staff hiring and adds new bureaucratic burdens for healthcare workers (ver.di 2024). While nurse salaries have risen in recent years and now exceed the national average in some cases,[7] nursing services in hospitals have remained understaffed and overworked. As a result, more and more nursing staff leave clinics for other sectors, reduce their working hours to protect their health, or take early retirement. Hospitals are now facing considerable problems in finding qualified nursing staff on the labour market (Auffenberg et al. 2022; Simon 2020, 179).

It is within this context that recent nurses' strikes must be understood: they are driven less by demands for higher wages and more by calls for adequate staffing. Nurses have voiced that, under current conditions, they can no longer provide safe and quality care. Their strikes are therefore often framed as acts of resistance against the market-driven logic that has come to dominate German hospitals. Before examining how understaffing impacts working conditions and care quality, I outline the state-level staffing regulations in hospitals and the TV-E campaign organized by nurses at the Private Clinic in autumn 2023 and spring 2024.

claim that the DRG system is not to blame for job cuts and work overload, but rather hospital overcapacity and insufficient investment in infrastructure (in Simon 2020, 180–81). The GKV also argues that the number of nursing staff in German hospitals per 1,000 inhabitants was "well above the EU average (GKV-SV 2018, 8). However, others dispute this based on methodological inconsistencies and misleading comparisons (Simon 2020, 181).

6 More details about the hospital reform can be accessed here Bundesministerium für Gesundheit 2026b.

7 This applies, for example, to nursing professionals with three years of vocational training (CARE4CARE Consortium 2024, 285).

## 4. Regulating Staffing Levels at Hospitals

*Mehr für uns ist besser für alle* (Slogan of the Hospital Movement).

The above slogan of the Hospital Movement in Germany (Habekost et al. 2022) —"More for us is better for all"—emphasizes that improving working conditions is inseparable from ensuring good care. Nurses and union organizers regard both goals as achievable primarily through significantly increased staffing levels. Although there have been attempts in Germany to regulate staffing levels by law, these measures have so far been insufficient to meet the needs of nurses.

### 4.1 PPR and TV-E

As an early attempt to address understaffing, Germany introduced a "Regulation on standards and principles for staffing requirements in inpatient nursing care" (*Regelung über Maßstäbe und Grundsätze für den Personalbedarf in der stationären Krankenpflege*, short *Pflegepersonal-Regelung* (*PPR*)) already in 1993. The regulation was mainly designed to determine the necessary number of nursing staff in hospitals by calculating the daily nursing care requirements of inpatients (Simon 2020, 180). However, the law was repealed in 1997 on the grounds that meeting the mandated staffing levels was unrealistic (Keun and Prott 2008, 11), especially due to opposition from health insurance providers (Lützkendorf 2022, 22).

Until 2024, there had been no effective, legally binding mechanisms for setting minimum staffing levels in hospitals—the exception was the Nursing Staff Minimum Limits Ordinance (Pflegepersonaluntergrenzen-Verordnung, PpUGV) in 2019, which applied only to selected wards (e.g., intensive care) and could be easily circumvented by hospital management (Simon 2020, 202–3). In 2024, the new PPR 2.0, now called the "Nursing Staff Assessment Regulation" (*Pflegepersonalbemessungsverordnung*), came into force, which had been developed by ver.di, the German Hospital Association (*Deutsche Krankenhausgesellschaft*), and the German Nursing Council (*Deutscher Pflegerat*). PPR 2.0 so far only provides a framework for calculating staffing needs, but does not impose any sanctions if hospitals fail to meet them (Bundesministeriums für Gesundheit 2024).

The *Collective Agreement Relief* (*Tarifvertrag Entlastung*; *TV-E*) has been a response by the unions to this lack of staffing regulations. It is negotiated at the company level between representatives of the nursing staff, including nurses themselves and ver.di organizers, and hospital management as the employer, with the option to call a strike if no consensus is reached.[8] In contrast to the

[8] The maximum amount of additional paid leave granted per year, along with other benefits—such as sabbaticals, early retirement options, or cash bonuses—is defined individually in each TV-E. For example, in the Collective Agreement for Healthcare Professions at Charité (TV Gesundheitsfachberufe), these provisions are laid out in detail at Charité – Universitätsmedizin Berlin 2021.

PPR 2.0., it creates legally binding ward- and shift-specific minimum staffing requirements based on nurse-to-patient ratios with enforceable sanctions.[9] If staffing requirements are not met during a shift or if nursing staff are exposed to other stressful situations, e.g., if they have to work in another ward outside their specialization, work with a high number of temporary staff, or experience violence from patients, they are entitled to so-called relief points (*Entlastungspunkte*). Once a certain number of points have been accumulated, employees can redeem them for additional paid days off or other benefits.

The underlying logic behind this mechanism is to pressure hospital management to hire more staff, as it eventually makes understaffing more costly than employing additional nurses (Berliner Krankenhausbewegung 2023). While the TV-E currently exists only as a company-level agreement—sometimes under different names (see footnote 13), it has so far been implemented in several, mainly public hospitals across Germany (Herausgeberinnenkollektiv 2023). Unlike government regulations such as PPR 2.0, perhaps its most important feature is that nurses themselves play a central role in determining what they consider to be fair staffing levels, as the following campaign shows.

### 4.2 TV-E Campaign at the Private Hospital

Building on these efforts to address understaffing, the campaign for the TV-E at the Private Hospital began in autumn 2023, when ver.di, with support from the organization Organizi.ng and activists from the Berlin Hospital Movement, held a two-day kick-off workshop with the nurses from the hospital.

The first meeting was held in a large seminar room located in an old socialist-era building in former East Berlin. As I observed and listened to the participants over the next two days, I noticed that nurses from a wide range of wards—intensive care, neonatal, psychosomatic, paediatric, geriatric, and others—had come together for the workshop. The majority was women between the ages of twenty and sixty. Some had worked as nurses, sometimes at the same hospital, for more than 40 years, while others were still undergoing vocational training. Several were union or works council members;[10] others were new to union organizing, or had once been members but left ver.di for various reasons. For many newcomers, it was the first time to openly discuss the challenges they face daily,

[9] When the nurses discussed in this article campaigned for the Tarifvertrag Entlastung (TV-E), the PPR 2.0 had not yet been fully implemented.

[10] Germany has a dual system of worker representation: (1) a collective bargaining system between trade unions and employers, and (2) a works council system. Works councils function as co-determination bodies at the company level, dealing with workplace conditions, social matters, and certain operational decisions, but—unlike trade unions—they cannot call for strikes or negotiate collective agreements, instead, they conclude works agreements. They are elected in companies with at least five permanent employees (Sec. 1 BetrVG) and represent the interests of all employees toward the employer, regardless of union membership or participation in the election (CARE4CARE Consortium 2024, 248).

to realize how widely these experiences are shared by colleagues, and to learn about the legal mechanisms available to push for more staffing.

The workshop organizers explained the benefits of the TV-E and the collective organizing efforts behind it, employing interactive methods to engage participants. For example, they conducted a simulation exercise in which the organizers acted as hospital managers, while a group of nurses, acting as elected members of the collective bargaining committee (*Tarifkommission*),[11] negotiated their collective demands. Following these activities, the organizers outlined a detailed campaign plan for the coming months, structured into three stages:

1) Building contacts with colleagues on their wards and assessing their readiness to support the action and a potential strike.
2) Conducting questionnaires to identify and agree on a central demand for each ward, and
3) Presenting these central demands to hospital management, granting a limited time for a response. If the management refused to negotiate or offered an unsatisfactory deal during the negotiations, the plan called for a strike.

During the first phase, the nurses met almost weekly with ver.di and other campaign organizers in a community space near the Private Clinic. These weekly meetings, which were attended by as few as a couple or as many as a few dozen nurses, served as gatherings where nurses updated each other and the organizers about their progress. In particular, they discussed the signatures they had collected on petitions with their colleagues on their wards, which served as organizing units, to determine who was willing to join the campaign and who was willing to strike.

Once enough signatures had been gathered to confirm that colleagues were ready to take action, the campaign moved into its second phase. In this phase, nurses, sometimes with the help of organizers, surveyed their colleagues using the ver.di questionnaire, which was also used to determine the TV-E demands in other hospitals. The questionnaire focused on what each nurse considered a fair nurse-to-patient ratio for their ward, what additional factors constituted an overburdened shift, and how many relief points should entitle someone to benefits, such as additional paid leave.

In the third phase, the results were compiled into a single document summarizing the key demands of the wards where the nurses had organized themselves, which was then presented to the hospital management. The nurses also elected the members of the collective bargaining committee who would take part in the negotiations with the hospital management. However, the management refused to enter into negotiations within the deadline set by ver.di. In response,

[11] A collective bargaining committee is an elected body of employees, mainly union members, from a respective company or industry that plays a central role in negotiations with the employer during collective bargaining (ver.di 2023).

a warning strike[12] was organized and attended by the majority of the hospital's nursing staff, along with the support from the Hospital Movement. Nevertheless, the campaign did not progress as planned. In the summer of 2024, ver.di paused the effort due to legal complications that mainly arose in connection with the upcoming wage bargaining in the hospital and the specific corporate structure of the hospital, which made it more difficult to negotiate the TV-E than in public hospitals.

Nevertheless, the campaign offered a valuable insight into why sufficient staffing is essential not only for patient safety and good working conditions, but also as a prerequisite for what the nurses I talked to regard as *good care*. Having enough time for patients was central to their sense of professional identity, yet this was only possible with adequate and properly trained staff. It is to this professional and ethical reasoning in nursing that I now turn in the following section.

## 5. Professional and Ethical Responsibilities during Staff Shortages

My interlocutors identified understaffing as the most pressing problem they and their colleagues faced in their hospital. It directly affected their ability to meet the professional and ethical responsibilities they considered central to their work. The ethical dimension was tight to the strong sense of responsibility they felt toward both their patients and their colleagues: they not only feared for their patients' safety under such conditions, but also did not want to leave their colleagues to work under exhaustive conditions.

In the following subsections, I analyse how my interlocutors experienced the effects of understaffing in relation to their responsibilities towards patients (5.1), towards their colleagues (5.2), the emotional labour required of them (5.3), and, finally, the provision of good care (5.4).

### 5.1 Responsibility Towards Patients

> I believe that the ethical basis is that we must guarantee patient safety, and at the moment I cannot promise them this (Gambina, delivery nurse).

In the existing literature, the shortage of nursing staff is repeatedly linked to risks for patients and a decline in the quality of care (Auffenberg et al. 2022; Drennan et al. 2024; Isfort 2013). These findings resonate strongly with the experiences shared by my interlocutors. Many described how understaffing compromised their ability to carry out essential tasks and maintain patient safety. Vivi, a delivery nurse, explained that monitoring the vital signs of new-borns is a crucial part of the responsibilities of nurses working in the maternity ward—alongside assisting births, administering medication, and supporting distressed

[12] A warning strike is a temporary, short work stoppage during ongoing collective bargaining negotiations. Trade unions use warning strikes to emphasize their demands in the ongoing negotiations (ver.di 2007).

patients. However, due to persistent understaffing, she is often responsible for several patient rooms at once, making proper monitoring impossible. She recounted an incident during an emergency when there were not enough staff at hand to respond in time:

> I just happened to be at the monitor because I wanted to take a shorter route to my room. I saw that a child wasn't getting enough oxygen, and I was completely alone because all my colleagues and doctors were busy with an emergency in another room. I had to decide whether to join them because my name was being called and I was needed there, or to stay here. And that shouldn't happen in 2024 in Europe, in a developed country.

While Vivi did not disclose what happened, Marlene from the neonatal intensive care ward described a similarly critical situation that led to the death of one of the new-born twins, both of whom were not breathing at birth. Due to understaffing, she and her colleagues were forced to decide which infant to resuscitate first, aware that such a delay could have life-threatening consequences.

> There were three of us. It was already tight, but manageable. Then twins were delivered, and one nurse had to go downstairs, leaving two of us with twelve children. The twins needed resuscitation. The doctors came, but with so few people, we couldn't manage both and one died. I thought, we could have saved both if there had been more staff.

Life-threatening situations for patients can also happen when nurses are assigned to help their colleagues in understaffed wards. Temporary assignment to a ward outside one's own area of expertise has been recognized in several TV-Es as a burden that grants a relief point.[13] Several of my interlocutors recounted being called in or assigned to wards requiring different skills and experience to cover staff shortages and support their colleagues. Wendy, a nurse in the paediatric intensive care ward, described a situation in which she lacked the necessary clinical knowledge to adequately care for a patient:

> Well, there are always difficult situations. For example, when a nurse has to take a child for a CT scan, but I'm working on a ward without that training. In an emergency, of course, I can try to react and do what I think is best to my knowledge and belief. For me personally, this is a difficult situation because if something happens, it weighs on my conscience, my well-being, and my work.

A similar concern was voiced by Franzi, a nurse working in the day clinic of the hospital's geriatric department,[14] who was regularly called to fill in on other wards: "I understand that sometimes you have to help out elsewhere. But you're not trained for that work and it adds extra stress. All you can do is offer assis-

[13] TV-E of Charité, for example.

[14] In a day clinic, elderly patients usually spend several hours in the geriatric ward undergoing examinations, eating, and participating in social activities, returning home at the end of the day.

tance". Such reassignments create potentially dangerous situations for patients and place additional strain on nurses: not only on those who do not have the necessary training, like Wendy and Franzi, but also on experienced staff who have to work with untrained colleagues, especially those who are still in vocational training. Steffi, a nurse with nearly thirty years of experience in paediatric intensive care, emphasized this point:

> On our ward, it often happens that just three of us are responsible for six, sometimes even ten children. But usually only one of us is experienced and knows the ward well, while the other two are new or with little training. That's always a difficult, potentially life-threatening situation. It leads to medication being mixed up or given too late, documentation errors or a nurse not knowing how to respond in an emergency and calling for help, by which time the newborn's condition may already have worsened.

As Steffi's case also illustrates, in addition to their regular responsibilities, experienced nurses are often expected to supervise junior colleagues who are still completing the mandatory practical part of their vocational training. Trainees typically lack the experience required to manage patient care independently, and several of my interlocutors described that it was difficult to support them while also keeping up with their own tasks. Similar challenges arose with temporary nurses hired through employment agencies to bridge staffing shortages.[15] Far from easing workloads, they were frequently described by my interlocutors as an additional burden (Riedlinger 2024),[16] since nursing relies heavily on teamwork and familiarity with the ward—an aspect I now turn to.

### 5.2 Towards Colleagues

> We all grew up in teams. Many people work in these teams almost from the start of their training. Nursing is teamwork, it's like a family. If someone in your family offers to help, you try to help them. I spend eight hours with these people, and we have a goal to provide good care for the patients. We can rely on each other. The team spirit is there. Even though we know that our teamwork is exploited by the management, we do it anyway because each of us knows how grateful one is when someone is in this situation themselves. (Lilly, paediatric intensive care nurse)

[15] Nurses employed through temporary employment agencies usually work in several wards or hospitals. Several of my interlocutors viewed this arrangement as a means to reduce their working hours, increase their earnings, or temporarily switch wards in order to recover from the responsibilities they usually carry (Riedlinger et al. 2020)—for example, one nurse worked about 30 hours at the Private Hospital where she was employed and about 5 hours through a temporary employment agency at other hospitals.

[16] Under the TV-E for university hospitals in North Rhine-Westphalia, a shift in which 50% of a team consists of temporary staff is considered a high-burden situation (dbb beamtenbund und tarifunion 2022).

Lilly's words illustrate that nursing is practiced as a collaborative endeavour that fosters a strong sense of mutual responsibility—sometimes even described as a kind of professional kinship. My interlocutors not only perceived teamwork as a necessity for performing their tasks, but also, at times, a source of emotional attachment and solidarity among colleagues.

Studies across different professions demonstrate that teamwork develops through shared work experiences and the attachments that emerge from them (Hodson 1997, 430). In nursing, teamwork is not only an organizational structure, but also an ethical sentiment based on responsibility towards patients and colleagues (Dinius et al. 2020; Winter et al. 2021). However, as Vivi, a delivery nurse, stressed, this responsibility has two faces:

> You have to imagine that we are always together. During the holidays, on weekends, when something bad happens to us or something like that, we are not just colleagues, we are also part of a family. This work family supports each other, but that also brings more stress for everyone.

This sense of collegiality and familial bond also generates additional pressure, as nurses often feel compelled to cover for colleagues or work overtime. When asked whether they felt ethically obliged to step in for their colleagues, my interlocutors consistently answered with conviction. They explained that leaving their colleagues work understaffed shifts created the feeling of guilty conscience, or as Wendy, a paediatric intensive care nurse, put it: "You don't want to leave your colleagues and patients alone in such a shitty situation". Vivi expressed a similar sentiment, emphasizing the emotional toll that the sense of responsibility toward colleagues takes:

> You want to help. Even though it's not really your fault, you feel guilty in that moment, so you usually feel like you're the bad one because you say no. I want to be at home sometimes, with my family, with friends, or just have a day off, but you live with this guilty conscience. And then you think, no, no, you can't say no now. You can't leave your colleagues alone. Then, of course, it causes even more stress.

The guilty conscience many nurses described often stemmed from solidarity with their colleagues, not wanting to leave them to struggle with understaffed shifts. Yet this guilt was also driven by the awareness that they could easily find themselves in the same position one day. As Danny, a nurse working in the psychosomatic ward, explained:

> Because you feel guilty towards the other person being there alone and you know exactly that it's bad when you're working alone, and that's why you come in even though you have the day off. It's bad for colleagues, but it's also bad for patients because they are not well cared for.

While the sense of inter-collegial responsibility has also been documented in other professions, such as among automotive industry workers, teachers, cocktail waitresses etc. (Graham 1995; Hodson 1997; Laaser and Bolton 2017;

2020; Spradley and Mann 1975), it has a special ethical significance in nursing given the direct responsibility for the well-being of patients (Theodosius 2008). Nurses are concerned that not stepping in to fill an understaffed shift may compromise the quality and safety of patient care. As Illiana, a nurse working in palliative care, put it:

> There's so much at stake. It's not just the guilty conscience that the staff has to work understaffed again, but it's also a problem that my patients need to be cared for, so I can't just say, no, I'm not stepping in, when I know full well that there are far too few staff on duty again and the patients are not being cared for.

The concern that patients might be left without adequate care is directly tied to the professional ethos of nursing, which, among other things, places emphasis on promoting health, alleviating suffering, and patient advocacy (International Council of Nurses 2021). For Steffi, this professional ethos also implies a sense of honour, intimately linked to an inner disposition of empathy that nurses are expected, and even required (7) to embody:

> You have to be empathetic; otherwise you can't do this job. You can't leave the nurse alone; everyone has such high expectations of themselves and others, and also a sense of honour, that you simply have to do it to feel good about yourself.

This is not to suggest that nurses never refused requests to fill in or that there was unconditional solidarity among them. Marlene from the neonatal intensive care ward, for instance, emphasized how much time and emotional effort it took her to learn to say *no* when asked by colleagues or supervisors to cover additional shifts. Yet it was precisely this sense of responsibility and the difficulty of saying no that hospital management often exploited to push nurses into understaffed shifts instead of hiring new staff. As Illiana puts it:

> But the problem is that managers exploit precisely this attitude, which many people in the care sector have. They know full well that staff can't say no; that we'll step in and work overtime, so they don't need to hire new staff because we'll get things done anyway.[17]

Understaffing thus created conditions under which not only filling in for others but also working overtime became a routine part of my interlocutors' shifts. As Marlene put it: "If the emergency call comes ten minutes before the end of your shift, you can't just leave the colleague and the patient alone". Many agreed that such unplanned overtime did not bother them as much as overtime that resulted from being unable to complete their tasks within regular hours due to understaffing. Out of a sense of ethical responsibility, many felt guilty

[17] Similar concerns are documented in the book published by the Berlin Hospital Movement, which describes how the moral and emotional commitments of care professionals are strategically instrumentalized by hospital management to stabilize understaffing (Habekost et al. 2022, 24).

about leaving unfinished work to colleagues, since this would only add to their workload. Some of my interlocutors reported accumulating over 100 hours of overtime per year—hours they were often unable to convert into time off due to on-going staff shortages.

The sense of responsibility towards colleagues and patients (Section 5.1.) forms an important part of collective professional identity of nursing staff (Auffenberg et al. 2022, 68). This expectation becomes emotionally burdensome when filling in shifts and working overtime shifts from an exception into the norm. These teamwork experiences and challenges help explain why the key demands of nurses at the Private Clinic focused on enforceable regulations to guarantee sufficient staffing. Their demands were driven not only by the need for better working conditions, but also by the desire to ensure *good care*, which required emotional presence and time for patients.

### 5.3 Emotional Exhaustion and Emotional Labour

> In the end, I couldn't look myself in the mirror because I couldn't do my job anymore in a way that met my standards. I had to decide which child should survive. I believe that what we did there was dangerous care (Marlene, neonatal intensive care ward).

Sections 5.1 and 5.2 illustrate that emotional burden and exhaustion are the main consequences of nurses being unable to fulfil their ethical responsibilities to patients and colleagues due to staff shortages. As shown, these responsibilities are directly tied to nurses' professional identity and when they cannot be fulfilled, nurses experience moral distress,[18] devaluation of their work, and, consequently, diminished job satisfaction (see also CARE4CARE Consortium forthcoming).

The emotional burden and exhaustion[19] associated with nursing work has been widely documented (Chen and Meier 2021; Woo et al. 2020; Wright and Cropanzano 1998). While these emotional strains are tied to nurses' frequent exposure to situations involving illness and death (Smith 2011; Theodosius 2008), chronic staff shortages leave nurses with little time for emotional recovery during or between shifts. This has led to high rates of sick leave among nurses (Gohar et al. 2020; Petersen et al. 2022) and many deciding to leave the profession altogether (Auffenberg et al. 2022; Garcia González and Peters 2021).

Among my interlocutors, emergencies were described as particularly emotionally stressful. Gambina, a delivery nurse, recounted a situation in which a pregnant patient had to undergo an emergency delivery after the foetus stopped

[18] Moral distress is defined as: "the burden felt by a nurse who believes they know what the professionally ethical behavior would be in a particular care situation but, due to impediments, is unable to act accordingly (Petersen and Melzer 2023, 4; see also Kleinknecht-Dolf et al. 2017).

[19] Emotional exhaustion is defined by feelings of being emotionally overextended and exhausted by one's work (Wright and Cropanzano 1998, 489).

showing vital signs on the monitor. The medical team reacted too late, and the new-born had to be resuscitated immediately after birth. Although the child survived, Gambina was deeply shaken by the experience:

> When I came out of the operating room, I lost track of everything and kept thinking it was my fault. I was in shock. And I had to perform another delivery immediately afterwards. It was successful, but all I could see was the baby from before who wasn't breathing. So after an emergency, you have to get back on your feet quickly. You can't just go home. You can't ask for a day off. You have to be there. It wears you down. It also takes toll on your motivation, because you need moments when you can sit down, take a breather, before moving on to the next patient.

Such emotional distress was not limited to emergencies. Albana, a nurse working in an intensive ward, explained that such situations are a constant part of her every day and that one has to act as if nothing happens and simply carry on, even though, emotionally, it remains extremely difficult. Several of my interlocutors pointed out that at the end of their shift, they would go home carrying the stress with them, often dreaming about work and hoping they had done everything they were supposed to.

Importantly, Gambina's example also illustrates the dual nature of emotion management nurses have to deal with: managing their own inner emotional responses and taking care of emotions of patients and their families (James 1992; Theodosius 2008, 43; Yildiz et al. 2024). Jojo, a nurse on the surgical ward, said that besides cleaning and mobilizing patients after surgery, she also has to talk to them and offer them emotional support, as post-surgical period is a difficult experience for many:

> People always say that patients are important. Yes, they are. We are there for them. But sometimes we need help too, because our heads are spinning. There are so many emotions, so much frustration. It makes you feel powerless and you always have to smile. But I can't always do that, because just like the patient, I am also human. And patients are often confused after surgery and they sometimes become aggressive.

Nurses are thus expected to compose themselves after emotionally intense situations, continue working, and showing emotional support to patients. These experiences highlight that a crucial component of nursing is emotional labour. Emotional labour has been defined as the management of one's own feelings and expressions in the work process, as expected and evaluated by professional norms and standards, particularly in the service sector where interactions with clients, customers, or patients are central (Bolton 2005; Hochschild 2003).

While in many professions emotional labour serves to influence others' experiences—to sell a product or enhance customer satisfaction, such as a flight attendant maintaining a cheerful demeanour to reassure passengers (Hochschild 2003), in nursing it is directly tied to the safety, wellbeing, and care out-

comes of patients (Theodosious 2008). Most of my interlocutors agreed that emotional labour is a crucial aspect of their work, particularly because patients or their close ones are vulnerable and often in need of compassionate presence and comfort. For example, Lilly, a paediatric intensive care nurse, pointed out that emotional labour is essential when providing instructions and reassurance to parents of premature or seriously ill babies:

> The parents need to be told what is happening with their baby. They are extremely depressed, the women often feel very bad, they need a lot of support and care and guidance, comfort, encouragement. We talk a lot and it's very challenging; we pay attention to their mental state. We have different techniques and conversation skills that we have to use so that they can process and learn everything.

In Lilly's case, emotional labour serves as a prerequisite for completing other tasks, such as teaching parents how to care for their seriously ill children. On the other hand, some saw emotional labour as having a therapeutic quality (Theodosius 2008, 47), as illustrated by Jojo, who noted: "Most of the patients lying in bed are elderly and they want to talk. However, nurses don't have time for that. But it's important for the patients". However, both the instrumental and therapeutic aspects of emotional work are not mutually exclusive. This is evident, for example, in Marlene from the neonatal intensive care ward, who emphasized emotional labour as part of the broader interactional qualities of nursing work, which also affects nurses themselves:

> If you have a child whose parents are not in the hospital, then you have to sit by the bed and you have to talk to the child. You can then prepare the food in the way that the child feels like eating it. But I also learned how to do crafts and I really enjoy doing it instead of just providing medication to one patient and running to another.

Hence, interacting with patients was also something that some nurses described as enjoyable and as a meaningful part of their work (Bone 2002; Smith 2011). Nurses like Albana emphasised the unique role nurses play in patient care and how their responsibilities differ from those of other medical professionals: "In the end, we're the ones who stand at the bedside for hours. And we're the ones who have to talk to the patients". This can be exhausting because, as Vivi, a delivery nurse, explained: "Each patient comes with their own wishes and demands".

This on-going emotional strain reflects the weight of ethical responsibility nurses feel towards their patients while working understaffed. Some of my interlocutors expressed the sentiment that hospital management prioritizes cost saving or profit maximization over the well-being of staff. While Franzi, a geriatric nurse, and some of her colleagues from other wards expressed a desire for increased psychological support to better cope with the everyday emotional demands, most believed that many emotionally stressful situations could be prevented primarily through improved staffing levels. This was urgently needed if *good care* was to be provided.

### 5.4 Nurses' Understanding of Good Care

"I save your life. That's all there is to it" (Anja Voigt, intensive care nurse and union organizer; Dück and Garscha 2022, 39).

This constant emotional strain—manifested both as exhaustion and the emotional labour required for patient care—is not only a consequence of poor working conditions, but also a barrier to providing good care. While, as we have seen, emotional labour is an essential part of nursing, good care cannot be reduced to it alone. Moreover, as the above quote illustrates, good care cannot be defined solely by patient safety. It is also crucial to consider what nurses themselves regard as constituting good care, as this forms an essential part of their professional identity.

Nursing entails a complex spectrum of physical, emotional, cognitive, and organizational tasks (Jackson et al. 2021, 1). These include: developing in-depth knowledge of patients and assessing their individual care needs; monitoring vital signs and documenting health status; administering medication; coordinating care processes; communicating medical information and providing emotional support to patients and families; as well as engaging in lifelong learning and professional development (ICN 2021, 7–12).

However, due to the staff shortages, nursing is often reduced to completing only the most immediate and essential tasks, leaving nurses with limited time for individual patients. Not having enough time to spend with patients often made my interlocutors feel like "robots", or, in Vivi's words, as if they were just "jumping from patient to patient". This experience was not only distressing because it posed risks to patient safety, but also because it prevented the nurses from delivering what they considered to be *good care*. For all of my interlocutors, good care was inextricably linked to having enough time for patients.

Steffi and Wendy, both paediatric intensive care nurses, expressed a desire for more time to perform their tasks in a more orderly manner, for example, to properly wash their patients. Steffi added that having more time would also allow her to communicate with patients without the constant pressure of attending to several others simultaneously. Illiana, a palliative care nurse, described good care as encompassing multiple dimensions of nursing practice:

> In my opinion, good care is not just about handing out pills, but about taking into account the needs, wishes, and fears of the patient, seeing them as a whole person, and not just treating their broken leg, but also taking care of other things, such as their family and entire social environment. I believe that good care is when I take care of my patients as a whole. What is needed for this is time. And time is only possible with sufficient staff.

Illiana's framing of good care aligns with a holistic approach to nursing, emphasizing emotional presence and attentiveness to each patient's individual needs and social environment rather than treating them as passive recipients of care (Aldridge 1994). This stood in partial contrast to the more technical, evidence-based perspective voiced by Lilly:

> Good nursing care means evidence-based nursing. That means there are nursing standards and guidelines. The reserved activities of nursing are the planning, implementation, and evaluation of nursing goals and measures. In practice, no one has time to write a care plan and plan the care process, evaluate it, determine measures, discuss it in a team, get the patient on board, provide care, and make rounds. This is our job, but it doesn't happen.

The differences between Illiana's and Lilly's views of good care may be shaped by the wards in which they work, influencing the types of interactions possible with patients under varying conditions, and by their own personal preferences. Despite these differences, my conversations with nurses in Section 5 illustrate that good care requires sufficient time to attend to the physical, cognitive, organizational, and emotional needs of patients, as well as the ability to engage in effective teamwork.

For this reason, union organizing and participation in the TV-E campaign are so crucial: they allow nurses themselves to define what constitutes fair staffing and to negotiate conditions that make good care possible in practice. Being able to provide good care forms the core of their professional identity, grounded in ethical responsibility toward patients and colleagues. Without the conditions to fulfil this responsibility, nurses will continue to leave the profession, deepening the staffing crisis and further jeopardizing patient care.

## 6. Discussion

In light of current debates on how to tackle chronic staff shortages in Germany (Auffenberg et al. 2022; Penter et al. 2023; Schmedding et al. 2025), the central argument of this article is that a legal mechanism to ensure minimum staffing levels in hospitals is essential, as nurses depend on teamwork and need sufficient time to provide what they consider to be good care. Having this time is inseparably tied to their professional identity, which is shaped by an ethical responsibility toward both patients and colleagues. At present, however, many nurses are struggling to ensure even safe care for their patients while simultaneously compensating for absent co-workers. This situation generates intense emotional strain and deteriorating working conditions, which in turn drive attrition and exacerbate the difficulties of recruiting and retaining staff.

In 2024, Germany employed around 1.7 million nursing workers, of whom roughly two-fifths were employed in hospitals (Bundesagentur für Arbeit 2025). Projections indicate an additional need for between 270,000 and 500,000 nursing staff by 2030 (CARE4CARE Consortium 2024, 265).[20] While the DRG system has undoubtedly worsened the situation in hospitals, particularly in terms of staffing levels, understaffing was already a problem well before its implementation in 2004 (Simon 2020).

[20] However, the projected demand for nursing staff extends beyond hospitals, encompassing long-term care facilities such as nursing homes as well as outpatient services.

Over the years, numerous legislative changes have been made to improve the attractiveness of the profession—for example, by raising nurses' salaries, reforming the training system (including the introduction of university-level nursing degrees), and, not least, introducing the nationwide PPR 2.0 to better assess staffing needs. Despite these changes, however, staff shortages remain a pressing problem (CARE4CARE Consortium 2024, 265–66).

While increased wages are certainly an important factor for recruitment and retention (CARE4CARE Consortium 2024, 297; Roth et al. 2022), they alone cannot address the vicious circle of poor working conditions driven by understaffing: poor working conditions lead to higher sick leave and attrition, which in turn exacerbates understaffed shifts and perpetuates the cycle.

Professionalization through higher education, such as university or continuing education programs that grant more professional responsibilities, can increase job satisfaction by increasing employee autonomy (Schmedding et al. 2025, 8). However, this is questionable in the context of nursing, which heavily relies on teamwork. Nursing is a collective responsibility shared among colleagues, and teamwork contributes to good care rather than individual autonomy alone.

Moreover, in recent years, there has been increasing debate, particularly by trade unions, about reducing overall working hours to improve quality of life and make the profession more attractive (CARE4CARE Consortium 2025, 9). While such measures are important, they remain limited in their effectiveness if adequate staffing is not secured. Without enough nursing staff, reducing working hours could simply lead to a redistribution of the workload rather than a reduction.

Similarly, recent legal instruments such as the PPR 2.0 represent an important step toward determining necessary staffing levels in hospitals; however, they exclude nurses from direct participation in setting these levels and do not include sanction mechanisms to ensure compliance.

Campaigns organized by the Hospital Movement headed by ver.di and nurses have demonstrated the importance of securing better staffing levels in hospitals across Germany through collective agreements. These campaigns not only brought nurses together and empowered them to articulate their concerns and demands, but also resulted in the creation of legally binding mechanisms to sanction hospitals that fail to meet agreed staffing levels. Moreover, they also serve as best-practice examples of how to increase unionization among nurses.[21] The failure of the TV-E campaign in the Private Hospital, however, underscores the need for more effective legislative measures to guarantee binding staffing ratios.[22]

[21] During my fieldwork on the campaign in the Private Hospital, nurses and organizers reported that several dozen nurses had joined ver.di in the course of the mobilization.

[22] While non-union members usually also benefit from the TV-E, its shortcoming is that its applicability is limited to those wards where nurses have organized and actively participated in the collective negotiations.

Adequate staffing levels must therefore be supported by enforceable legislation and strong workplace organization. This entails both further reform of the DRG system and the immediate introduction of enforceable sanctions within the existing PPR 2.0 framework, supported by collective agreements that surpass minimum requirements set by the legislation. These are essential countermeasures against the on-going marketization of hospitals, without which neither safe and good care nor the long-term retention of nursing staff will be possible.

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CHAPTER 12

# Proposals on the Improvement of the Social Care Services System in Spain: Debates of Interest to the European Union

Ferran Camas Roda, Andrea Cano Redondo

## 1. Introduction

During the period from 2023 to 2025, the Labour and Social Security Law Research Area of the Department of Private Law of the University of Girona (UdG), directed by Ferran Camas Roda, has made available the "Horizon Europe research project" (2023–2025), entitled "We Care for Those who Care", with the acronym (CARE4CARE), led by the University of Florence. As part of this project, the living and working conditions of people who are paid to care for others have been analyzed from a comparative and multidisciplinary perspective, with a special focus on domestic work. In turn, given that caregivers are mostly women and immigrants, the research group at the University of Girona has identified and addressed situations of discrimination that may arise in the care sector on the basis of two specific grounds: gender and the migrant status of people who work caring for others.

The purpose of this article is to show some of the results of the research of the research group of the University of Girona in the areas mentioned above, that is, the working conditions of people who work for pay caring for other people and the situations of discrimination based on gender or their status as migrants that they face. However, this study will go further and will also include a special study of a political strategy designed by the Spanish Government with the title "State Strategy for a new model of care in the community. A process of deinsti-

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tutionalization (2024-2030)" (Gobierno de España 2024). This strategy of the Spanish Government aims to reform the long-term care model. Its recipients are mainly people with support and care needs, especially people with disabilities, elderly people in a situation of dependency, children, adolescents in the protection system, and young people who have gone through it and the homeless. In any case, the Strategy is also designed to support the families of these people, as well as workers in the care and support sector and the people they care for.

The backdrop to the debates on how to address a quality care system, and in particular a long-term care model, is the process of change that Spanish society is undergoing, and in particular the demographic change resulting from the progressive aging of its population. At this point, it is worth mentioning the Spanish government's response to the recommendations made by the Council of the European Union to Member States on December 8th, 2022, regarding access to high-quality and affordable long-term care (European Care Strategy Implementation 2024, 6). This document warns that Spain has one of the longest-lived populations on the planet and is the fourth country in the EU (EU-27) in terms of the number of people over 65 years of age (European Care Strategy Implementation 2024). Thus, it was stated in the document that according to data from the Spanish National Institute of Statistics, as of January 31st, 2024, Spain had a population of 48,592.909 inhabitants, of which 49% were men (23,807.546) and 51% were women (24,785.363); As for the older population, the 2023 data indicated that 20.15% were 65 years of age or older (9,687.018 people), of which 43.50% were men and 56.50% were women. According to the document, this difference between the sexes of the population increases with age, so that of the 2,871.096 people aged 80 years or older in our country, 37.11% are men compared to 62.89% of women, which reveals the higher "life expectancy at birth" of women (85.7 years) compared to men (80.4 years).

If we talk about life expectancy at birth, it is important to also talk about "healthy" life expectancy at birth, that is, the fact that during aging the functional capacity that provides well-being in old age is maintained, so that this stage of life can be enjoyed as fully as possible; according to the Spanish Government in its response to the EU Council recommendation of 8 December 2022 on access to high-quality and affordable long-term care, this healthy life expectancy at birth stands at 62.8 years, and 10.5 years once a person reaches the age of 65. This must be taken into account because, although we have seen that life expectancy at birth exceeds 80 years for men and women, healthy life expectancy, when 65 years has been reached, only reaches ten more years, which implies a lag of several years in which the person may not enjoy their full capacity that produces well-being, and therefore need help in the form of care.

In relation to the quality of life of the elderly, the Spanish Government also states in its response that according to the Living Conditions Survey published by the National Institute of Statistics in 2023, with income data from 2022, the average income of people aged 65 and over stood at 16,185 euros per person. 15% above the national average income of 14,082 euros. If we look at the indicator of severe material and social deprivation, we see that for people 65 years of

age or older, the indicator is 3.4 percentage points below the national indicator (5.6% for people 65 years of age or older compared to 9% in the case of the general population). Even so, 18.3% of people aged 65 and over are still below the poverty line, which according to the aforementioned 2023 Survey was 10,989.5 euros for a single-person household. This difference in the poverty rate presents a significant gender gap, as it stands at 15.8% for men compared to 20.3% for women below the poverty line.

It is also worth mentioning the migratory phenomenon, which with a population of 8,775.213 foreigners has increased considerably in recent years, representing 18.2% of the total Spanish population in 2023 and being the main source of population increase in the country. Of this group, 6,089.620 people maintain their foreign nationality and, of these, 5% are 65 years of age or older. Therefore, the foreign population is young compared to the Spanish population, although it is expected that over the years it will increase.

On the other hand, in the case of people with disabilities of working age, 1,941.900 in 2022, the unemployment rate is 21.4%, 8.6 points higher than that of the population without disabilities. The proportion of the active population between 16 and 64 years of age is 35.3%, 42.7 percentage points below the population without disabilities. In terms of salary, the INE indicates that in 2021 the average gross annual salary of employees with disabilities was 21,544 euros, 17.2% lower than the average for people without disabilities. In addition, there is a clear gender effect, as the salary was 10.3% lower for women.

With these statistical bases, this work will be structured in making a specific delimitation of jobs in the care sector and addressing some of their working conditions, either in a general way or in relation to certain groups.

## 2. A Specific Delimitation of Care Jobs

The task of defining which types of jobs (therefore, I will focus on paid care work) can be incorporated into the care sector is not an easy one, since it requires starting from an understanding of what care means, what care workers are, and finally, the scope of the care sectors specifically.

The International Labour Organization has carried out some very interesting work in this area in its 2019 report "Care work and care workers. For a future with decent work" (ILO 2019), which identifies two general types of care activities: on the one hand, *direct, face-to-face, and relational care activities* (sometimes referred to as "nurturing" or "relational" care), such as feeding a baby, caring for a sick spouse, helping an elderly person bathe, performing medical checks, or teaching young children; and on the other hand, *indirect care activities*, which do not involve face-to-face personal care, such as cleaning, cooking, washing clothes, and other household maintenance tasks (sometimes referred to as "non-relational care" or "domestic work"), which provide the preconditions for the provision of personal care.

On this basis, the ILO defines care workers as those who work in exchange for benefits or remuneration and whose professions involve the provision of face-to-face services that develop the human capacities of the care recipient

(personal care or "affective" care). Thus, the ILO points out that care workers would include medical and nursing staff, early childhood educators, primary and secondary school teachers and their assistants, therapists, and personal care workers, but also, according to the report I am reviewing, domestic workers, basically because the provision of care involves not only care personnel, but also "indirect care work" (ILO 2019, 168).

In this sense, a first approximation of jobs related to care functions in Spain would be the following: firstly, people who "provide services for the family home" (who could be defined in English as "home caregivers") would be included.

In this area of services provided in the family home, two different groups of workers must be taken into account: on the one hand, it must be borne in mind that companies providing personal services may hire workers to go and care for another in their home, in which case, this employment relationship is of a common nature, that is, as the one provided for any employee, therefore subject to Royal Legislative Decree 2/2015, of 23 October, approving the revised text of the Workers' Statute Law (hereinafter LET). However, not only companies providing personal services can hire staff to work in a family home, but also the owner of the family home can directly hire a worker to perform domestic tasks, in which case this employment relationship would no longer be part of the common regime (the LET) but would be covered by special regulations: Royal Decree 1620/2011, of 14 November, which regulates the special employment relationship of the family home service; it should be remembered that according to art. 1 of this Royal Decree 1620/2011, the object of this special employment relationship is the services or activities provided for the family home, which may take on any of the modalities of domestic tasks, "as well as the management or care of the home as a whole or some of its parts, the care or attention of family members or people who are part of the domestic or family environment", and other work that is carried out as part of the set of domestic tasks, such as nursery, gardening, driving vehicles and other similar tasks.

In conclusion, the provision of care functions can be carried out under the umbrella of different labour legal regimes, with the result that the "special" regime (Royal Decree 1620/2011) is characterised by a general reduction in the minimum rights that apply to working personnel compared to the regulation of the common or standard regime (in general, more protective for the worker), differences that have already been described as "protection gaps" (Mercader Uguina et al. 2018).

To this observation of the bifurcation of regulatory regimes that can occur with respect to common personnel who go to care for other people at home, common labour on the one hand, special labour on the other, must be added the emergence of technological platforms that manage care services without the coverage of the regulations of employed work, but under those of self-employment or directly without any formal umbrella (it must be said that the twenty-third additional provision of the LET that regulates a "presumption of employment" in the field of digital platforms for the delivery or distribution of any consumer product or merchandise would not be applicable to these people).

In addition, it should be remembered that art. 2 of Royal Decree 1620/2021, which regulates the special employment relationship for the provision of services in the family home, excludes from its application those employment relationships that are entered into by the provider companies or those carried out through temporary employment agencies (to which the common or standard regime would apply); but also the relationships of professionals caregivers hired by public institutions or private entities, in accordance with Law 39/2006, of 14 December, on the promotion of personal autonomy and care for people in a situation of dependency; and finally the relationships of non-professional caregivers consisting of the care provided to people in a situation of dependency at home, by people in the family or their environment, not linked to a professionalized care service in accordance with Law 39/2006, already referenced.

It is of fundamental importance to bring up the dependency system. As stated in the first article of Law 39/2006, this regulation recognises the care of people in a situation of dependency, through the creation of a System for Autonomy and Care for Dependency: thus, according to its art. 2, dependency is understood as the permanent state in which people find themselves who, for reasons derived from age, illness or disability, and linked to the lack or loss of physical, mental, intellectual or sensory autonomy,

> require the care of another person or persons with significant assistance to carry out basic activities of daily living or, in the case of persons with intellectual disabilities or mental illness, of other supports for their personal autonomy.

In this sense, Law 39/2006, through the System for Autonomy and Care for Dependents, creates a series of benefits and catalogues of care and care services for dependent people, as well as, for example, offering the following services to people who have been recognised as being in a situation of dependency: the Telecare Service; the Home Help Service; the Day and Night Center service or the Residential Care Service.

At the end of 2023, the System for Autonomy and Care for Dependency was providing services and financial benefits to a total of 1,387.863 people (European Care Strategy Implementation 2024, 13 ff.). Among these benefits and catalogues of services are, for example, the economic benefit of care in the family environment (with which the person can remunerate a caregiver, for example under the umbrella of a special employment relationship of service of the family home), which was attributed to 558,234 people, and as services, telecare (427,677) and the home help service, that is, the provision by the public administration or company of a caregiver, which is enjoyed by 343,152 people.

Within this framework, the home help service to hire a worker to perform care functions for the dependent person is channelled through the so-called professional caregivers, which in English could be included within the notion of "Basic care workers", if by such we mean professionals who, once they have accredited the completion of a training course, they carry out varied and low-complexity care tasks, basically for personal care, domestic help and hygienic-sanitary services.

Within this regime of professional or professionalized caregivers, nursing assistants or auxiliary nursing care technicians could also be included, who are hired by companies providing care services to provide their services at home. In fact, these nursing assistants, who in English would be included in a general notion of "Social and care worker" (not to be confused with what we call in Spain as social workers, but rather as nursing assistants or auxiliaries), have secondary education to be able to access courses or training studies specifically accredited by public bodies. Their tasks include taking care of patient hygiene, providing logistical support to the activities of doctors and nurses, supporting patients in the administration of food etc. and they can work both in self-employment, as well as be employed in nursing homes and hospitals.

Thirdly, very close to the previous group, in fact, they could have been included in the same group if it were not mainly for the higher education they must obtain to perform the functions that correspond to them as such, are health professionals (doctors, nurses, midwives, physiotherapists etc.) who work in public institutions (nursing homes, hospitals), whether public or private, also including those that do so on an autonomous basis if the requirements of labour legislation are met to qualify as such. In any case, it should be mentioned that, within the framework of the health services that make up the National Health System, people who have acquired the rank of public servants are subject to a special regime regulated by Law 55/2003, of 16 December, on the Framework Statute of the statutory staff of the health services.

In any case, this section should not be concluded without noting that in Spain the family often assumes the care of dependent people, dedicating a large number of hours to care to the detriment of their own leisure time or the time dedicated to their work and professional development. According to the Evaluation Report of the System of Autonomy and Care for Dependency, 46.1% of caregivers who live in the same home in Spain dedicate more than 10 hours a day to caregiving. In addition, 51.8% of primary caregivers have been providing this care for more than eight years, which implies a very high direct and indirect cost. In contrast, 44% of the hired caregivers spend less than two hours a day in the home of the user of the Autonomy and Dependency Care System. As a result, public social services and privatised care become residual resources compared to the care provided by the family (European Care Strategy Implementation 2024, 24 ff.).

### 2. A Specific Delimitation of Care Jobs

A general rule for all care workers, both the so-called domestic service caregivers and the so-called professional caregivers, is their high level of feminization. Thus, for example, starting with domestic workers in Spain, it should be mentioned that according to the 2019 International Labour Organization Report *Care work and care workers for a future with decent work* to which reference has already been made, it is highly feminized and composed of the immigrant population, providing data to justify it that domestic workers represent 6.5% of female employment in Spain (and 0.7% of male employment), with 55% of those

born abroad (ILO 2019, 214). In addition, the fact that domestic service has become more of a niche job for foreign workers, as part of a process of gradually replacing native women, has had positive effects on the latter, since the fact that many Spanish women have been able to delegate domestic tasks to other personnel, especially foreign personnel, has allowed them to enter the labour market and thus increase their activity rate in the labour market, even if this means that foreign women pay the high price of disconnecting from caregiving and employment in their places of origin (Defensor del pueblo 2019).

With regard to nursing staff, it is worth mentioning the statistics from the National Statistics Institute on registered healthcare professionals, which include nursing staff, who make up the majority (35.5% of the total), followed by medical staff (30.9%) and pharmaceutical staff (8.4%). Focusing on the former, in 2022, a total of 336,321 people were registered as nurses, of whom 53,023 were men and 283,928 were women (specifically, there were 656 men and 9,206 women registered as nursing staff with midwifery qualifications). In fact, the National Statistics Institute confirms that the healthcare profession is predominantly female, as in 2022 there were more women than men registered in 13 of the 15 professions analyzed by this statistic on registered healthcare professionals. It also states that the groups with the highest percentage of women were speech therapists (93.1% were women), occupational therapists (90.4%), and nurses (84.2%) (Defensor del pueblo 2019).

I must also refer to other care groups such as those known as professional caregivers who provide services for the care of dependent persons. It should be noted that in the formal economy, they are composed of healthcare professionals, mainly nursing staff (who, according to studies carried out by the individual, practice their profession in public institutions or institutions partly financed by the public budget, providing non-medical care -non-health-related care- to dependent persons) (Instituto de la mujer 2008, 69). In any case, mention should be made of the data published on non-professional caregivers (family members), a group that, according to the *XXIII Report of the Dependency Observatory of the State Association of Directors and Managers in Social Services*, published in April 2023, is made up of 74% women and 26% men (Asociación Estatal de Directoras y Gerentes en Servicios Sociales 2023); in fact, two considerations should be brought up in this opinion, firstly, the statement that many women become caregivers not by free choice, but by economic and social imposition, while men do not assume the role of caregivers equally, which results in a discriminatory assignment of care functions, feeding back into inequality. Finally, I would also like to highlight your statement that the regulation of the most suitable professional profiles to carry out personal assistance tasks within the framework of the dependency system cannot be postponed, since the use of "domestic service" contracts for this purpose—which do not reflect the work to be carried out nor do they presuppose professionalisation and which obviously clearly fail to protect workers. It is not the right way and the managing administrations should not accept these formulas for which others must be enabled urgently (AEDGSS 2023, 42–3).

In any case, in the field of nursing homes for the elderly, published analyses (Montserrat Codorniu 2023) also highlight the high degree of feminization: almost 90% (86.9%) of all workers are women, although there are signs of a growing presence of male workers: in 2019 they represented 13.1% of all workers, compared to 11.7% in 2015.

With these statistical bases, trying to unify the virtues and deficiencies of the working conditions of the care workers in which they provide their services may not be a useful issue since, as seen above, different job profiles are incorporated within the care worker staff under different legal regimes and even different collective agreements if any. In any case, it will try to make some considerations of general interest, without prejudice to focusing on some aspect of special interest in the specific field of domestic work, and then, in a later section, deal with the field of nursing home staff, for example for the care of the elderly or people with disabilities, as well as home help services within the framework of the dependency system.

In general, precariousness in employment relationships is detected in the care sector, particularly in temporary and part-time jobs. Also, the low amounts of remuneration. In fact, as to whether or not these wage remunerations have a gender mind, it should not be lost sight of the fact that, as Workers' Commissions has published to this effect, with respect to the salary levels of care workers, the sectors with low wages are characterised by a greater weight of female employment in relation to male employment; thus, sectors such as domestic employment or personal care services had average monthly salaries well below the average in 2022, the former with 858 euros and the latter 1,450 euros.

In general, it should also be noted that a factor common to all care personnel is the issue of occupational accidents, or in other words, the high number of occupational accidents shown by the 2022 statistics of the Ministry of Labour regarding the jobs of health service workers and care workers. which include care workers in health services; others who provide their services for the care of people, and also personal service workers (Ministerio de Trabajo 2022). In fact, public statistics show that the care sector is particularly prone to workplace accidents resulting in sick leave. The fact that many female care workers do not appreciate the limits of the physical effort they are exerting or do not know, due to a lack of training, how to physically or psychologically manage a person who requires their care may be factors that contribute to this accident rate. Other reasons are well-known, such as healthcare *burnout*, for example, among geriatric workers due to low expectations of recovery among patients, as well as the stress experienced by care workers in general, but even more so when caring for seriously ill or severely disabled patients (Durán M. A. 2019, 446). To this could also be added those related to psychosocial risks at work such as violence or harassment at work, or stress.

On the other hand, it must be borne in mind that violence, especially sexual violence, is a widespread situation in the domestic sphere. The Spanish legislator intends to combat it in terms of its effects on the person's health, especially by preventing the risk they entail, but also by applying the measures contained

in the Violence and Harassment Convention, no. 190 of 2019, which has been ratified by Spain. In addition, situations of sexual harassment or violence should be specifically considered by the regulations when it comes to immigrant or foreign employees, the main victims of this scourge.

Studies carried out on violence against women caregivers have shown that on many occasions, women caregivers suffer cross-sectional violence, that is, that suffered in the workplace, which they may suffer for racist or sexist reasons in the social and family sphere, as well as, in the case of being foreigners, the situations of violence they have suffered in the migratory process together with those experienced when they arrived in the host country (Albertín P. et al 2022). On the other hand, these situations of violence can come from the very people receiving care, in the form of harassment (Albertín P. et al 2022).

In response to this, the recommendations being implemented are basically to ensure that long-term care workers receive high-quality initial and ongoing training; to also provide them with psychological support to cope with caring for people in the final stages of life and in situations involving challenging behaviour management (Instituto de las mujeres 2023).

On a different note, and focusing on domestic work, it is worth highlighting the reform that took place with Royal Decree-Law 16/2022 of September 6 regarding the provision of family home services, as well as the entry into force in February 2024 in Spain of the "International Labour Organization Convention on Domestic Workers, 2011 (no. 189)" (BOE 2023), both of which represent an increase in the rights of domestic workers and have been positively assessed by agents in the care sector:[1] thus, for example, the right to safety and health at work is recognized in accordance with the Law on the Prevention of Occupational Risks that applies to all workers; domestic servants are recognised as having unemployment benefits when they end their employment relationship; it also provides people who work in domestic service with the coverage of the institution of the Wage Guarantee Fund, consequently, said Fund will be able to pay unpaid salaries in cases of insolvency of the family unit that has hired the domestic servants; it also promotes the consideration of indefinite contracts in the field of domestic work and guarantees that domestic workers receive information on the essential conditions of their employment contract; Finally, the possibility that the owner of the family home can terminate the contract by his or her sole decision to withdraw is repealed.

In any case, a problem to be addressed in the family home sector is the persistent informality of the work carried out regardless of the nationality or migratory status of the caregivers: although it is not possible to verify specific data on informality since it is naturally not registered by its very nature, however, the

[1] Thus, for example, the Advisory Board on Care, which in its Document of Bases for Care, has stated that these measures represent an important advance for the dignification of care work, an advance for its professionalization and an improvement for the consideration of workers in the sector as a whole (Instituto de las mujeres. *Documento de Bases por los Cuidados*, ya citado anteriormente).

former is presumed to be high if the data on the set of people affiliated to the Special Social Security System that were published in August 2022: 373,101 people, are compared with the figures published by the Active Population Survey for the second quarter of 2022 with respect to the personnel employed in households that are employers of domestic staff, which shows the figure of 545,700. Therefore, according to the differential parameters between the two latitudes, it is found that there could be some 172,599 domestic workers who, despite providing their services for employer households, would not be registered with Social Security. As a result, it must be confirmed that the fact that it is a sector with a high level of informality is also a favorable place for foreign workers in an irregular situation to consider it as a priority gateway to the labour market, which may also allow them to apply for an exceptional residence and work permit for a period of time later on in accordance with the legislation on foreigners.

Another issue is that this informal work can lead to situations of labour exploitation, which has been denounced by social organizations such as Cáritas (2022), for whom this situation is a breeding ground for the defencelessness of women who are often unaware that they are being exploited, normalizing it and thinking that it is a necessary step to get a better job. Cáritas adds that in the case of immigrant women, being away from their country of origin, they assume that they must "put up with" everything; in fact, although many of them are aware that they are being violated, they do not report it for fear of losing their jobs, because they believe that they are useless or because they do not feel justified in doing so.

In order to face all the realities set out above, it is worth highlighting the proposals made by the Workers' Commissions Union, according to which "care activity should not continue to be synonymous with precariousness, low wages, low social consideration and strongly feminized"; also that care is a public issue, not a private one or for women, since society as a whole suffers the consequences of care deficits in terms of care for the elderly, children, people with disabilities or those who are in a situation of dependency; and finally, "the urgency of transforming the care model". With this justification, the Workers' Commissions Union proposes "100 measures for a comprehensive and state Care Pact", among which I would like to highlight the following: articulate a comprehensive public care system with the support of a Care Law, with sufficient funding and finality; improving the regulatory framework for care jobs, which may involve the legal reduction of working hours, better regulation of part-time hiring and the extension of the contents of the so-called Spanish "Ryder Law" to the entire platform economy, including those of care for people and care, that is, to carry the presumption of labour in labour relations both from platform workers who distribute products to platform workers who provide care; and to establish, through collective bargaining, co-responsible conciliation measures that improve those recognised in the legislation and that favour the involvement of companies and workers (especially men), especially in terms of paid leave, flexibility in entry and exit time slots, priority in holiday or holiday periods for those who have care responsibilities etc.

With regard specifically to the labour rights of people who care for them, I would like to draw attention to some of the measures proposed by the trade union Workers' Commission, such as the assessment of jobs of equal value by comparing the different sectors, feminised and masculinised, to take into account those strongly feminised factors that have historically not been adequately valued. in order to equalize remuneration; as well as establishing guarantees and formulas in public procurement so that ordinary contracting is full-time, except for justified causes, without part-time contracts in any case exceeding the figure of 25%. Likewise, split working days will be avoided except for justified reasons and a minimum working day of 24 hours per week will be established, with duly accredited exceptions of a minimum of 16 hours per week.

## 3. A Review of the Working Conditions of Care Workers in General

The purpose of this section is to deal with the issue of professional caregivers in care centers or residences, for example, for the elderly or people with disabilities, as well as with respect to those caregivers hired within the framework of the dependency system.

To begin with, it should be noted that in the field of residences or care centers, the doctrine of Labour Law has advanced that the strategic importance of the care sector for job creation contrasts with the poor quality of employment (with a high turnover and frequent atypical schedules, night shifts and holidays, the lack of training and the lack of professionalization in the sector) (Moré Corral 2021, 481). In fact, studies have shown that this sector is made up of workers with a low level of education, as more than half of them (55.5%) have only completed primary education, with or without first-level vocational training, while the rest are divided between 20.5% with secondary or post-compulsory education and 24% with higher education (Montserrat Codorniu 2023). The issue of (little) training in the field of care must deserve special attention because in order to avoid the situations of job insecurity that are noted in many cases of care work, it is necessary to professionalise care through the offer of training actions and exemption from professional certifications of the experience acquired, which should also be in step with formulas for the formalisation of labour relations (especially in the field of home care) (Quintero Lima 2023, 650). In this area, it is interesting to bring up the proposal of the *Document of Bases for Care* published by the Women's Institute in April 2023, which demands that with regard to workers in care and health centers (nursing homes, mental health centers etc.), social and health assistants, personal assistants or domestic employment, their professional skills be recognized through certificates of professionalism. In addition, the document states that each of the professional categories should have a specific training plan with the aim of improving the conditions of workers and their users (Instituto de las mujeres 2023).

In the field of what we have called professional caregivers in accordance with the delimitation made above, basically people hired by public administrations or companies to perform functions of the home help service within the

framework of the System for Dependency, as well as caregivers who perform their functions in residences and hospitals, It must be said that official statistics show that 44% of caregivers hired in the home help service spend less than two hours a day at home. In fact, public social services (thus including care homes) and privatised care become residual resources compared to the care provided by the family (European Care Strategy Implementation 2024, 24). For this reason, the SAAD Evaluation Report of 2022 requested to extend the intensity of its working hours, improve the professionalization and professional accreditation of its staff, and improve socio-health coordination.

Following this trend, the Agreement on common criteria for the accreditation and quality of the centres and services of the System for Autonomy and Care for Dependents (hereinafter, the Accreditation and Quality Agreement), established a series of requirements that must be met by the companies that provide this service to guarantee its quality, specifying its extent, the training of the personnel who provides this care, the working conditions or the way in which the service is organized, so as to guarantee dignified treatment and the exercise of the rights of the person who receives this care. Thus, this Agreement provided that in order for the centres, residences and home help services of the dependency system to be accredited as such before the Public Administration to carry out their functions, they must accredit, among other factors, that in terms of personnel, the corresponding standards on personnel and quality of employment were met, both in terms of the number of professionals as well as in their qualifications, training, and working conditions. To specify these standards, this Agreement requires guaranteeing that 80% of employment contracts are indefinite of the total employment contracts of the centres and services of the Dependency System, except for justified and accredited causes due to lack of staff supply. In fact, according to the statistics that are considered by the Spanish Government, permanent contracts represent 58.86% of the total, and in terms of working hours, full-time contracts represent 58.98%. However, there is a relatively higher proportion of part-time temporary contracts, suggesting a certain precariousness in working conditions (European Care Strategy Implementation 2024, 41).

Likewise, the Accreditation and Quality Agreement also specified specific percentages of a high nature in relation to the contracts of direct care personnel with respect to the set of hours contracted by the entity, and as a matter to be emphasized, it was required that people who work as employees, within the scope of the Dependency System, they will be framed in the General Social Security Regime, and their framework of labour relations must be that established in general terms in Royal Legislative Decree 2/2015, of 23 October, which approves the revised text of the Workers' Statute Law. Finally, under this agreement, a process was promoted to address the urgent need to increase qualified personnel for the care sector, in particular the creation of new qualifications or revision of existing ones to respond to the professional needs of the sector.

In addition to these considerations, according to the annual salary structure survey, the average annual earnings per worker in the health and care services

sector stood at 17,435.22 euros in 2021, 32.7% less than the average earnings for all occupations in the country (European Care Strategy Implementation 2024, 41). As the Spanish Government also warned, precariousness in the sector is also more acute depending on the sex of the worker, with significant gender pay gaps persisting, with men earning 30% more than women in this sector during the same period. This disparity significantly exceeds the gender pay gap in other sectors, which stands at approximately 22.5% in the economy as a whole, underscoring the precariousness and wage discrimination faced by women in the field of dependency compared to the economy as a whole.

To deal with this, collective bargaining would be playing an important role, although it seems insufficient in certain cases, as will be explained in the following paragraphs.

In this area, it is necessary to start with an interesting fact: with respect to the care of the elderly, 22.7% of care centers or care homes for the elderly are publicly owned compared to 77.3% privately owned, and with respect to people with disabilities, 20% of care centers for this group are publicly owned compared to 80% privately owned. Therefore, most residences or care centers are mainly private, in a very visible way with respect to the elderly.

On this basis, and as has been expressed in the previous section as a common or general factor for all care personnel, low salaries are also detected in the framework of professional caregivers. In fact, the Workers' Commission union echoed that until 2023 there was intense labour conflict, mainly to ask for wage increases (Comisiones Obreras 2022). As a result, the "VIII State Framework Agreement on care services for dependent people and development of the promotion of personal autonomy" was signed, which is in force until 31 December 2025. This agreement applies to companies and establishments (which are not publicly owned, i.e. private entities) that carry out their activity in the sector of care for dependent people and/or development of the promotion of personal autonomy: residences for the elderly, day centres, night centres, sheltered housing, home help service and telecare. In the union's opinion, this agreement led to significant wage improvements, as well as a notable improvement in work activities, although as the doctrine has pointed out, there are still considerable differences between the salary and working conditions of workers in the public and private sectors, being better in the case of the public sector, which is where most professionals in the care sector are not found. since they mostly provide their services in privately managed centers (European Care Strategy Implementation 2024, 44–5).

Finally, it should also be noted that there is a gap in the prevention of occupational risks in professional caregivers of the home help service: Royal Decree 893/2024, of 10 September, which regulates the protection of safety and health in the field of the family home service, included a first final provision that favoured the safety and health of home help workers for people in a situation of dependency, which forced companies to carry out certain obligations such as specific risk assessments, which entailed a visit to the homes where the caregivers went to work; as well as obliging companies to adopt whatever measures were necessary according to the risk assessment, including the use of mechanical means

for handling loads, in a greater number of personnel to carry out tasks, in the extension of breaks between services in homes, or in the use of personal protective equipment. These measures, i.e. the First Final Provision of Royal Decree 893/2024 itself, have been annulled by the Supreme Court Judgment of 29 September 2025 for non-compliance with formal requirements in the approval of the regulation. This issue should be raised and the standard reissued to better prevent safety and health at work, especially when more than half of the illnesses and injuries of auxiliary home help care personnel at home are musculoskeletal, presumably caused by the handling and transfer of people with reduced mobility.

### 4. On Professional Carers in Social Services and Staff Hired Under the Dependency System

It is of interest for a study on the care regimen to analyze when it occurs with respect to people with amyotrophic lateral sclerosis, since recent legislation introduces novelties that will deserve to be followed in case the initiatives they create have continuity in other groups.

To begin with, it is necessary to bring up Law 3/2024, of 30 October, to improve the quality of life of people with Amyotrophic Lateral Sclerosis and other diseases or processes of high complexity and irreversible course, published in the BOE of 31st October 2024, is a transcendental regulation for the rights of people who, suffer from Amyotrophic Lateral Sclerosis and other diseases -which I will go on to qualify as similar, although the main object of this commentary will focus on the regulation that is contained with respect to "caregivers", that is, those people who perform functions of care for people in forms of amyotrophic lateral sclerosis.

According to Article 1 of Law 3/2024, its purpose is to

> improve the quality of life and access to specialized services of those people who suffer from Amyotrophic Lateral Sclerosis and other diseases, or processes of high complexity and irreversible course referred to in Article 2.

In this sense, this article 2 contains the requirements that such "irreversible and highly complex neurological diseases or processes" must meet in order to be applicable to the law, which are the following: that they have an irreversible condition and with a significant reduction in survival; that they have not had a significant response to treatment or that there are no therapeutic alternatives that will improve the functional status or prognosis of these people (in relation to this, it is worth noting that this Law 3/2024 amends the General Social Security Law to favour the recognition of permanent disabilities in people with certain diseases even if no previous treatments are carried out for them); that require complex social and health care, focused on the home environment and that has a high impact on the immediate environment of the affected people; and finally, that they have a rapid progression, which imposes speeding up administrative processes of assessment and recognition of the degree of disability or dependency. In any case, the precept that is being brought up also provides

for the application of the law to diseases or processes that are not neurological but which, in their evolution, meet the requirements set out.

With regard to people suffering from amyotrophic lateral sclerosis or other diseases that may be equivalent (i.e. non-neurological and irreversible diseases but that meet the criteria of art. 2), the law aims to establish

> a legal framework that reflects the commitment of society and, in particular, of the competent public administrations, to ensure dignified, respectful, and appropriate treatment for the people included in its scope of application, as well as their families, taking into account, in particular, the reduced time ranges of survival in the case of ALS and other similar diseases.

Following this affirmation, the Law regulates in its article 3 the recognition of the disability situation of the people to whom the law applies; Article 4 establishes an "emergency procedure" for the review of the degree of disability; Article 5 regulates the procedure for the qualification and review of the "degree of dependency" and the right to the benefits of the System and the procedure for the review of the individual care program in the case of people with Amyotrophic Lateral Sclerosis and similar diseases. It is also of interest that the regulation offers social protection measures for people who are working and who must stop working to care for people with amyotrophic lateral sclerosis or similar, in particular in relation to the maintenance, after leaving their job, of Social Security contributions at 50%. Resulting in the fact that the rest that they had been paying to Social Security will be paid by public entities of the State itself (specifically, Social Security entities).

It is also worth mentioning the Third Additional Provision of the regulations under discussion, relating to *Employment Policy for Carers*, which regulates that:

> Caregivers who have been forced to give up their work or professional activity in order to take care of people included in the scope of application of this law will be considered a group of priority attention for employment policy, in the terms provided for in Article 50 of Law 3/2023, of 28 February, on Employment.

On the other hand, in the fourth Additional Provision of Law 3/2024, the Government is attributed the need to adopt a series of measures within a year from 1 November 2024 (or as a holiday, from 2 November 2024). Among these measures, I would like to highlight those aimed at the Government to make proposals to the Territorial Council of Social Services and the System for Autonomy and Care for Dependency with direct influence on caregivers, especially to adapt the services provided within the framework of a Home Help Service; also include specific training in the courses for professional caregivers who work in the Dependency System, to provide them with the necessary tools to care for people with diseases or processes of high complexity and irreversible course such as amyotrophic lateral sclerosis; and finally, to develop a framework of reference in socio-health coordination and integration that, among other issues, addresses "integrated care" of care and services provided to patients with highly complex diseases such as amyotrophic lateral sclerosis by the social services and the care services of the National Health System.

According to the precept, these proposals

> will incorporate measures aimed at ensuring a public guarantee of supervision and 24-hour specialized continuous care that may be required to prevent the risk of avoidable death of people diagnosed with amyotrophic lateral sclerosis or other diseases or processes of high complexity and irreversible course, in that advanced stage of the disease that determines a complete dependence for basic activities of daily life, as well as instrumental and personal assistance derived from respiratory problems and dysphagia.

It would be relevant to underline the commitment established by the Law to incorporate measures aimed at ensuring a public guarantee of supervision and 24-hour specialized continuous care.

This issue has been developed by Royal Decree-Law 11/2025, of 21 October, which establishes measures to strengthen the System for Autonomy and Care for Dependency and to comply with the obligations established in Law 3/2024, of 30 October, to improve the quality of life of people with Amyotrophic Lateral Sclerosis and other diseases or processes of high complexity and irreversible course (on the date of writing this report or article, this Royal Decree-Law has yet to be validated by the Congress of Deputies).

According to this Royal Decree-Law 11/2025, a new degree or level of protection of "extreme dependence" is created within the framework of the dependency system, to which a specific minimum level of protection must be assigned, guaranteed by the General State Administration; In fact, the regulation says that people who have this degree of extreme dependency will be recognized, either access to an economic benefit linked to the service, which can only be used for home help, or to an economic benefit of personal assistance. In this regard, it is established that the amount of the minimum level of protection guaranteed by the General State Administration for each beneficiary of the System for Autonomy and Care for Dependents included in this degree of extreme dependency is 4,930 euros/month. In any case, the maximum amounts of both the financial benefit linked to the home help service and the economic benefit of personal assistance are set at 9,859 euros.

### 5. Special Attention to the Care Regime for People With Amyotrophic Lateral Sclerosis and Other Highly Complex Diseases

In 2024, the Spanish Government adopted the "State Strategy for a new model of care in the community. A process of deinstitutionalization (2024–2030)". As advanced in its own Introduction, its adoption responds to the commitment assumed in Component 22 of the Recovery, Transformation and Resilience Plan, aimed at the modernization and reinforcement of social services and the long-term care model.

Its recipients are mainly people with support and care needs, especially people with disabilities, elderly people in a situation of dependency, children, adolescents in the protection system, and young people who have gone through it and the homeless. In any case, the Strategy is also designed to support the fam-

ilies of these people, as well as workers in the care and support sector and the people they care for.

The justification offered by the Strategy is the need to urgently address the transition from a model of care based on institutionalised environments or derived from a culture of care, to a model of support based on the community and within families (in the case of children), that is, to services and supports provided in the person's immediate environment. Focused on their will, decisions and preferences and, in addition, in the case of children and young people, taking into account their best interests. To carry it out, several operational plans have to be approved, the first of which, for the 2024–2025 biennium, has not yet been approved at the time of writing. In any case, its purpose will be the measures to be carried out in the first two years of implementation of the Strategy.

From the beginning of the reading of the document, a concern can be seen to conceptualize what is meant by institutionalized or welfare-based care, and what is proposed to overcome it.

In this sense, the Strategy conceptualizes the institutional or welfare culture as

> any type of situation or relationship of care and support in which the following features are present: uniform treatment and rigidity in routine, generic and non-individualized access to services, segregation and social isolation, absence of choice and control, lack of decision-making about one's own life, predominance of the interests of the organization over the needs of the people and an asymmetrical relationship between the people who care and those who are cared for. All these features result in a normalized use of restrictions, understood as acts or practices, dynamics or omissions, which have the purpose or effect of restricting movement, the freedom to decide and/or act independently of a person or the free development of their personality.

For the Strategy, this institutional culture can be present in different environments, whether they are large residences, small collective accommodations, family homes or even the home itself. In this sense, institutionalization processes do not only occur through internments in centers, shelters, or residences (such as physical spaces), but are also crossed by behaviors, values, and beliefs about ways of supporting and caring that tend to depersonalization, rigidity in routines, group, and uniform treatment, as well as distance, segregation, and social isolation. Consequently, the Strategy considers that the so-called institutional or welfare culture refers to a framework of understanding of institutions and care relationships that is clearly opposed to the culture of human rights.

In view of this, the Strategy proposes a process of deinstitutionalization, that is, a process of social, political, and cultural change that provides for the transition of care in environments of isolation and segregation, generically identified as institutions towards the development of the environment, respect their choices, will, and preferences and promote social participation and inclusion in the community.

For this reason, the Strategy advocates transforming the model of care and support, taking into account the will and preferences of people, the vast majority

of whom do not want to live in institutions, but demand to exercise their rights under equal conditions, as well as personalized support to be able to develop their life project in the community. Eight out of ten people in Spain consider that people who reside in care centres or institutions are to some extent on the margins of society as a whole and believe that it is necessary to take measures so that these people can live more included in society.

On this basis, it is of interest to know the figures offered by the Strategy on the social group to which the Strategy is addressed:

a) In Spain, between 4,421.110 and 6,565.901 people require care and support, which represents more than 10% of the population. The Strategy adds that of all these people, at least 350,258 receive support in residential care resources: 288,765 people over 65 years of age, 32,934 people with disabilities, 17,061 children and adolescents in the child protection system in residential care and 11,498 people in a situation of homelessness (in any case, the Strategy itself indicates that there are foreseeably more if people with disabilities under 65 years of age are cared for in residences and people in mental health institutions, as well as other population groups.
b) It should also be noted that according to the Strategy, the use of residential care services increases with age, especially from the age of 80, and also increases among women. Women account for 69.8% of older people living in Residential Care Services, compared to 30.2% of men (aged 65 and over).
c) On the other hand, institutionalization in centers is the main first response for children and adolescents who enter the protection system (in 2021 and 2022, 75% of discharges from the system for minors went directly to residential care, compared to 25% of discharges from foster care), and also to a large extent for the homeless (40.3% of this population receives support in shelters, centres or residences) and people with complex support needs, such as people with intellectual disabilities or multiple disabilities.
d) The Strategy confirms in any case that family care continues to be the backbone of long-term care in Spain: it quantifies this by stating that almost 70% of people in a situation of dependency are cared for only by one member of the family.

The main family caregivers are women: daughters, mothers, and partners. The same goes for people with disabilities. On this point, the Strategy states that

> the traditional care model has generated, for decades and continues to do so today, gender inequalities, which limits the autonomy, professional development and quality of life of the women they care for.

The care system, therefore, "is fundamentally supported by women". In this regard, the Strategy adds that there are 720,014 people affiliated to Social Security in social services (fourth quarter of 2023), of which 82.2% are women, compared to 17.8% of men. Of the total number of people working in social services, more than 600,000 work in the system of care for autonomy and dependency, where part-time employment rates are very high, salaries are low and physical

and mental risks are greater than in other sectors. On the other hand, the Strategy points out that despite the fact that the current labour regime of domestic workers directly hired by families excludes them from the provision of care to people in a situation of dependency, it is common for them to provide support and care to people who need it.

In any case, the Strategy points out that the care sector has great potential for job creation due to the expected increase in the population in need of support. The population over 65 years of age, which currently represents 20.1% of the total population (9,527.262), will represent 25% in 2035 (12,881.952 people) and 30% in 2047 (15,841.916 people). People aged 80 and over will represent 26.9% of the general population in 2065, reaching the figure of 10,120.175, according to INE projections. In this sense, this Strategy emphases the important social value of caregivers, mainly women, proposing lines of action aimed at valuing care work, improving working conditions and social protection for caregivers, and generating specific services and support to prevent care from falling on women and families.

The implementation of the Strategy is articulated in Principles, Axes and within each of them, Objectives and Lines of action.

In relation to the principles, there are the guarantee of rights to people in need of support and care for their families; respect for dignity and good treatment; independent living and in the community; personalization of care and support; freedom of choice and control of support and care; the gender perspective; intersectionality; prevention of institutionalization and universal and affordable accessibility.

Of interest is the definition he makes of the principle of intersectionality since it aims to eliminate any type of discrimination in the provision of care. The Strategy says that intersectionality

> is understood in this context as the situation by which the same person can suffer discrimination as a result of multiple social categories that converge in them simultaneously, such as gender, socioeconomic class, disability, place of origin, among other factors. Adopting an intersectional approach helps to articulate measures taking into account factors that impact people's lives and the exercise of rights in different ways, i.e. belonging to a vulnerable population group that faces other vulnerabilities at the same time, such as: sex, having a disability, belonging to the LGBTIQ+ community, socioeconomic class, educational level, having been born in another country, among other factors that can increase vulnerability and discrimination.

There are five axes of the Strategy: Axis 1, on Prevention of institutionalization dynamics, in which the Strategy attributes the provision of options to people so that care and support systems can be personalized and community-based; maintains the need to address social and structural factors that increase the risk of institutionalisation, such as the difficulty of accessing housing or the lack of agility in responding to support needs at initial or critical moments; Axis 2, on Participation of people and social awareness, in which the Strategy expresses

in this axis the need for cultural changes based on Human Rights that reconfigure the way in which care is planned, designed and provided, both by Public Administrations and by service providers, respecting the will, preferences, self-determination and freedom of choice of people; Axis 3 on Transformation of care and support models, which is developed later; Axis 4, on Development of services for the transition to life in the community, where the Strategy seeks the development of community- and family-based supports and services, as well as the strengthening of the social and community fabric to facilitate control over one's own life. To this end, it is proposed to strengthen coordination between the different agents and support resources that intervene in the community and people's lives; and Axis 5, on Enabling Conditions for Deinstitutionalization, which the Strategy describes as the need to equip oneself with a normative and legal framework that guarantees the right to live a chosen life and to have sufficient support in the community.

With regard to Axis 3, on the transformation of current care models, it must be said that the Strategy considers it basic to transform the functioning of organizations, which translates not only into a change in professional practice but also into the improvement of working conditions that allow a better provision of support and care. And addressing the deficit of professionals, as well as the activation of the monitoring, quality, and evaluation mechanisms necessary to guarantee the adequate provision of services and activities.

The objectives of this Axis 3 are the following:

1) Promote the transformation of care and support, orienting them towards person-centred care and independent living in the community. The Strategy states that meeting this objective requires a requalification of professional personnel in the care sector and the creation and updating of certificates and degrees towards person-centred care, intervention, and community development. For this reason, a line of action is proposed aimed at promoting training processes for the acquisition of new skills of people-centred support, promotion of professional development and updating of curricula and vocational training programmes.
2) Encourage the personalization of living environments so that people's rights are a priority. According to the Strategy, this objective seeks to promote the personalization and transformation of the environments where people live, their preferences, intimacy, self-determination, and rights are at the center of attention.
3) Improve working conditions to guarantee decent work and promote the increase of available personnel in the care sector (later development of the provisions for this Objective 3).
4) Guarantee the quality of services through mechanisms for evaluation, inspection, accountability, and support for continuous improvement. On this point, the Strategy says that lines of action are articulated aimed at generating a common framework of quality standards, which serve as a basis for the evaluation, and continuous improvement of support and care services, from the perspective of personalization, the community base, and deinsti-

tutionalization; strengthening transparency and accountability, and, finally, improving the inspection action of public administrations and establishing early warning systems in the event of possible cases of malpractice.

5) Generate an ecosystem of social innovation that multiplies the possibilities of collaborative learning to respond to the social challenges linked to deinstitutionalization. With respect to this objective, the Strategy states that it is considered that supporting continuous improvement and the development of services under this new model also implies generating an ecosystem of social innovation that multiplies the possibilities of collaborative learning in an open and integrated way with various agents, aimed at understanding and responding to the complex social challenges linked to deinstitutionalization.

In any case, in relation to Objective 3 "Improve working conditions to guarantee decent work and promote the increase of available personnel in the care sector", it must be said that it has two lines of action: Line of action: 3.3.1. Review and improvement of the working conditions of professionals in the care sector; Line of action 3.3.2. To address in a coordinated way the challenge of the need to increase qualified personnel for the care sector. With regard to the first Line of Action 3.3.1 on "Review and improvement of the working conditions of professionals in the care sector", the description made by the Strategy is that the improvement of working conditions must be deepened as one of the changes necessary to promote a new model of care and support in the community.

Based on this, it states that:

- It is advisable to continue with the line undertaken to review the partial contract and the prevention of occupational risks for workers who provide care and support in private homes.
- It states that "the occupational diseases of home care workers must be reviewed".
- It points out that it is "necessary to study the possibilities of improving the ratio of care to adapt care and support to the needs and will of the people, as well as to work with the agents involved to increase the salaries of workers above the minimum interprofessional wage".
- Finally, it is described that it would be necessary to address the reduction of occupational gender segregation in the care sector, both horizontally and vertically.
- Finally, it points out that it would be necessary to promote the formation of cooperatives of the social care economy.

With regard to Line of Action 3.3.2. "Address in a coordinated way the challenge of the need to increase qualified personnel for the care sector", the Strategy points out that addressing this important challenge requires analyzing, together with the set of competent administrations, the elements that, together with the low quality of employment, have an impact on the increase in the deficit of care professionals; to then implement the pertinent changes in access to the profession, without renouncing the qualification of profes-

sionals, exploring the possibilities that facilitate the regulation of professionals from other countries, informal caregivers or domestic workers until now hired by the families themselves.

## 7. Mapping of Cases of Discrimination Based on Gender and Migratory Status of People

The aim of this chapter is to focus on the problems found by various bodies in detecting situations of discrimination in the general field of the care sector, and above all to address whether the current regulations address the specificity of the working personnel who provide services in it, especially the legislation on foreigners in view of the significant presence of migrant personnel who work to care for other people.

1) In relation to the analysis of situations of discrimination based on sex that may occur in the field of the care sector, it is necessary to begin by saying that the Research Group notes deficits of statistical information on the specific problems that women may suffer, particularly in the field of care or jobs that are linked to this function. In other words, there is a lack of statistical data on the situations of women in care work, such as their needs for the use of time or for reconciling work and family life, or even their motivations for having a full-time or indefinite contract in that sector etc. In fact, this has been affirmed in 2022 by the Economic and Social Council in its report *Women, Work and Care: proposals for the future* (Consejo Económico y Social 2022), in which it expresses the existence of information gaps on the specific problems that women may suffer, particularly in the field of care, since the indicators included in official data sources do not always include disaggregation by sex nor do they usually record issues, incorporating qualitative analyses that would be relevant for their interpretation from a gender perspective. In this sense, the report concludes that "it is necessary for statistical bodies to strengthen the production and updating of data disaggregated by sex that, in addition to complying with the regulations in this regard, allow for improved knowledge of the reality of women in different areas (use of time, income, affiliation to Social Security, health and access to health care, entrepreneurship, digitalization, science and technology, social protection, among others) in order to identify the obstacles to effective equality". In addition, the Economic and Social Council advocates the inclusion of a gender perspective in studies and research of all kinds, in order to know the specific reality of women in all its dimensions and to detect the inequalities that persist.
   On the other hand, in relation to the issue of the equitable distribution of time and care work, the report concludes that in order to achieve an inclusive labour market that does not discriminate against women or waste a crucial part of their human capital in a context, it will be necessary to pay special attention to issues such as the diversity of women and the specific problems of certain groups in vulnerable situations due to their age, educational level, origin, situation of single-parenthood, gender violence or others specifical-

ly, the Economic and Social Council points out that it would be necessary to advance in formulas that also allow conciliation for women who are self-employed and in care jobs.

In general, applicable to both working and non-working women who perform care work, the Economic and Social Council calls for due consideration of the need of families with dependents to have access to affordable professional services and care infrastructures to facilitate the participation of all people in the labour market. As well as the need, in short, to promote co-responsibility beyond the individual sphere, that is, involving public administrations, companies and society as a whole to create environments more favourable to a fairer distribution of time, work and care from a gender perspective.

2) With regard to the analysis of the regulatory framework for foreigners made up *of Organic Law 4/2000 of 11 January 2000 on the rights and freedoms of foreigners in Spain and their social integration*, and the regulations implementing it, which are discussed below, it must be confirmed that they do not have specific treatment for the care sector, beyond a specific reference to domestic workers according to the payment of the fees that must be paid for the processing of residence and work permits (see arts. 45 and 46 of Organic Law 4/2000 in relation to the eighteenth additional provision of the regulation).

However, in the regulations that develop Organic Law 4/2000, specifically *Royal Decree 1155/2024, of 19 November,* some mentions of interest in the field of care are made, which should be summarised as follows:

1) In relation to the possibility that a foreigner with a residence permit in Spain may "reunite" his or her family members in that country, he or she may bring to Spain "a son or daughter of the adult of the sponsor or of his or her spouse or partner who is going to exercise the status of caregiver of the sponsor and who has recognized any of the degrees of dependency contemplated in Article 26 of Law 39/2006, of 14 December, on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency".

By the way, in cases of family reunification in Spain of foreigners, the same regulations require that the person who reunites proves that he or she has sufficient fixed and regular resources for his or her own maintenance and that of the members of his or her family. In this sense, the regulation itself establishes the amount of these resources. However, it also points out that this amount may be reduced when it is a question of reuniting minors in Spain, when there are proven circumstances that advise such a reduction in accordance with the principle of the best interests of the child. The rule adds that the circumstances of the specific case will be taken into account, assessing the age, physical and emotional development of the reunited family member, the relationship with their sponsor, and the number of members of the family unit, making an interpretation favourable to family life, and also meeting the other legal and regulatory requirements for the granting of the residence permit for family reunification.

We consider that this possibility of reducing economic amounts required of the foreigner who intends to reunite minor relatives in Spain (their children), can benefit foreigners who work in Spain in domestic service or in the care sector in general, due to the low salaries that, as we have seen, they receive in Spain.

2) Spanish citizens who intend to bring a foreign family member (who is not a national of a Member State of the European Union) to Spain may apply for a specific residence permit to be granted for that foreign family member. Among other family members, he can have the Spanish citizen reunited in Spain by "a single family member, up to the second degree, who carries out or will carry out the care required by a person with Spanish nationality who has recognised any of the degrees of dependency provided for in Article 26 of Law 39/2006, of 14 December, of Promotion of Personal Autonomy and Care for People in a Situation of Dependency".

As can be seen, the legislation has promoted bringing relatives of foreign and Spanish citizens to Spain provided that they carry out care functions for these foreign and Spanish citizens.

## 8. Conclusions

With respect to the working conditions of care personnel, this work has already advanced the dispersion of legal regimes, not only between care occupations (or those of the care sector), but especially within labour relationships such as domestic service where, in addition to the standard and special labour regime, jobs dominated by informality or under the protection of self-employment emerge. In addition to this, a high degree of job insecurity and low working conditions, especially wages, have already been confirmed, both with respect to those jobs not covered by collective bargaining and with respect to those that may be, mainly due to the high feminization of this sector and the low level of training or qualifications that are detected.

With regard to situations of discrimination against care sector personnel, the study we have carried out shows the need to adopt an intersectional approach in the field of guaranteeing the principle of non-discrimination of care workers, mainly from their triple gender perspective, migrant status (a factor not assumed as such by our legislation as a discriminatory reason), and mainly on the basis of ethnic origin. This issue should lead legislation, particularly on foreigners, to take into account the circumstances that these care workers may suffer with respect to access to employment (especially because certain occupations such as domestic workers become a niche for informality and the work of migrants in an irregular situation).

In any case, in view of the feminisation of the care community, it is urgent to have statistics or data that make it possible to effectively assess issues related to the sex of people by occupations in the care sector, and especially with regard to the use of time, income, affiliation to Social Security, health and access to health care. Entrepreneurship, digitalization, science and technology, social

protection, among others, which affect working women who are employed to care for other people.

Finally, we believe that in terms of care, and especially in the field of professional caregivers, proposals that are being promoted should be taken into account, such as the articulation of a Comprehensive Care Pact in Spain. We believe that such a pact should reflect and solve problems such as staff shortages or the facilitation of legal and safe ways to attract immigration. Also, to improve the training and qualifications of personnel.

On the other hand, it is also necessary to develop important aspects that the Spanish Government has highlighted in its Strategy in relation to residential centres, for example, reviewing the partial contract and the prevention of occupational risks for workers who provide care and support in private homes; or

> review the list of occupational diseases of home care workers; also to study the possibilities of improving the ratio of care to adapt care and support to the needs and will of people, as well as to work with the agents involved to increase the salaries of workers above the minimum interprofessional wage;

or finally to "address in a coordinated way the challenge that constitutes the need to increase qualified personnel for the care sector".

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CHAPTER 13

# The Language of Care: a Labour Law Review of Language Requirements for Care Workers in Sweden

Andrea Iossa, Jenny Julén Votinius

## 1. Introduction

The aim of this chapter is to examine implications of the recent evolution of legal requirements for Swedish language proficiency among care workers, from a labour law perspective and with a special focus on work environment for care workers in elder care. Against the background of the broader EU legal and policy context and drawing on the role of verbal communication in care work, the analysis focuses on national Swedish labour law and social partner involvement.

While Sweden has long been a society where many languages are spoken alongside Swedish as the principal language (Fuster and Bardel 2024),[1] recent decades have been marked by a rapid increase in linguistic diversity, accompanied by a growing proportion of residents with limited proficiency in Swedish (Statistic Sweden 2026). The care sector experiences certain challenges in terms of language proficiency, related to crucial communication needs and patient

[1] In addition to Swedish, which is statutory protected as the principal language of the country and the common language in society, five minority languages are officially recognised and protected: Finnish, Meänkieli, Sami, Romani Chib and Yiddish, Sections 5 and 6 of the Language Act (2009:600). Alongside the recognised languages, immigrant communities have introduced a wide array of other languages into everyday life.

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safety. In the care sector, the share of migrant workers has steadily increased and is considerably higher than in the entire labour market. The increase has been especially marked in core care occupations such as assistant nurses and care assistants, where the share of foreign-born workers has grown rapidly over the past decade. The development accelerated sharply in the late 2010s, following broader migration patterns and the subsequent integration of newly arrived migrants into work in the care sector (Salar 2025).

For a number of years and increasingly over time, concerns have been raised by government inquiries, administrative authorities, and trade unions, that inadequate language skills jeopardize both care quality and the work environment for care workers. In response to these concerns, the regulatory framework concerning language proficiency in the care sector has been expanded beyond licensed nurses to other groups of care workers. In July 2023, as the title of assistant nurse became protected, its granting became subject to a statutory language requirement.[2] The most recent step in the legislative development is the introduction of a statutory language requirement in elder care, placing the responsibility on providers of elder care to ensure adequate language proficiency among all workers involved in the care of elderly to entry into force on 1 July 2026 (Government Bill 2025/26:93).

The issue of language in care professions is relevant also from an EU perspective. At EU level, the question of working conditions for workers in the care sector is closely linked with the question of care services and their quality. The package of EU policies launched in September 2022 under the name "European Care Strategy" has at its core the need for improving the quality of care services to address the demographic challenges that EU Member States face in terms of both the ageing of population and the participation of women to the labour market (Caracciolo di Torella and Masselot 2024). Addressing working and employment conditions in the care sector is detected as a key objective of the European Care Strategy to contribute to improve the quality of care services by expanding it and making it more attractive as to target the structural problem of staff shortages. In this context, language proficiency constitutes a fundamental factor contributing to improving both working conditions, in terms of facilitating the performance of tasks, and quality of care services, by enabling better communication between care givers and care receivers.

This chapter applies a legal-analytical method is applied in the sections analysing and explaining statutory law and integrates an industrial relations approach in the discussion on the role of the social partners. Statistical and other empirical material, as well as legal and industrial relations scholarship is used throughout to situate the analysis and discussion in a wider political and labour market context. The structure is as follows. Section 2 provides a discussion on the role of verbal communication skills in care work. Section 3 discusses the is-

[2] This requirement is now set in Chapter 5 Section 15 and Chapter 6 Section 1 of the Patient Safety Ordinance (2010:1369).

sue of language proficiency in care work as matter of national and EU policy. The section provides a background on the Swedish care sector, the share of migrant workers in the workforce and reports on negative effects of language shortcomings among workers in the care sector, and it highlights relevant aspects of the European Care Strategy. Section 4 highlights relevant initiatives and activities undertaken by Swedish social partners. Section 5 presents the legal framework related to requirements for Swedish language proficiency among care workers, and the recently introduced language requirement for employees in the elder care sector. Section 6 analyses the language requirement, first, in the broader labour law context, including free movement of workers, non-discrimination and employment protection, and, second, in the context of health and safety at work and the regulation of the work environment. Section 7, finally, provides a discussion and conclusion.

## 2. The Role of Verbal Communication in Care Work

Language proficiency is fundamental in care work. It is the key to communication, which is an indispensable factor in the interaction between the care giver and those who receive care. It is also a necessary condition for compliance with professional standards, patient safety requirements and accountability mechanisms.

Language – the possibility to communicate between each other – contributes to improve the human contact in care, which has been deemed as an essential element of a human right to receive care (Fast Lappalainen 2022). While much of the literature has approached these issues through normative and ethical frameworks, the relevance of language in care work can equally be analysed in terms of legal structure and institutional design, enabling communication necessary for informed consent, continuity of care and the exercise of individual rights within the care relationship. Feminist scholars have underlined the relational nature of care, which can take on different forms and constellations, but which always include emotional labour that needs to be expressed, also in words (Fisher and Tronto 1990). From a legal perspective, this communicative dimension is a precondition for the employer's ability to organise, supervise and evaluate work performance within the employment relationship. Even when care is carried out within the frame of paid work and therefore subject to formal rules of employment as well as to norms at the workplace (Selberg, Sandberg and Mulinari 2022), emotions and the need and duty to communicate about them are at the core of care work as to define it as "labour of love" (Graham 1983). The relational nature of care work makes it particularly exposed to asymmetries of power that are legally relevant within the employment relationship (Tronto 2015). For the individual employee, language proficiency affects the capacity to participate in workplace decision-making, to understand instructions and to assert their rights, and even to report wrongdoings as in the case of whistleblowing. Starting from the assumption that "the ability to give and receive adequate care is central to human well-being", feminist scholar Fiona Robinson suggests

that [i]njustice is thus understood, at least partially, as those practices, institutions, structures and discourses which inhibit or subvert adequate care or which lead to exploitation, neglect or a lack of recognition in the giving and receiving of care' (Robinson 2013, 137). Given the relevance of migration in the context of care work – as highlighted by research on "global care chains" (Yeates 2004; Zbyszewska and Sekalala 2023) – language proficiency assumes a significance that goes beyond the need for achieving a certain degree of professionalism of the care worker. To have access to the language in order to be able to communicate is then an instrument to balance the relationship – to make it more equal – between the care giver and those who hire them and direct their work as well as their colleagues (Lundberg 2025).

## 3. Language Proficiency in the Care Professions: a National and EU Policy Matter

### 3.1 The Swedish Care Sector

The care sector in Sweden is primarily public, with a small but growing private sector. About 80% of care services are provided by regions and municipalities (Statistics Sweden 2021). In the private care sector, care services are provided by private commercial companies, including temporary work agencies, and by private non-profit organisations. Swedish elder care policy is based on the principle of ageing in place, encouraging elderly to remain in their homes for as long as possible with various forms of support (SOU 2017:21). The great majority of elderly persons live in their homes with or without care services.[3] A large part of the public health and elder care is carried out in the form of domestic care work. In 2021, the most common occupation in Sweden was assistant nurse in domestic care and in-residence homes for elderly persons (Swedish Occupational Register 2021). Only a smaller portion of assistant nurses work in residence homes, whereas most of these employees carry out their work in private homes, as do approximately 6,000 nurses (Claesson 2022).

The challenges related to the shortage of manpower in the care sector are severe, with recruitment difficulties and obstacles increasing, much like in the rest of Europe (Rönnmar 2025). Sweden's municipalities and regions estimate that by 2031, due to retirements within the sector and due to a general increased need of staff, they will need to recruit more than 30,000 new nurses, 93,000 assistant nurses and 20,000 new care assistants (Salar 2022).

Persons born abroad make up a larger share of the employees in the care sector than in other sectors, and this applies particularly for persons born outside Europe (Julén Votinius 2025). In public healthcare, 12.5% of employees are born outside the EU, while the corresponding figure in private care is 20%, compared to 9% in the labour market as a whole. Looking closer to certain healthcare occupations, the figures are even higher: among care assistants,

[3] In 2020, only 4% of the age group 65–79 and 11% of persons above 80 lived in residence homes for elderly, Swedish National Board of Health and Welfare 2021; 2023.

53.3% are born outside Sweden, while the figures are 36.8% for assistant nurses in elder care and home services, and 34.8% for personal assistants (Rönnmar and Julén Votinius 2025). Among the care workers born abroad, only very few are labour immigrants.[4] Instead, the majority are people who have migrated to Sweden for other reasons, and for whom the care sector offers a way into the Swedish labour market. The role of the care sector in immigrant integration has attracted attention for both its positive effects in addressing labour shortages and facilitating labour market entry, and its risks, including segmentation and concentration of migrant workers in low-paid and insecure positions, as well as risk in relation to care quality and the work environment for care workers (Simmons, Rodrigues and Szebehely 2022; Eriksson et al 2023; Kommunal 2019).

In this context, increasing attention has been paid to quality deficiencies in the care sector, particularly in elder care, due to insufficient knowledge of the Swedish language among employees. The matter has for instance been addressed in several Government Inquiry Reports, a comprehensive report from the Swedish Municipal Workers Union (*Kommunalarbetareförbundet*), and in their yearly reports, the Health and Social Care Inspectorate (IVO) has repeatedly highlighted serious negative effects of language shortcomings (SOU 2019:20; SOU 2020:80; SOU 2021:52; Kommunal 2022). The 2023 report found that in 97% of the municipalities, there are health and care workers in residential elder care who lack enough knowledge of the Swedish language to understand what the patient expresses and to be able to convey this information correctly. Nearly one in five patients interviewed stated that they had experienced situations where they neither understood nor were understood by the health and care workers (IVO 2023; 2022). These various reports have been covered by the media and sparked debate. Some municipalities have introduced language tests in recruitment to certain parts of the care sector, including elder care and personal assistance for persons with a disability. The Municipal Workers Union (*Kommunalarbetareförbundet*), while noting the importance of preventing ethnic discrimination, has welcomed this development, which is aligned with their own efforts to highlight the importance of language both in relation to care quality and to the work environment in the care sector (Erlandsson 2022).

### 3.2 The European Care Strategy

In September 2022, the EU Commission launched the European Care Strategy, a new policy in the field of care services. The policy is composed of a Communication from the Commission (European Commission 2022) and

[4] A labour immigrant is defined as a person who's right to reside in Sweden is based on a work permit. Between 2019 and 2023, the yearly average of work permits issued by Swedish Migration Agency was 29 permits for nurses, 63 permits for assistant nurses, 43 permits for care assistants and 103 permits for carers including personal assistants for persons with a disability, Swedish Migration Agency, statistics on work permits.

of two Council Recommendations (Council of the European Union 2022a; Council of the European Union 2022b). It was adopted on the basis of the European Pillar of Social Rights and in particular on its Principle 18, which states that '[e]veryone has the right to affordable long-term care services of good quality, in particular homecare and community-based care' (Caracciolo di Torella 2023, 59). The overall aim of the European Care Strategy is to improve the quality of care in the EU, to make it more accessible, and more affordable. This aim is identified as the adequate response to the demographic challenges that EU Member States face, especially in relation to the ageing of the population (European Commission 2022, 3).

The European Care Strategy places significant attention to the question of working and employment conditions of care givers, and it has been deemed innovative in its "holistic" approach due to the direct link it provides between the quality of *care* and the quality of *working in care* (Caracciolo di Torella 2023, 60). In other words, the EU Commission acknowledges that better working conditions would make working in the care sector more attractive and therefore contribute to addressing the structural problem of staff shortages (European Commission 2022, 12), which is a common problem in many EU countries (Rönnmar 2025). Staff shortages are seen as affecting the quality of care by limiting accessibility. To address this problem, the European Care Strategy promotes measures to facilitate recruitment in the care sector, in particular by making the sector more attractive in terms of working conditions and possibilities of professional development (European Commission 2022, 9). These aspects are reflected in Arts. 7 – 9 of the Council Recommendation on access to affordable high-quality long-term care, which includes specific recommendations to Member States to introduce measures to improve working conditions, in particular wages, and promote professional development and career advancement.

Both the Communication from the Commission and the Council Recommendation place great emphasis on the need for Member States to increase opportunities for care workers to receive adequate training and have access to education also in terms of acquiring new skills. However, those documents make no explicit mention of language skills and access to language education. This seems to be at odd with the emphasis that both documents instead place on migration as a possible way to address the problem of staff shortages in the care sector (Schelkle and Kyriazi 2025). The Communication describes legal migration as 'a key driver to remedy labour shortages' (European Commission 2022, 14) and commits the Commission to map conditions of admission and stay in the Member States as well as rights for long-term care workers, and to promote initiatives in field of training as to enable care workers to acquire needed skills for their professional development (European Commission 2022, 15). Similarly, the Council Recommendation identifies "migrant care workers" among "vulnerable groups of workers" (Art. 7.c) and recommends Member States to "address skills needs" of long-care workers by "designing and improving the initial and continuous education and training to equip current and future long-term care

workers with the necessary skills and competences" (Art 8.a). As said, there is no explicit mention of language as a necessary skill to improve the quality of care and the quality of working in care.

## 4. Initiatives by the Social Partners

The Swedish industrial relations tradition includes an involvement of the social partners in meeting labour market challenges and a readiness for collectively bargained solutions, sometimes in a tripartite form backed up with State subsidies. The largest employer organisation in the Swedish care sector is the Swedish Association of Local Authorities and Regions (*SKR*). Other employer organisations include Sobona, for local government companies, the Association of Private Care Providers (*Vårdföretagarna*), and Kompetensföretagen, for temporary work agencies. The main employee unions are the Swedish Municipal Workers' Union (*Kommunalarbetareförbundet*), affiliated to the blue-collar trade union confederation LO, which organises assistant nurses, care assistant, and personal assistants, and the Swedish Association of Health Professionals (*Vårdförbundet*), affiliated with the white-collar trade union confederation TCO, which organises general and specialised nurses (Rönnmar and Julén Votinius 2025, 15).

In the care sector, the issue of language skills is one of the areas where the social partners cooperate to find solutions. In 2008, the social partners, the Swedish Municipal Workers' Union and the employers' organisations SKR, Sobona, and Fremia, launched the association *Vård- och omsorgscollege* (Health and social care college) with the aim of providing trainings for care workers in different areas, including language. The association works as a training centre in line with a long-lasting and well-established tradition of the Swedish social partners to provide specific training and educational programmes to their members. The association has developed a specific project on the development of language skills called *Språket på jobbet* (Language at work), that aims at improving social communication at work and in the work environment by strengthening language skills among care workers. The project is implemented through the production of online courses and webinars as well as of material that can be easily accessed by workers and employers. This joint association also developed the concept of the *språkombud*, which can be translated as the "workplace language facilitator" (SOU 2024:78, 168). The concept refers to a specific person among the employees that would have the task of supporting colleagues who are in need for developing adequate language skills. In this sense, the *språkombud* would facilitate the communication at the workplace under the supervision of the management and work to the aim of making the work environment a place to contribute to language development. The governmental inquiry suggesting the introduction of language proficiency requirements for care workers in elder care welcomed these initiatives as a positive development and acknowledged the efforts placed by the social partners in designing specific training programmes targeting both employees and managers.

Language skills and the need for language training targeting care workers have been for long a key demand put forward by the Swedish Municipal Workers' Union *Kommunalarbetareförundet*. In a report issued in 2022 (Kommunal 2022), the union points at the need for good language skills among eldercare workers both to improve the quality of care towards people with cognitive diseases and to enable them to carry out work tasks in administration that requires good language skills. The report observes that migration and international recruitment can be solutions to the structural problem of staff shortages in eldercare. Yet it also stresses that the sector cannot function as an integration tool, meaning that migrants working in eldercare cannot be expected to learn Swedish and acquire a good level of the language just along by working. In the union's view, this would inevitably affect the quality of the care provided and increase workloads for the migrant workers and their colleagues. In addition, poor language skills are also identified as a factor possibly causing social isolation at work, in particular for those working in home care services for elderly. Given the relevance that social work environment has in Swedish regulatory framework for occupational health and safety (see below), according to the union's report, it is important to address language skills as a factor that contribute to better social relationships at work and therefore to a better work environment. In this sense, the report stresses the need for providing adequate language training as a part of the professional development of the worker.

## 5. The Development of Statutory Requirements on Language Proficiency for Care Workers in Sweden

Traditionally, Sweden did not apply any explicit statutory language requirement for employees in the care sector. The National Board of Health and Welfare has issued guidance documents to set a required level of competence and provide support to care providers, including with regard to language skills.[5] Language proficiency has been regarded as an implicit component of professional suitability and a part of the general duty of the care provider to deliver safe and appropriate care. This was particularly evident in relation to employees educated within the EU/EEA applying for a license as a nurse under the then Directive 2005/36/EC on the recognition of professional qualifications. The Swedish National Board of Health and Welfare interpreted the Directive to exclude the possibility to take any account of the language skills of the applicant when deciding on issuing a license (SOU 2014:19, 331). As a result, it was left to the potential employer to verify and assess whether the language skills were sufficient for the practice of the profession. The situation changed with the implementation of the modernised Professional Qualifications Directive 2013/55/EU.

[5] For example, the National Board of Health and Welfare's general guidelines (SOSFS 2011:12) state that staff working in elder care should, at a minimum, be able to understand, speak, read, and write Swedish. However, individual employers set recruitment requirements according to their quality and competence needs, Government Bill Prop. 2025/26:93, *Ett språkkrav inom äldreomsorgen*, p. 10.

While already the earlier Directive 2005/36/EC, imposed a language proficiency requirement for licensed professions (which was also implemented in Sweden), such as nurses, specialised nurses and midwifes, it was unclear to what extent a Member State was permitted to impose controls regarding this qualification. The modernised Directive 2013/55/EU stresses the obligation for professionals to have the necessary language skills and clarifies the importance, in particular for patient safety reasons, that language controls be applied before the professional accesses the profession in the host Member State.[6] The controls, which shall be carried out by, or under the supervision of, the competent authority must be limited to the knowledge of one official language of the host Member State, provided that it is also an official language of the Union; in Sweden this is Swedish (Art. 53 Directive 2013/55/EU). It can be noted that the patient interest in respect to language proficiency requirements has been articulated in CJEU case law since the first directive in this area, where for example the Advocate General in the early *Haim I* case stressed that "the quality of care, the central objective of any public health policy, depends on the possibility of a genuine dialogue between the practitioner and the patient".[7]

Following the implementation of the modernised Directive, since 2016, an applicant for a licence as a registered nurse is required to demonstrate adequate knowledge of Swedish, or of Danish or Norwegian as stated in Ch. 5, Section 15 and Ch. 6 Section 1 of the Patient Safety Ordinance (2010:1369). This requirement applies regardless of whether the education has been obtained within or outside the EU/EEA. Language proficiency is normally demonstrated through formal qualifications corresponding to level C1 CEFR (advanced) but other recognised evidence can be deemed equivalent.

Different from nurses, assistant nurses are not a licenced profession, but from 2017, an inquiry chair was appointed by the Government to present at proposal on how to make the title assistant nurse a protected professional title (*skyddad yrkestitel*). In the care sector, and particularly in elder care, assistant nurses and care assistants constitute the largest occupational categories and are also the categories where the largest proportion of employees have a foreign background. In 2023, the reform came into force and assistant nurse is today a protected professional title (Prop. 2020/21:175). Those who were permanently employed as assistant nurses when the requirement entered into force will be able to continue to use the title until 30 June 2033 without submitting an application. The reform aims to strengthen professionalisation by requiring completion of an approved education programme for assistant nurses. In addition, an applicant who has received their education outside Sweden (including Swedish citizens) must

[6] European Parliament and Council Directive 2013/55/EU amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) No 1024/2012 on administrative cooperation through the Internal Market Information System ('the IMI Regulation'), [2013] OJ L 354/132, Recital 19 and Article 53. See Van der Jeught 2023).

[7] Opinion of Advocate General Mischo, Salomone Haim v Kassenzahnärztliche Vereinigung Nordrhein (C-424/97) EU:C:1999:253. p. 107.

meet requirement for proficiency in Swedish, alternatively Danish or Norwegian (see above). The language skills must be at the equivalent level B2 CEFR (upper-intermediate) and can be demonstrated through an educational certificate or through an assessment made by a healthcare provider and documented in line with certain instructions.[8]

The most recent step in this regulatory development is the statutory provisions regarding language proficiency of care workers in elder care that entered into force in 1 July 2026. The provisions were adopted in response to earlier and more recent monitoring reports, notably the Health and Social Care Inspectorate (IVO) 2023 report which highlighted important quality deficiencies in elder care resulting from insufficient language skills of care workers. The reform aims at strengthening quality and safety in elder care through improved linguistic competence among care workers, set at B2 on the CEFR scale.[9] It covers all employees who take part in the care services, among which the majority are assistant nurses and care assistants (Government Bill 2025/26:93, 10). However, a defining feature of the new regulation is that does not impose a formal eligibility requirement directly on the employees. Instead, the amendment is to the Swedish Social Services Act (2025:400), where it requires the *employers* to ensure that the care workers have the level of language proficiency adequate to their tasks. The preparatory works frames this responsibility as a continuous part of the organisation and management of the care activity, stressing that adequate knowledge of the language is necessary in order to be able to communicate effectively with care recipients, relatives, and colleagues; to understand and convey information relevant to care; to follow instructions and routines; and to document and report in accordance with applicable requirements. Language proficiency among the care workers is thus considered an integrated element in the obligation to deliver elder care services in compliance with statutory standards and subject to monitoring and inspections. The preparatory works stress that, given the difficulties in recruiting competent staff for elder care, the language requirement must not be understood as a condition for employment and shall not make it even harder to recruit or keep employees (Government Bill 2025/26:93, 9). The Government Bill does not set out timetable for when service providers must achieve the required language standard, but the responsible minister has stated that the Health and Social Care Inspectorate (IVO) will monitor implementation and may impose fines on municipalities that do not initiate work towards compliance. Alongside the obligation on service providers, the Government Bill emphasises the importance of relevant authorities contributing to raising

[8] When a Member State decides to adopt a new protected professional title, it may impose language knowledge requirements to the extent necessary to practise the profession. Article 7.3(i), European Parliament and Council Directive (EU) 2018/958 on a proportionality test before adoption of new regulation of professions (2018) OJ L 173.

[9] The provisions do not specify the level of language proficiency required but authorises the Government to decide details in issue supplementary regulations. The preparatory works discusses only the B2 level.

the level of language skills among elder care staff, and allocate funding for this purpose in the 2026 budget (Government Bill 2025/26:93, 21).

## 6. The New Language Requirements and Labour Law

### 6.1 The New Language Requirements in Relation to Labour Law Protection

Since the responsibility for working towards that employees have sufficient language competence lies with the employer in the capacity as care provider, the new language requirement as such does not in itself constitute any significant changes in labour law. Employers already have the authority to set requirements and organise work in accordance with legitimate operational needs, including language skills, under the managerial prerogative and the right to organise and allocate work. However, the broad discretion afforded to employers under the design of the provisions means that they must ensure that the measures they adopt to promote the required level of language proficiency among employees comply with labour law (Government Bill 2025/26:93, 13). Among the disputes that may raise in relation to such measures, the most obvious are in the area of free movement of workers within the EU and non-discrimination law, particularly in recruitment. Disputes also may raise in the area of employment protection.

Under EU law, the free movement of workers (Article 45 TFEU, Regulation 492/2011, and Directive 2004/38) guarantees that workers from other Member States can access employment on equal terms with nationals.[10] This right under the treaty has both horizontal and vertical direct effect, and can thus be invoked against private as well as public employees.[11] Regarding the specific matter of language proficiency requirements for access to employment, under Article 3(2) of Regulation 492/2011 Member States are allowed to impose "conditions relating to linguistic knowledge required by reason of the nature of the post to be filled".[12] A language requirement that disproportionately affects workers moving from another Member State may be considered an obstacle to this fundamental freedom and could constitute indirect discrimination if it is not objectively

[10] TFEU Art. 45, Art 15 of the Charter of Fundamental rights of the EU. This freedom of movement, one of the four fundamental freedoms of the internal market, applies to EU citizens, EEA nationals (Iceland, Liechtenstein, Norway), and Swiss nationals, as well as their family members. Restrictions on family integration are considered obstacles to mobility.

[11] Van Duyn (C-41/74) EU:C:1974:133, paras 6–7. Watson (C-118/75) EU:C:1976:106, Angonese (C-281/98), EU:C:2000:296, para 36, RaccanellGii C-94/ 07 EU:C:2008:425, paras 45–6.

[12] Groener (C-379/87) EU:C:1989:599; [1990], 19, ruled under the previous art. 48 EEC and Regulation (EEC) No 1612/68 of the Council of 15 October 1968 on freedom of movement for workers within the Community, OJ L 257 of 19/10/1968, 2. There is no later case law developing the proportionality criterion as regards the level of language proficiency needed or the requirements linked to nature of the post. The few subsequent cases that have appeared before the court has dealt with what documentation can be required to confirm proficiency in the language and made clear that the documentation must be possible to obtain also for a migrant worker. See, for instance, Angonese (C-281/98) EU:C:2000:296 [2000].

justified, proportionate, and necessary to achieve a legitimate aim, such as ensuring safe and high-quality care.

From the perspective of Swedish non-discrimination law, which builds on the EU directives, language requirement may amount to indirect discrimination. Such discrimination arises when someone is disadvantaged by the application of a provision, a criterion or a procedure that appears neutral but that may put people of a certain group at a particular disadvantage, unless the provision, criterion or procedure has a legitimate purpose and the means that are used are appropriate and necessary to achieve that purpose.[13] Here, the group potentially disadvantaged by the introduction of the language requirement can be identified in persons of foreign background. While language is not an explicit protected ground against discrimination, the preparatory works points to the fact that newly arrived workers are likely to be more affected by a language requirement than those born in Sweden (Government Bill 2025/26:93, 13). In order to avoid indirect discrimination, any language requirement must be closely linked to the legitimate aim of ensuring safe care, and the methods used to assess language skills must be capable of being met by all candidates who possess sufficient practical competence (SOU 2024:78, 147).

While language requirements at the recruitment stage must be designed so that they do not risk unlawfully excluding qualified applicants, different considerations apply in a dismissal context. The crucial question here is to what extent reluctance or incapacity to further develop language skills can be regarded as a factor against the employee where a dismissal is being considered. Swedish employment protection is governed primarily by the Employment Protection Act (1982:80), which requires objective grounds for dismissal (Section 7). A distinction is made between dismissals for personal reasons and for redundancy. In cases of personal reasons, the employer must fulfil extensive obligations, including reassignment, training, and rehabilitation measures, in line with the ultima ratio principle. In 2022, a legislative reform, following a political agreement between the political parties forming the then government majority and called January Agreement and subsequent social partner negotiations, introduced greater scope for deviations through collective agreements at central level. The reform was closely linked to a cross-sectoral agreement on security, transition, and employment protection in the private sector, and parallel adjustments were made in the municipal and regional sector. The framework emphasises employability and transitional support, including training (Rönnmar and Julén Votinius 2025).

Thenew requirement that service providers, i.e. employers, in the elder care sector must act to ensure that employees have sufficient knowledge of Swedish must be understood against this background. Within this legal context, insufficient language proficiency might, ultimately and depending on the circumstances, constitute a lack of capacity to perform the work adequately. Before dismissal for personal reasons can be considered, the employer must have taken

[13] Chapter 1, Section 4, p. 2, Discrimination Act 2008:567.

reasonable measures to support the employee. With respect to language development for workers in elder care, such an obligation follows also from the new requirement for service providers. If, despite such efforts, an employee fails to participate in or contribute to their own language development, persistent and significant language deficiencies that affect patient safety, quality of care, or cooperation at the workplace could likely be regarded as a factor weighing in favour of dismissal, provided that the proportionality and ultima ratio requirements under the Employment Protection Act (1982:80) are met.

Alongside any potential implications in the area of employment protection, the impact on the regulation of the work environment appears even clearer. This observation has also highlighted in many reports and not least in the governmental inquiry suggesting the introduction of a language requirement for workers in elder care. The issues of the language requirements are closely linked to employer obligations relating to the health and safety in the workplace. The following section addresses language requirements in relation to employers' obligations concerning the work environment, including patient safety and communication at the workplace.

### 6.2 The New Language Requirements in Relation to Employer Health and Safety Obligations

Language – meant as the capacity to express oneself – assumes a relevant connotation also in relation with the regulation of the work environment and health and safety at work. Communication is a key element for the social environment at work, as have been explained in detail with respect to the Swedish care sector in the 2022 report on the importance of language proficiency published by the Swedish Municipal Workers' Union *Kommunalarbetareförundet*. The negative effects on the work environment of care workers that derive from deficiencies in language skills are highlighted by the governmental inquiry suggesting the introduction of a language requirement (SOU 2024:78, 100–1). In their response to the referral of the legislative proposal on a language requirement in the elder care sector, the trade union expressed positive comments about the proposal to introduce a language requirement to work in elder care (Kommunal 2025).[14] Overall, the union welcomes the introduction of a language requirement for eldercare workers as a way to improve the quality of care and the wellbeing of care workers and care receivers alike. They stress that eldercare workers often provide care to people with cognitive disabilities and long-term diseases that affect their ability to communicate. Therefore, improving language skills for care workers will contribute to improve communication with patients.

[14] The legislative process in Sweden includes a mandatory referral of the inquiry report and its suggestion for the legislative proposal. Only after considering the responses in the referral, the Government can present the Bill.

Effective communication enables employees to address workplace issues with colleagues and managers in a constructive manner. It also fosters positive social interactions, which can strengthen relationships and make the work environment more supportive and less stressful. Swedish work environment law and regulations of health and safety at work attribute significant relevance to the social dimension of the work environment. The concept of "social work environment" (*social arbetsmiljö*) has been codified already in 1980 and then later with Swedish Work Environment Authority's regulations on organisational and social work environment (AFS 2015:4), but attention towards psychosocial risks already existed in Swedish work environment law (Steinberg 2015). With the adoption of dedicated regulations, specific obligations for the employer emerged in relation to the social dimension of the work environment (Holm 2020). From 2023, the social dimension of the work environment as a factor contributing to health and safety at work, is regulated in the Swedish Work Environment Authority's Regulations on the Planning and Organisation of Systematic Work Environment Management (AFS 2023:2). Here, social work environment is defined as "conditions and circumstances of work, including social interaction, collaboration, and social support from managers and colleagues" (2 Ch. Section 2 AFS 2023:2). Following the overall obligation for the employer to take "all measures necessary" to prevent the employee from being exposed to ill health or accidents at work (Ch. 3 Section 3 the Working Environment Act (1977:1160), the social dimension of work is one of the factors that the employer has to take into consideration when assessing possible risks and evaluating how to intervene in order to achieve a good work environment.

According to the Working Environment Act (1977:1160), the conditions of the work environment must be "satisfactory" having regard with "the nature of the work and to social and technological development" (Ch. 2 Section 1). The preparatory works to the WEA clarify that the psychosocial elements of work are among the factors that contribute to the definition of the work environment as "satisfactory" (Government Bill 1976/77:149, 223; see also Ericson 2025, 44). In this regard, it is possible to argue that migration represents a significant social development in contemporary society. Migrant workers make up a substantial share of migrant workers of the workforce in healthcare professions and therefore the significant impact of migration as a social development shaping the conditions of work and the working environment. Workplaces become multi-lingual and the issue of language become a key factor affecting communication at work. Ensuring sufficient language competence and effective communication structures is therefore not merely a matter of operational efficiency but of work environment responsibility and risk prevention for the employer. The second paragraph in Ch. 2 Section 1 WEA states that working conditions shall be adapted to the different psychical and psychological capabilities that people have. This entails that an employer is required to take measures to adjust the work environment to the different psychical and psychological capabilities of their employees. This applies to accessibility of the workplace as well as to feasibility of working tasks, also in relation to the social dimension of work (Ericson 2025, 124). The preparatory works to the WEA includes in the definition

of "different capabilities" (*olika förutsättningar*) also the specific position of migrants. It is explained that migrant workers have special conditions that need to be addressed as a work environment's issue (Prop 1976/77:149, 258). Specific attention is dedicated to the issue of language with regard to the need for migrant workers to receive proper information about risks and guidelines on health and safety procedures as well as about their rights to health and safety at work. In this regard, it emphasizes the role of local and regional health and safety representatives in facilitating the process of information about health and safety standards and procedures towards newly employed migrants who might not have a good knowledge of Swedish. The preparatory works also highlight the importance of providing easy access to an interpretation service to facilitate communication (Government Bill 1976/77:149, 347). Language can therefore be understood both as part of the social environment and as a factor that may generate workplace risks when inadequate communication compromises health and safety.

This aspect develops a further and distinct connotation when care services are provided in someone's home rather than in healthcare facilities. This is the case with personal assistants to persons with disabilities or to elderly people. Given that a core element of care is communication (see above), the issue of language is then central in ensuring the quality of the service as well as the safety of the care workers, especially when care services are provided to persons in vulnerable positions. To be able to communicate improves "personal chemistry" and the trust between the care giver and the care receivers and enhances care giver's rights to a safe work environment (Schömer 2017). For this category of care professionals the issue of communication shall be considered also in relation with the nature of "lone working" (*ensamarbete*) that working in someone's home entails (Holm 2023). Swedish regulations on health and safety at work provides for special rules for work that is performed in physical and social isolation (Holm 2024, 93). In these cases, the employer has a stronger obligation to assess further risks that might derive from working in isolation and how to address them. In the case of home care givers, the lack of communication abilities due to poor knowledge of the language of the care receivers might entail risks to being exposed to harassment and degrading treatments (Schömer 2024).

Communication is a key element of the organizational work environment too (Holm 2020). The Regulations on the Planning and Organisation of Systematic Work Environment Management (AFS 2023:2) includes communication as one of the conditions and prerequisites that constitute the organizational work environment (Ch. 2 Section 3 AFS 2023:2). In addressing issues related to the social working environment, the employer must have as aim to promote health and increase the organization's ability to prevent illness at work (2 Ch. Section 5 AFS 2023:2). In the guidelines and advice that the Work Environment Agency includes in its regulations, it is also clarified that the employer's objectives in relation to the organizational and social work environment shall be designed "to strengthen and communication, learning, leadership, cooperation, influence and employee participation". Following Ch. 3 Section 3 WEA, the employer has the responsibility to ensure that employees acquire good knowledge of the of

the conditions under which the work is carried out and the working tasks they are expected to perform as well as of the risks they might entail, and of the protective measures and procedures they need to follow to avoid those risks. This obligation is then specified by Ch. 2 Section 7 AFS 2023:2, which, in the general guidelines provided there, clarifies that the employer shall consider employees' different communication needs and abilities (Holm 2024, 81).

The employer has therefore an obligation to oversee that communication among colleagues happens in the best way possible to prevent accidents and illness, but also social exclusion. This aspect is highlighted within Swedish work environment law by the obligations that the legal framework places upon the employer in relation with harassment and offensive treatments (*kränkande särbehandling*). These conducts are defined in the Regulations on the Planning and Organisation of Systematic Work Environment Management (AFS 2023:2) as "actions directed at one or more employees in an offensive or abusive manner that may lead to ill health or result in the employee being excluded from the workplace community". The element of social exclusion is thus relevant in assessing whether conduct, treatments or behaviours from a colleague or a manager constitute harassment in legal sense under the scope of work environment law (Ericson 2025, 94). It follows from the definition that conduct, treatment, or behaviour may be considered harassment or offensive treatment already if they can lead to a risk of exclusion from the workplace community (Mårtensson and Malm 2019, 68). Poor knowledge of the working language can be a factor contributing to feelings of exclusion at work as an element of harassment (Leighton 2014).

The preparatory works to the new language requirement suggest that improved communication resulting from care workers acquiring a higher level of Swedish would have positive effects on the work environment due to the improvement of trust between colleagues and between care givers and care receivers. In its response during the referral process before the adoption of the language requirement, the Work Environment Agency stressed the relevance of language and communication as core elements of the good work environment and welcomes the inclusion of a work environment perspective in the legislative proposal, while at the same time raising concerns that the requirement may entail more far-reaching commitments and obligations for both employers and employees. Against this background, it bears noting that in the same referral process, the Swedish Municipal Workers' Union *Kommunalarbetareförundet* simultaneously stressed the importance of not excluding any professions within eldercare from the language requirement as not to create what the union calls "an A-team" and "a B-team" at the workplace, with different language skills. According to the union, language training and language courses should be attended during working time, as part of the work tasks, and the employers should take responsibility in the frame of their obligations within occupational health and safety to design the work environment as a space that enables language development to all employees. In this regard, the union reminds that in order to allow all employees to have the possibility to access language training, it is important to increase staff numbers in eldercare. The responses from the employers' organisations show

less enthusiasm towards the possible positive impact on the language requirement on the work environment: no explicit mention was made in the response provided by SKR, besides welcoming the effect on the communication skills as part of the organisations; while a generic mention of the positive effects on the work environment was included in the response provided by the Association of Private Care Providers (*Vårdföretagarna*).

## 7. Concluding Discussion

Following the legislative process, the language requirement for care workers in elder care entered into force on 1 July,2026. However, it is difficult to predict the impact it will have in the areas of labour law. The requirement is indeed designed and implemented as an obligation placed upon the employers in their quality as service providers rather than as employers in the labour law meaning. This means that the employers will have the obligation to oversee that their employees have good language proficiency in Swedish as a matter of the quality of the care services provided by the organisation (or by the company for private care providers). The requirement must therefore be carefully tailored so that it targets actual competence in performing care tasks, including language competencies, provided that the assessment method chosen is appropriate and necessary for achieving the legitimate aim of safe and high-quality care.

However, it might still be possible to indicate potential repercussions in specific areas of labour law and anti-discrimination law. More specifically, the obligation of a language requirement might influence employers' decision regarding dismissal for personal reasons in those cases in which an employee would not demonstrate a sufficient proficiency in Swedish. In this regard, a possible evolution concerns the extent to which the employee would be demanded to cooperate and make efforts in learning the language as one of the possible grounds to justify or not a dismissal. At the same time, the obligation for the employer to ensure language proficiency in the provision of care services might (or will) certainly affect the decisions in hiring native speakers like as well as those who – also, in some cases, based on preconceptions – might be better placed than others in delivering on the language requirements, due to linguistic backgrounds closer to Swedish, like other Northen or European languages (Schepens, Van Hout and Jaeger 2020; Forsberg Lundell and Rehnberg 2024). These are questions that will deserve closer scrutiny at a later stage, once the langauge requirement has been in place long enough to allow for an assessment of its effects.

Fewer reservations emerge on the impact of the introduction of the language requirement for the regulation of health and safety at work for eldercare workers. Even though the requirement is not designed as if its implementation will alter the current regulation of the work environment, the introduction of an obligation for the employer to prove language proficiency will constitute a further factor in the organisation and planning of the work environment and therefore fall within the scope of the regulation of health and safety at work, in particular in relation with the social and organisational work environment.

In this regard, the extent and the manners in which the employer will be willing to comply with the requirement assume particular relevance. The practical consequences on workloads, stress and other organisational aspects of health and safety at work will vary depending on how seriously the employer takes the obligation, how they interpret the quality standards, and how much effort and resources they will be willing or able to invest.

Overall, the preparatory works, including the legislative proposal, offer little guidance in assessing the impact of the language requirement in labour law areas. Furthermore, they do not contain any indications on how the obligation of a language requirement will be supervised and monitored and how to follow possible violations. As well, they do not provide any indications on a time frame. In this respect, the legislator's approach appears consistent with that previously adopted in connection with other important reforms having an impact on the labour market, such as youth unemployment or integration.

The Swedish model attributes wide prerogatives to the labour market parties and entrusts them in solving individual labour conflicts as well as in being able to find solutions to major problems through self-regulation. In line with this, it is to be expected that the labour market parties will work collaboratively both at national sectoral and local level, within established collaborations such as *Vård- och omsorgscollege* and through new initiatives, to implement and strengthen language skills in elder care. The labour market parties have a shared interest in ensuring that the language requirement will not entail conflicts between the employers and their employees as well as it will not result in unemployment or in contributing to unhealthy working conditions. At policy level, the reform will entail a significant increase in the budget allocated by the national government to municipalities, who have competences in the elder care services. This is done by a combination of separate municipal grants specifically linked to the implementation of the requirement and increased financing of the national skills initiative Elderly Care Boost (*Äldreomsorgslyftet*), where the social partners are expected to help shape and support competence development. Given that the largest employers in elder care are municipalities and regions and that the trade union that represents elder care workers, Kommunal, is the biggest Swedish trade unions in Sweden in terms of members, the institutional capacity and established channels of cooperation provide a strong basis for implementing the language requirement effectively, which is conductive to improving the quality of care, safeguarding workers' rights and promote the working environment for care workers, regardless of their linguistic background.

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PART 2

# Policy Proposals and Practical Tools to Improve Care Workers' Rights and Wellbeing

CHAPTER 14

# Decent Work in the Care Sector: Policy Gaps and Ways Forward. The CARE4CARE Policy paper

Eva Kocher

## 1. Introduction

Care systems throughout the European Union are in crisis. There are multiple reasons for these crises: they originate in the history of care work as women's work to be provided in the family; the undervaluation of care work on labour markets; and the fact that the demand for care work is rising rather than diminishing[1]—labour shortage is now at the heart of care crises in most EU member states. Due to the complex character of the crises and the interrelatedness of labour shortages, workloads and working conditions, it is challenging to find solutions and ways forward. The COVID-19-pandemic highlighted many of these problems and showed how essential care work is for our societies (European Commission 2022; Council of the European Union 2022).

The working conditions of care workers are among the determining factors in the quality of care. But care services are diverse; it is one thing to organise decent care in early child education but another to organise decent care for sick people or elderly and disabled adults. Care systems have also developed quite differently in EU Member States. The diversity of care workers is also high—in training, recognition and work activity as well as in social background.

[1] See Care4Care Consortium – WP2 2024, from now on WP2 2024.

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Against this backdrop, the CARE4CARE Project:

- Looked at working conditions for professional (paid) care workers who have at most a Bachelor's degree and provide personal assistance and/or health assistance to elderly persons, sick persons, and persons with disabilities, in hospitals and residential care as well as in home care.
- Studied legal and institutional frameworks, working conditions and dimensions of gender and migration, in care sectors in France, Germany, Italy, Poland, Spain and Sweden[2]
- Focused on proposals for improving working conditions and tackling disadvantages and discrimination based on gender and migration in care sectors at EU level.

We draw on this research when we propose below policy proposals for EU Member States and the EU. Note that issues that concern the fight against undeclared work, "care drains" or the regulation of agencies and intermediaries, while very relevant in care sectors, have not been at the centre of the attention of CARE4CARE research. This policy paper focuses on working conditions, in particular considering gender and migration.[3]

## 2. Policy Objectives

### 2.1 Problems to bee Addressed

The care economy and care work are key for the future of European societies and economies (European Commission 2022). However, the CARE4CARE Project's research highlighted the great diversity of institutional settings in which care work as a social service is organised. Across EU Member States, there is a multitude of public and private actors and entities which provide care services, in both public and private care sectors. For example, they may be offered at regional or municipal level, provided by private commercial companies, including temporary work agencies and placement agencies, and by private non-profit associations. Moreover, care services are offered by individual care workers, often home care workers, who provide care services directly to the care recipient; often this is done by live-in workers, i.e. care workers who work and live in

[2] The research results have been published in the Care4Care team's comparative reports; they are publicly available on the project's website: <https://www.care4care.net/wp-reports-results/>. For the comparative report as part of Work Package 2 (WP2), see WP2 2024; for the comparative report as part of Work Package 3 (WP3), see Care4Care Consortium – WP3 2024 (from now on WP3 2024). Note: all the pages cited from the national reports in this policy paper refer to the Adobe Acrobat Reader pages and not to the pages of individual national reports.

[3] In addition, the CARE4CARE Project developed, as societal output, seminars for social partners in order to foster collective bargaining in care sectors; and a platform that will give care workers information on their labour rights.

the household of the person they care for. Undeclared work,[4] including "bogus" self-employment,[5] is present in care work in many countries within the EU, especially in live-in-care,[6] with risks not only of exploitation and substandard working conditions, but also of unfair competition against institutions that offer regular employment. Digital platforms increasingly play a role in the provision of home care and live-in work (Trojanski 2020; Lenaerts et al. 2024, 10; Poblete and Kocher forthcoming).

We have seen in our research that two key debates shape the public discourse on the care crisis, namely, 1) the debate about low wage levels, poor quality of working conditions, including health and safety concerns, and lack of effective enforcement of working conditions and protection for care workers (WP2 2024, 14, 56, 145, 169, 225, 347, 367, 368); 2) the debate about skills and staff shortages and the challenges of recruitment and talent management in care sectors, problems that are continuing to shape care work as labour shortages are expected to worsen in the future, given the age demographics of care workers, many of whom will retire in the coming years (Eurofound 2020, 13).

We have also seen that these two debates are closely interrelated: Difficult working conditions and low wages contribute to making work in care sectors an unattractive professional choice for many. In fact, care sectors often show high incidences of flexible, often precarious, forms of employment, and low wage levels, as well as low rates of trade unionisation (especially in live-in care), a fragmentation of collective bargaining and low coverage by collective agreements (WP2 2024, 17, 28, 56, 61, 145, 169, 225, 367, 368). Vicious circles are in place here, with labour shortages contributing to high workloads, and high workloads making care work less attractive. In rural areas, the availability of care services is often even more difficult.

The care workforce is heterogeneous in many ways. Firstly, our research shows that the professional character of work, qualifications and skills in health care, in residential care and in home care is recognised differently in the EU Member States, with live-in work in private households often not being formally recognised at all.

Secondly, care work is clearly structured along gender dimensions and migration backgrounds, a phenomenon that has been an important focus of the CARE4CARE Project. The strong gender dimension shows itself very clearly,

[4] We use the term "undeclared work" as a general and all-inclusive concept to define any paid activities performed by any worker (national or non-national, documented or undocumented) that are lawful as regards their nature but not declared to public authorities, taking account of differences in the regulatory systems of the Member States (see WP3 2024, 11).

[5] We use the terms "false self-employment" and "dependent self-employment" as commonly understood as involving persons/workers registered as self-employed whose conditions of employment are de facto dependent employment (see WP3 2024, 11).

[6] We use the term "live-in carers" for paid professionals, with or without formal care training, whose work primarily involves long-term care provision while living in a private residence with the care receiver (WP3 2024, 26); Eurofound 2020, 26.

as most people providing and in need of care are women. Women make up more than 75% of the formal care workforce in almost all countries.[7] Moreover, responsibilities for unpaid care in the family keep many more women than men out of the labour market (European Commission 2022). The gendered character goes back to the gendered division of labour that is prevalent in most countries. Forms of work—paid and unpaid—that are associated with emotions and social interactions are often still considered women's work; this is particularly the case with care work. As a consequence, many funding systems and social security systems have a "familiaristic" structure, in that they are built on the general assumption that care work is primarily to be performed in private settings, and is implicitly assigned to women (WP2 2024, 297).

Migrant workers also play an important role in the care industry, especially in live-in-care where they usually make up the largest proportion of the workforce (Eurofound 2020; SPC and DG EMPL 2021, 74). We have seen that migrants may not always have a substantial presence in other sectors of the care economy, but they are increasingly in demand by care service providers and states, which look to foreign labour markets in view of existing workforce shortages (WP3 2024, 27–30). In other countries, these policies may lead to an outflow of skilled care workers (the "care drain").[8]

The care crisis is not the only crisis European societies are having to address at the moment. Our research also points to the development of new technologies, in particular digitalisation and artificial intelligence, which presents both an important future potential and challenge for care work that has to be considered when developing policy proposals (WP2 2024, 13, 25, 169, 340, 445; Lenaerts et al. 2024, 18). Technologies can help with tackling people's needs, but it is hard to say how far they are already able to reduce workloads as they may need specific training. Attention should also be paid to the development of algorithmic management in care work, and the trend towards platformisation of work.

### 2.2 General Policy Objectives

Already the European Pillar of Social Rights (principles 16 and 18) emphasises the right to timely access to affordable, preventive and curative health care of good quality, as well as the right to affordable long-term care services of good

[7] WP2 2024, 15, 59, 162, 237; Eurofound 2020, 10; Social Protection Committee and DG EMPL 2021, 12.

[8] The term "care drain" refers to a phenomenon resulting from recruitment strategies directed towards other countries. These provide job opportunities for individuals from these countries. To the extent that migrant workers use their income in the country from which they were recruited, or send parts of their income there, money flows from the recruiting country to the other country. On the flip side, however, the countries from which the care workers are recruited may experience difficulties due to the outflow of skilled care workers ("care drain") (see WP2 2024, 316; EMPL and FEMM 2022).

quality, especially home-care and community-based services. The European Care Strategy also calls for available, affordable and accessible high-quality care services across the European Union (European Commission 2022, 3–4; Council of the European Union 2022).

To this end, the situation for both care receivers and the people caring for them will have to be improved (European Commission 2022, 3–4). These objectives do not contradict each other but are instead intimately linked: Without improvements of working conditions for carers, decent care cannot be achieved for the care recipients.

The following policy proposals have been developed based on research in the CARE4CARE Project, focusing on working and employment conditions. In particular, we have looked at dimensions of gender and migration in care sectors in six Member States: France, Germany, Italy, Spain, Poland and Sweden. Please note that in this policy paper issues of the fight against undeclared work, "care drains" and the regulation of agencies and intermediaries are not covered in any detail, as they were not at the centre of our research.

When pointing to possible measures on the level of all Member States as well as on an EU level, we need to keep in mind certain structural limitations:

Firstly, care services are social services; states and societies have responsibilities for providing affordableand accessible care, and improving care work is an indispensable part of this. In particular, social partners, social dialogue and social welfare organisations have an important role to play. However, our analysis of the institutional settings of care work in the Member States has shown that the formal competences, roles, responsibilities and practices of different actors such as states, social partners, social welfare organisations and civil society, differ quite considerably between Member States. We will therefore name possible measures for the Member States, without naming specific actors at national levels.

Secondly, in many aspects of care policies, the EU has only very limited competences; responsibilities lie mainly with the Member States. National care systems are, on the other hand, closely related to social security systems, which have developed very differently in the Member States. Policy proposals at EU level need to take into account the division of competences and the diversity of national systems.

### 2.3 Overview

In the following paragraphes, we first develop general ideas on how to improve job quality and address undervaluation of care work (par. 3). We then take a look at adverse working conditions with a focus on working time, stress factors, workload as well as violence and harassment as issues of health and safety at work (par. 4). Par. 5 is dedicated to specific issues of live-in work. We then address migration (par. 6) and gender (par. 7) as cross-cutting dimensions. General considerations on funding and the design of governance and management systems for care work are developed in par. 8.

## 3. Better Job Quality; Addressing Undervaluation

The social and professional framework for care jobs is still lacking when it comes to making care professions more attractive. Questions of job quality and undervaluation are particularly relevant for live-in workers who work in private homes, often invisible to society. It is in this area in some countries where, according to our research, undeclared work is more prevalent than in other care sectors. The following proposals for improving job quality and addressing undervaluation cover these workers; home care workers should not be treated as second-tier professionals. Par. 5 will add more specific proposals for this kind of work.

Our general proposals for strategic changes in the professional environment cover: a) career development in care work; b) improving equipment and working environment; c) fighting undervaluation of care work by increasing wages; d) and, above all, as a precondition for the efficacy of measures, improving workers' voice and collective representation.

### 3.1 Possible Measures on National Levels

#### 3.1.1 Career Development

The European Care Strategy already calls for "building career pathways in the long-term care sector, including through upskilling, reskilling, skills validation, and information and guidance services"—a strategy that will have to go hand in hand with "strengthening professional standards, offering attractive professional status and career prospects […] to long-term care workers, including to those with low or no qualifications" (Council of the European Union 2022, sec. 8). In short, a system that enables career paths in care sectors has to be created. To this end, measures at various levels are necessary:

- Clear and standardised career paths in care work should be developed; enabling intersectoral mobility paths should also be devised.
- Professional skill certificates should certify and recognise competences and skills in care work. Care workers have both technical and interpersonal competences (for administrative tasks, see par. 3.1.2). Both are equally important and should be given equal recognition. In particular, recognition of competences and skills from third-country nationals, but also between EU Member States, should be facilitated. In addition, the recognition of work experience, including work in self-employment, informal learning outside of formal education and training, should be taken into account—while underlining that work experiences that come with caring for one's own family members are not equivalent to professional care for third parties.
- Opportunities for all carers—including migrant carers and home care workers—to participate in vocational education and training should be provided as part of the employment, during paid working hours, and publicly subsidised (Caritas Europa et al. 2022, 5–6). Education and training must be continuously designed so as to equip care workers with future skills and competences, including digital ones. Individual plans for competence development should

be available for all workers. Training opportunities and recognition should be made available in various formats and languages to facilitate access. In particular, trainings should be organised in flexible and adaptable ways that fit diverse work schedules of care workers.
- Legal and institutional frameworks should enable workers to make use of existing competences. One possible measure would be to regulate staffing levels with an obligatory minimum of care workers with specific qualification levels.els.[9]
- Remuneration and job evaluation systems should match career paths and give validation to acquired skills; higher competence and skill levels should correlate with higher wages.

### 3.1.2 Equipment, and Working Environment in General

In many areas, investment in the quality of care equipment and instruments, replacing obsolete devices with modern, ergonomic and adapted equipment, could contribute greatly to job quality in care work. Integrating new technologies will also enhance work quality and contribute to worker retention.[10] The state or social security funds should create a financial aid scheme for employers (including private households in the case of home care) to adapt facilities and workplaces, as well as provide for necessary training.

The attractiveness of jobs in the care economy would also be enhanced if workers could focus on care tasks in which they have acquired competences. Our research has shown that the quantity and burden of administrative and routine tasks is an important factor for care workers leaving their job. Promoting organisational, managerial and technical innovations that would enable a clearer division of tasks between workers, and specialisation in view of career development, can be a step towards better job quality. Job evaluation schemes also have to account for administrative work.

### 3.1.3 Increasing Wages

Career development (as sketched above) should serve as the basis for increasing wages so as to reflect the true value of care work; our research has shown how care work is in often undervalued compared to other professions. Here, in particular, the social partners have to play a central role. Recognition of the diversity of skills and competences in care sectors, including interpersonal and emotional work, has to be the starting point (see above par. 3.1.1).[11]

[9] Example from Germany: Sec. 113c SGB XI (Social Security Code no. 11 on social long-term care insurance) regulates staffing levels in full inpatient care facilities, see Rothgang 2022.

[10] Research shows that worker retention can improve if new technologies allow better client-to-worker matching, more control over shift scheduling, and more efficient staffing (Pavolini and Marlier 2024, 23).

[11] Our research shows that good interpersonal relationships and recognition of the emotional dimensions of care work are of above-average importance in all project partner countries for

Career development has to be reflected in job evaluation and remuneration. Pay scales should enable all workers, including live-in workers, to benefit at the end of their career from a comfortable salary.

In addition, seniority in the care profession should be a relevant factor in remuneration. Compensatory bonuses could be assigned not only for particularly physically and emotionally demanding tasks, but also for care workers who take night shifts or weekend shifts.

### 3.1.4 Collective Representation and Collective Bargaining in Care Sectors

There is general agreement on the importance of worker participation, social dialogue and collective bargaining in care work. Not only the European Care Strategy (European Commission 2022, 12–3), but also the ILO report on paid care work focuses on reward and representation of care workers (Addati et al. 2018, 25).

In fact, it is key for a social and sustainable development of care sectors that social partners play a central role. The legal and institutional framework for industrial relations in care sectors has to effectively enable collective bargaining both at sectoral and at local level. The CARE4CARE Project acknowledges this and will develop, as societal output, seminars for social partners in order to foster collective bargaining in care sectors.

Therefore, not only institutions representing workers need a voice, but also employers need to be represented. In particular, "user-employers" (i.e., persons employing care workers directly to work in their home) need a representation that acts as negotiating partner.

Our research has very clearly analysed the considerable differences of systems of collective representation and collective bargaining in EU Member States. In view of these differences, measures to further these goals might take on different shapes in the Member States. In some countries, unionisation efforts can be supported and collective bargaining can be promoted by extended central bilateral agreements and trilateral agreements with the participation of the state.[12] In other countries, incentivising care institutions and employers or employer organisations to bargain collectively may be an adequate instrument. In others with fragmented collective bargaining systems, a central representational organ of care professionals can be useful.

The Minimum Wage Directive (EU) 2022/2041 (European Parliament and Council of the European Union 2022, 33–47) provides an adequate framework for analysis and the development of specific policies, as it requires Member States with a collective bargaining coverage rate below 80% to adopt action plans to promote collective bargaining. In this context, union membership and collec-

nurses and healthcare professionals with vocational training or a Bachelor's degree. For the comparative report as part of Work Package 4 (WP4), see WP4 forthcoming.

[12] Example from France: Ségur de la Santé agreement signed on 13 July 2020 by the Prime Minister and the Minister for Solidarity and Health with several trade unions (FO, CFDT, UNSA) and the Fédération hospitalière de France (FHF).

tive agreement coverage in care sectors should be assessed separately, for private and public care sectors. When implementing the Directive, measures should be specifically targeted towards care sectors.

### 3.2 Possible Measures at EU Level

#### 3.2.1 Career Development

In the context of career development policies, the EU could and should contribute to standardising qualifications and recognising credentials across Member States, in relation to social, technical, linguistic and transcultural competencies and skills acquired (Caritas Europa et al. 2022, 6; Pavolini and Marlier 2024, 24). This would also facilitate the mobility of care workers.

In EU policies on skills and talents work (European Commission 2020a; European Commission 2023b), it is of utmost importance that emotional work as well as interactive work is recognised and valued adequately. In particular, these competencies will have to be integrated into the EU qualification frameworks. In order to develop adequate methods for such standardisation, pilot projects focusing on these skills would be an important step.

#### 3.2.2 Collective Representation and Collective Bargaining in Care Sectors

The EU can and should also support social dialogue and collective bargaining at national level in care sectors; such policies can be promoted in the framework of Section 8 of Chapter II of the European Pillar of Social Rights. In this context, the Minimum Wage Directive 2022/2041 is an important instrument, as it is designed not only to ensure adequate minimum wages in the EU Member States, but also to promote collective bargaining on wage-setting. In addition, the Council should recommend Member States to further strengthen social dialogue and collective bargaining at national level (Council of the European Union 2022; European Commission 2023c, 4). Evaluation and follow-up measures should look at care sectors in particular, in order to develop targeted measures with regard to this sector. A collection of data concerning collective agreement coverage at sectoral level would help understand how to promote collective bargaining in the sector.

In addition, ESF+ funds could be used for investments in worker and employer organisations that provide advice, information and support to migrant care workersspecifically. The Commission should, in particular, support national social partners with the organisation of live-in care workers, utilising ESF+ funds. In particular, cross-border cooperations between social partners should be fostered.

The EU should specifically invest in social dialogue and support the capacity building of social partners in care sectors at European level.[13] In all care sectors, including home care, key actors on both sides should be recognised as

[13] European Commission 2023a; see also, European Commission, Belgian Presidency of the Council of the EU, and European Social Partners 2024.

social partners (cf. European Commission 2023e; EFFE, EFSI, EFFAT e UNI Europa 2024). This should become an issue for the new Commission's Pact for European Social Dialogue, to be expected in early 2025.

## 4. Health and Safety Risks in Care Work

Health and safety aspects are a major problem in care sectors. Obviously, care work can present serious chemical and physical risks—for example, muscular-skeletal risks. But care sectors are also high-risk sectors in respect of psychosocial risks,[14] such as stress, workload, long working hours, violence and harassment. Our research has found that, in all Member States the CARE4CARE Project has worked on, care workers are exposed to a wide range of risks to their health and wellbeing (WP2 2024, 14–5; WP3 2024, 21, 31, 301, 378, 386; European Commission 2022a, 13).

It is therefore indispensable that all specific health risks associated with care professions are included in health and safety risk assessment. Prevention of these risks must be a primary objective. Care workers must be made aware of, trained in, and prepared for these risks. We have seen that Member States organise health and safety at the level of establishments and labour inspections in diverse ways (WP2 2024, 24, 62, 96, 103, 105, 173, 190, 211). Worker representatives should, however, always have an important role in health and safety at work, in addition to labour inspectors.

Where prevention is not possible or fails in specific cases, appropriate compensation systems should be in place.[15]

We have already mentioned the need to equip work spaces in care with modern, accessible, adaptable and ergonomic tools; such measures can not only enhance job quality and professional esteem, but also prevent health and safety risks. In the following, however, we focus on possible concrete health and safety measures concerning working time, workloads and violence.

### 4.1 Policy Proposals for Measures on National Levels

#### 4.1.1 Working Time

As our research has shown, long and irregular working hours[16] and insufficient rest periods are a constant and central problem in care work; they are

[14] European Agency for Safety and Health at Work (EU-OSHA) 2023, 1.

[15] Example from France: Art. L. 4163-1 et seq. of the French Labour Code regulates the recording of the exposure to risks in the form of points; see also Art. D. 4163-2 of the French Labour Code, which organises a system of funding by allocating points to private law workers who are exposed to predefined occupational risk factors. These points can be used to finance training, to reduce working hours while maintaining salary, to access early retirement or to finance professional retraining.

[16] Our research shows that domestic workers, in particular, experience a lack of control over working time (WP4 forthcoming).

closely linked to the shortage of care workers in the labour market. Too often, working shifts exceed 10 hours, shifts are frequently performed consecutively, the rest period of 11 hours is not guaranteed, working time on on-call duty is not always recognised. Most of these demands would be met by effective enforcement of European working time law (Directive 2003/88/EC, cf. European Parliament and Council 2003).

In addition, disconnection periods in which employers are not allowed to contact workers should be considered (on a general right to disconnect, see Lerouge and Trujillo Pons 2022). Due to staffing problems, care workers are too often contacted during rest periods, and asked to fill-in at short notice. This creates considerable stress for workers, while at the same time taking the burden of responsibility for the sustainable management of staffing levels off the employer.

It also has to be acknowledged that the time dedicated to coordinate within a group of workers ("team time"/"collective time") is working time. This is of particular importance for the integration of migrant workers into existing teams.

In general, there are good reasons for further reductions of working time in care work. We have seen that the gendered nature of care work, i.e. the fact that mostly women are employed in care work, also reflects on the working conditions: All the common issues of work/family balance—part-time contracts, temporary contracts, flexible work contracts—are very clearly present in care work. Moreover, it is also not uncommon for care workers to have multiple employers, partly due to a lack of full-time positions. Generally reducing the effective working time to a reasonable level, comparable to other sectors, might make work in care sectors more attractive, could help workers who want to work full-time instead of only part-time, and could thereby mitigate labour shortages.

#### 4.1.2 Workloads / Staffing Levels

Working time and workloads can often only be sustainably reduced if staffing levels are increased (WP2 2024, 266). Considering the fact that labour shortages are not limited to care sectors, but have come to be a structural problem of European labour markets (Eurofound 2023a), care sectors are in fierce competition with other sectors. Looking at hidden and potential labour forces, such as family carers and migrants, is becoming all the more important (see below par. 6 and 7).

Standards on nurse-to-patient-ratios[17] should nevertheless be regulated and implemented effectively. In this respect, Member States will have to choose diverse measures, as our research shows that regulations and institutional systems that allow for the setting of staffing levels differ quite considerably (WP2 2024, 266, 289, 416). In some countries, funding could be made conditional on the implementation of staffing levels; in others, direct regulation via public law

[17] Examples from the US, Australia, Asia and European countries are given by Simon and Mehmecke 2017; European Federation of Nurses Associations 2024.

may be possible. In any event, legal systems should allow for the effective fixing of staffing levels via collective bargaining.

### 4.1.3 Violence and Harassment at Work

We have seen that psychosocial risks are particularly common in care work; high workloads, irregular working hours and high emotional job demands can lead to burnout and post-traumatic stress which can impact workers' mental and physical health.[18] There are also still deficits in the recognition of stress factors as a health-and-safety-issue.[19]

Harassment, abuse and different forms of violence are more and more recognised as health and safety risks; this issue is particularly relevant in care work (WP3 2024, 21, 31, 301, 378, 386; European Commission 2022a, 13). In some countries such as Italy[20] or Sweden,[21] the safety of care workers against third-party aggression, in particular physical and verbal assaults, has already received attention. Apart from policies on increasing police presence and the application of criminal law, specific preventive approaches are important. In this respect, the ILO Violence and Harassment Convention 190 is important: It calls for health-and-safety measures to be applied in cases of violence and harassment. Member States who have not yet done so should ratify this Convention (Council of the European Union 2024a). Practical guides in relation to risks of violence and harassment at work will have to be developed; employers and workers should be trained and educated on these issues, psychological support systems should be set up. In line with health-and-safety procedures, employers should identify situations giving rise to violence, as well as implement safety protocols to manage the risks associated with care work.

Workers may also need training on how to act in case prevention fails and aggression takes place. Many care workers also lack effective access to justice in cases of violence and harassment. Free legal aid for care workers and information of their rights in clear, simple and accessible language is therefore paramount. States should also guarantee rights against victimisation and guarantee that workers who make a complaint of violence or harassment do not suffer any disadvantages.

[18] Our research revealed above-average levels of burnout due to physical, emotional, and mental exhaustion among all types of care workers in all countries of the project partners. In addition to exposure to traumatic events (such as death and suffering), family members of care recipients contribute to a particularly high level of stress among care workers. Emotional and social support contributes to higher life satisfaction and lower staff turnover (WP4 forthcoming.).

[19] WP2 2024, 21, 224; European Agency for Safety and Health at Work (EU-OSHA) 2023, overview of psychosocial risks in the sector and their prevalence and discussed effective interventions to prevent, reduce and manage psychosocial risks in health and care workplaces.

[20] Example from Italy: Gruppo di Studio Italiano CEASE-IT 2021.

[21] Example from Sweden: Government Inquiry Report 2024.

This is particularly important in the case of undeclared migrant workers who should be guaranteed legal protection and residency in the host country at least for the duration of enforcement procedures (see below par. 6 for migration policies in general). Safeguards should be in place preventing labour authorities from reporting undeclared workers to migration authorities.

A rigorous implementation of Directive 2012/29/EU on protection of victims of crime (European Parliament and Council 2012) would help provide effective support for care workers who are victims of violence and harassment. In particular, according to Art. 1 (1)(2), victim protection must not be dependent on residence status.

### 4.2 Policy Proposals for Measures at EU Level

As far as health and safety issues are concerned, the European Union should evaluate and analyse the instruments of European Union law in this area, with a view to adequately covering the specific health-and-safety risks in care work.

#### 4.2.1 OSH Framework Directive 89/391/ECC

The Framework Directive on Health and Safety 89/391/EEC (cf. Council of the European Communities 1989) already recognises in a very general way all possible health risks that work activities could pose and has introduced risk assessment as an adequate approach to developing targeted protection measures. Nevertheless, a specific Directive on psychosocial risks would be helpful to more effectively address not only psychological risks and stress, but also violence and harassment as health risks at work.

The European Social Partners' cross-industry Framework agreement on work-related stress of 2004 should also be updated in relation to psychosocial risks such as violence and harassment at work, in accordance with the ILO Convention on Violence and Harassment in the Worlds of Work (Convention No 190). The EU Commission could, on the basis of Art. 154 TFEU, initiate a dialogue on a new European Framework Agreement specifically addressing violence and harassment at work (European Commission 2021).

#### 4.2.2 Working Time Directive 2003/88/EC

The Working Time Directive 2003/88/EC (European Parliament and Council 2003) already establishes limits to an excessive use of workers' time. These standards should not be lowered, but instead enforced more systematically. The EU should follow up and monitor the enforcement of the Directive in the Member States.

The European Social Partners for care work should look into possible sectoral measures for the effective limitation of working time, in order to reduce stress in care work. In this context, the regulation of disconnection periods in which employers may not contact workers should be looked into (European Parliament 2021; Eurofound 2023b). The EU Commission could initiate such a process.

## 5. Live-in Work

Live-in-workers find themselves in particularly precarious conditions. Already the representatives of the European Economic and Social Committee who visited the United Kingdom, Germany, Italy and Poland in 2020 reported that representatives of the interests of employees, employers and those in need of care mostly agree in their criticism of many structural problems, especially the exploitation of migrant women (Roglewski and Florek 2020; see also, Ghailani et al. 2024). Our research confirms that the main problems in this sector are excessive working hours, a strong dependence on the employer's goodwill and a particular vulnerability to violence, harassment and discrimination due to isolation of the workplace (WP2 2024, 14, 256; WP3 2024, 31).

All the measures recommended above for the improvement of job quality and career development in care sectors are also valid for live-in-work. In addition, the following recommendations focus on questions of employment status, labour rights and enforcement. Note that undeclared work is highly prevalent in this sector (WP2 2024, 14; see also, Guzi et al. 2022), but mostly outside of the scope of this policy paper.

### 5.1 Policy Proposals for Measures on National Levels

#### 5.1.1 ILO Domestic Workers Convention

We call on Member States that have not yet done so to ratify and fully implement the ILO Domestic Workers Convention 189.[22] Live-in workers are an important sub-group of domestic workers as regulated in this Convention.

Ratification is an important step to grant full labour and social security rights and benefits for these workers. However, our research has shown that countries that have ratified the Convention are not necessarily compliant with it (WP2 2024, 13; WP3 2024, 200; Guzi et al. 2022, 34–5). While the Convention (Art. 2) does allow for subjecting domestic care workers to specific labour law protection, it also establishes limits and procedural requirements; in particular, it asks for "at least equivalent protection" for such workers. Any such exception needs to be reviewed in light of the Convention, and in light of EU law.[23] In particular, live-in-workers should have the same options to earn state support or benefits as workers in other sectors (Guzi et al. 2022, 3, 64).

#### 5.1.2 Employment Status

To establish pathways to a regular employment status for live-in care workers is maybe the most important policy objective in this area. Establishing

[22] For example, Germany, Italy, Spain, and Sweden, but not France and Poland, have ratified the ILO Convention 189 (WP2 2024, 13).

[23] ECJ 24 February 2022, Case C-389/20 (CJ v Tesoreíra General de la Seguridad Social (TGSS)); ECJ 19 December 2024, Case C-531/23 (Loredas); WP2 2024, 26.

the existence of an employment relationship is ultimately about whether all or none of the labour law (and social security law) standards apply. Nevertheless, our research shows that, in some countries, live-in-workers are classified as "self-employed" or a similar category, sometimes induced by posting agencies (WP2 2024, 263–64). This is highly problematic. These relationships will mostly have to be considered bogus self-employment.[24] Therefore, a "legalisation" of self-employment in live-in work only removes the little legal leverage these workers have. As the rules for classifying workers under EU labour law do not allow for exceptions for live-in-workers,[25] such measures do not provide legal certainty (Guzi et al. 2022, 28–9, 39), but risk providing nothing more than a disguise of employment.

We have seen, however, that in some countries, domestic home care is already on the way to becoming well-structured and regulated through systems for formal declaration and social and tax incentives, which help to promote legal employment arrangements. Such systematic measures, in addition to funding, are necessary in order to effectively promote compliance with labour law (see also below par. 8). People that are cared for in their homes need a variety of social services that cater to their individual needs. Regular consultation and adaptation of services to individual needs is paramount; this can reduce the work burden on live-in workers and enable them to have shorter working hours.

In this respect, it would also make sense to incentivise employment through agencies rather than having the family as user-employer; this allows for professionalised management of labour rights, working conditions and career development. In particular, such agencies could, with the help of social partners, coordinate or organise safe spaces and external intermediaries, as well as provide for working time slots dedicated to collective and group coordination that enable the formation of teams.[26] Other forms of co-employership could also be explored, following the French example of the funding of training and other measures by all user-employers, in the form of a social service (Perez and Vourc'h 2020). Another example is the German social security funds in the construction sector (SOKA BAU) as a joint institution of the social partners.[27]

[24] WP2 2024, 263–64; for the definition, see n. 6; see also, Kocher 2024.

[25] ECJ 24 February 2022, Case C-389/20 (CJ v Tesoreíra General de la Seguridad Social (TGSS)); see also WP2 2024 or WP3 2024.

[26] Example from France: Act no. 2024-317 of 8 April 2024 on measures to build a society for ageing well and independent living: The law created a professional card by 2025 for home carers working with the elderly and disabled; cf. Canieux 2020.

[27] In accordance with Section 4 (2) of the Collective Agreement Act, the provisions of the underlying collective agreement apply directly and mandatorily to the statutes of the joint institutions of the parties to the collective agreement and the relationships of their members. The SOKA-Bau collective agreement is generally binding and applies to the entire construction sector in Germany: <https://www.soka-bau.de/soka-bau-a-z/geltungsbereich> (February 6, 2025).

### 5.1.3 Enforcement

Although the laws of the Member States, in accordance with the European Working Time Directive 2003/88/EC, do not allow for excessive working hours of live-in-workers, we have found that these rules are often not enforced (WP2 2024, 14, 261, 364). The same is true for other kinds of labour law violations in households (Guzi et al. 2022, 28–9, 39). This is an issue that Member States must address. A first step would be to ensure that households are considered proper workplaces with all the consequences that derive from this, given national labour law and health and safety at work regulations.

However, employment in a private household has some specificities: possibly limited access of labour inspectorates, limited knowledge of user-employers of their duties as an employer, limited control over the workplace when employers are agencies etc (WP2 2024, 173; Ghailani et al. 2024, 14; Bakirtzi 2023). These characteristics require the design and implementation of specific instruments to facilitate law enforcement in the sector. In particular, Member States have to ensure that the regulatory framework for health-and-safety at work and its enforcement is effectively adapted to the special characteristics of live-in care work. Instruments to be considered include information platforms, apps to handle administrative declaration, preventative visits of labour inspectorates, or worker interviews by inspectorates. Employers in this sector will also need more advice and counseling than other employers.

Incentives for compliant user-employers as well as employing agencies are also an important instrument; social voucher schemes, tax incentives or social security incentives could be created.[28] Self-employment (as mentioned above) should not be included in such incentives.

## 5.2 Policy Proposals for Measures at EU Level

Council Decision 2014/51/EU authorising Member States to ratify ILO Convention no. 189 (European Parliament and Council 2014) implicitly recognised the relevance of specific measures in the area of live-in work. Against this background, the European Commission should adopt a recommendation indicating possible effective strategies and guidelines on the implementation of the Convention, as well as offer technical assistance to Member States to overcome the barriers for them ratifying the Convention or implementing it completely.

[28] Example from Italy: by 31 December 2025, employers hiring or converting domestic workers in indefinite employment contracts for assisting elderly individuals aged at least eighty years will be granted a 100% exemption from total social security contributions and insurance premiums for up to 24 months (WP3 2024, 17). Example from Spain: Bonuses are granted to employers hiring workers in family contexts, effectively reducing the tax or Social Security contributions required for such employment (WP3 2024, 17; see also, Guzi et al. 2022, 3).

### 5.2.1 Employment Status

These barriers also concern bogus self-employment, a phenomenon that is widespread in this sector, partly coordinated by agencies specialised in brokering cross-border work of care workers from Central and Eastern European countries posted to Western European Member States.[29] The European Labour Authority (ELA) could play a larger role in controlling these issues and could conduct inspections. It should be noted that the Temporary Agency Work Directive 2018/957 (European Parliament and Council 2018) applies to many settings in which live-in workers are employed by agencies and work in private households (European Commission 2024b). Problems lie in implementation of the Directive and the compliance of small agencies (which predominate in care sectors).

In general, however, problems of non-implementation of employment status are similar in this sector to those that gave rise to the Platform Worker Directive of 2024 and the Commission's Proposal on combating disguised employment of trainees of March 2024 (European Parliament and Council of the European Union 2024c; European Commission 2024a). A Directive creating a rebuttable presumption of employment for this sector, following the example of the platform work and traineeships, would therefore be a good option for live-in work. The Member States' implementation of such a measure would have to come with a package of complementary measures, funding and coordination of social services that cater to individual needs of the persons in need of care. Thus, the Directive should come with financial aid and guidelines for Member States and national social partners to address the specific challenges of employment and working time arrangements in live-in work.

### 5.2.2 Recognising Rights of Live-in-Workers

In its landmark judgment of 24 February 2022, the CJEU established that discrimination of live-in-workers can be considered a violation of EU gender equality law 79/7/EEC.[30] It reiterated this assessment in its decision from 19 December 2024.[31] Based on this conclusion, the EU should question the remaining exclusions from labour standards in EU law. In particular, it should clarify that domestic workers, including live-in care workers, fall within the scope of OSH Framework Directive 89/391/EEC.[32] We also call for a full inclusion of

[29] For example, Germany, Italy, Spain, and Sweden, but not France and Poland, have ratified the ILO Convention 189 (WP2 2024, 13).

[30] ECJ 24 February 2022, Case C-389/20 (CJ v Tesoreíra General de la Seguridad Social (TGSS)) (on Directive 79/7/EEC of 19 December 1978 on the progressive implementation of the principle of equal treatment for men and women in matters of social security); WP2 2024; see also Rönnmar 2023; Chieregato 2022.

[31] ECJ 19 December 2024, Case C-531/23 (Loredas); see also Kocher forthcoming.

[32] The relevant addendum to Art. 3 (a) and all similar rules in the associated Directives including the Working Time Directive should be deleted; Ales et al. 2018.

(domestic) live-in workers in the Directive (EU) 2019/1152 on transparent and predictable working conditions in the European Union.[33]

There is also a need for better statistical monitoring of the sector in terms of both worker profiles and their employment conditions, as well as user profiles and their needs, and coverage of collective agreements. A standard definition of households as workplaces that could be uniformly applied across EU Member States would facilitate inclusion in European statistical nomenclatures (Guzi et al. 2022, 2–3).

## 6. Migration as a Cross-Cutting Issue

Migration as well as discrimination of migrants are problems that are highly relevant for care sectors. As one consequence, the cooperation of migrant workers with workers educated in the host country can lead to conflicts, especially if workloads and working time are as precarious as they are in care work; our research has shown that stress and high workloads tend to endanger cooperative environments (WP3 2024, 261).

On the other hand, migrant workers are important for the future of care in Europe. Migrants (both intra-EU migrants and third country nationals) are, with good reason, seen as part of the hidden and potential workforces that could help address the problem of labour shortages. They bring valuable skills to the table that often remain unrecognised.

At the same time, migration policies tend to be dominated by objectives of restrictions to migration. These policies and the narratives that are sometimes attached to them can endanger objectives of both attracting qualified foreign care workers and of fighting discrimination against these workers. This inherent contradiction has to be taken into account not only when designing migration policies towards care workers, but also when designing policies about immigration to the EU in general.

In view of this situation, this Section particularly addresses legal migration pathways, reception and integration of migrants, working conditions, as well as non-discrimination and access to rights.

### 6.1 Policy Proposals for Measures on National Levels

#### 6.1.1 Legal Migration Pathways

Our research has pointed out the legal migration pathways that many Member States are exploring for long-term care workers from third countries.[34] To this

[33] European Parliament and Council of the European Union 2019b; Art. 1 (7) would have to be deleted.

[34] Examples from Germany and France: "Triple Win Program", organized jointly by the Federal Employment Agency and German International Cooperation Society (GIZ) (WP3 2024, 265); French Lab Migration, a laboratory for experimentation and innovation on migration in the private-sector employer sector, initiated in Marseille in 2022 by the French Federation of Individual Employers (FEPEM) and other social partners, in order to attract workers for the homecare sector (WP3 2024, 129).

end, it is crucial to simplify migration procedures to facilitate access to rights for migrant workers. Developing integration pathways through training for care sectors could be a useful instrument in this context.

We have also seen that some EU Member States have had good experiences with the regularisation of undeclared workers, while still many migrants already living (and sometimes already working) in a Member States are not granted permits for employment, or are in an undeclared status (WP3 2024, 134, 136, 163, 182, 187, 220, 271, 306, 365).

For these cases, regularisation policies should beimplemented. "Lane changes"—i.e., access to work permits for asylum seekers or facilitating migrant live-in workers' access to stable permits—should also be considered.

When implementing schemes for the regularisation of workers, Member States should take care to also regularise their immediate family members.

### 6.1.2 Support: Reception, Recognition, Integration

Opening labour markets in care to migration means much more than just creating legal migration pathways. Migrant workers need support, including adequate measures for reception and integration. The recognition of professional competences and diplomas and de-bureaucratised recognition processes are the most important measures in this context. Transparent and fast administrative procedures should also be accessible for employers.

This also involves language training, which should be cost-free for workers and be offered during working time. In addition, care should be taken to match language requirements to the specific job and the communication requirements with both the persons in need of care and co-workers. In this regard, adequate group and collective time has to be guaranteed, allowing for the creation of teams and enabling good communication. The acknowledgment of group and collective time as working time has to be ensured.

The funding of care services also needs to account for employers' cost for language training, group time, and related expenses.

### 6.1.3 Monitoring Working Conditions when Issuing Permits

Member States that open their labour markets to foreign workers have a responsibility to prevent exploitation and unfair working conditions. Migration laws should consider these risks which our research has clearly shown (WP3 2024, 222–23, 276, 306, 394, 412). The most important measure to this end is to avoid the binding of residence permits to individual employment. Any permit should take into account the reality of multiple employments within the sector and, in addition, allow a change of employer and status.

In addition, on a migrant's first entry into the national labour market, states could review employment contracts for compliance with labour standards and ensure that contracts are written in a language that the worker understands. In particular, governments should require wages and other working conditions to be not lower than those set by collective agreements or established industry practices.

### 6.1.4 Fighting Discrimination and Granting Access to Rights

CARE4CARE research shows how migrant care workers suffer from different forms of discrimination (WP3 2024, 30–1, 93, 127, 139, 268). Although we have seen that migrant status is not uniformly recognised as a discriminatory factor in all legal frameworks, migrant status often intersects with factors such as race, ethnic origin, religion, or nationality. Based on the Equal treatment Directive 2000/43/EC,[35] all Member States have legal frameworks in place in order to combat such discrimination (WP3 2024, 24, 275). They should introduce, nevertheless, special non-discrimination rules for migrant workers, when implementing Art. 1 (1b) of the revised Single Permit Directive (EU) 2024/1233 (European Parliament and Council of the European Union 2024a).

However, migrants who experience discrimination in care work frequently refrain from reporting incidents because access to legal services is difficult and costly, and because they fear prosecution in the event of undeclared employment or lack of legal status (WP3 2024, 31–2, 271). It is therefore indispensable for workers to be able to access a residence status independent of a specific employment or work relationship.

Structures for legal support, advice, counselling and empowerment are needed in order to promote better access to workers' rights for migrant care workers. Members States should provide systematic information to care workers about their rights, support organisations, and mechanisms for complaints and redress (see also above for live-in-workers). General awareness-raising programmes on racial and ethnic stereotypes, as well as public action to collect statistical data and support scientific research on discrimination could accompany these measures.

Equality bodies have a key role in facilitating migrant workers' access to justice, as well as in addressing structural aspects of discrimination. The standards put forward by Directive (EU) 2024/1499 provide important guidelines here (Council of the European Union 2024b; see also European Parliament and Council of the European Union 2024b).

The CARE4CARE Project will develop a web platform as a pilot for six EU member states, which will provide information on care workers' rights.

## 6.2 Policy Proposals for Measures at EU Level

### 6.2.1 Legal Migration Pathways

In order to support Member States in furthering the labour mobility of third-country migrant workers, aimed at addressing labour shortages and promoting access to work permits and social rights for migrant care workers, the EU should provide a framework. The EU Talent Pool can be considered an element of such policies (European Commission 2023d), as are the simplification

[35] Council of the European Union 2000. This policy papers uses the terms "race" and "ethnic origin" in conformity with the Directive.

of migration procedures and the improvement of migrant workers' rights as promoted by the European Commission's Legal Migration Package (European Commission 2022b).

At EU level, the European Commission's Blue Card Directive facilitates the recruitment of highly skilled non-EU workers, including those in care roles. The Commission has already announced that it will begin mapping the admission conditions and rights of long-term care workers from non-EU countries in different Member States, with a view to exploring the added value and feasibility of developing an EU-level admission scheme to attract migrant workers (European Commission 2023b; 2022a, 15). On this basis, the potential to expand the Blue Card Directive to include specific pathways for care professionals could be explored. It is paramount, in this context, to enable non-EU workers to change employers and/or work for multiple employers (as the revised Single Permit Directive (EU) 2024/1233 intends to do). This is essential to ensure fair working conditions and to eliminate undue pressure.

The ELA has an important role in this respect, in particular in the development of policies on cross-border care work, by sharing information concerning working and employment conditions, employment support services, but also by conducting joint labour inspections and helping Member States with tackling undeclared work. The EU should also invest in worker and employers' organisations that provide advice, information and support, including specific outreach and counseling for migrant workers. The ELA can be entrusted with specific tasks in this regard.

### 6.2.2 Fighting Discrimination

Art. 1 (1b) of the revised Single Permit Directive (EU) 2024/1233 creates a principle of non-discrimination of migrant workers, "irrespective of the purpose of their initial admission to the territory of that Member State, based on equal treatment with nationals of that Member State". Implementation in the Member States should be carefully monitored.

In general, the Commissioner for Equality, when developing a New Anti-Racism Strategy for post-2025, should take great care to consider migrant care workers and cross-border care work.

As concerns the working conditions and fair treatment of workers, the UN Migrant Worker Convention (United Nations 1990) is an important instrument. The EU should therefore explicitly authorise and recommend Member States to ratify this Convention.

## 7. Fighting Discrimination Based on Gender

Care work is gendered work; our research has shown that it is an expression of occupational gender segregation, both horizontal and vertical (WP3 2024; see also, Mollard et al. 2021, 15). Fighting gender discrimination must therefore consider the social structures and stereotypes that are inherent in our societies.

It is not surprising that the measures generally discussed in order to create more just and equal societies would also be important measures to counteract the social division of labour that assigns devalued care work to women. These concern:

- Abolishing structural barriers that hinder women's access to the labour market, and adopt public services (day care centers etc.) to cope with family care functions.
- Fighting all forms of violence against women, and provide shelter places.
- Preventing sexist and homophobic messages and hate speech in the media, including in social media.
- Promoting work-life balance, establishing the right to access more flexible work arrangements, and parental leave for all genders without victimisation, in line with the EU Work-Life Balance Directive (EU) 2019/1158.[36]
- Creating obligations for employers to draw up equality plans, identify discrimination, particularly in relation to pay (through pay audits) (WP2 2024, 434; WP3 2024, 379–80, 382). The implementation of the Pay Transparency Directive (EU) 2023/970 (European Parliament and Council of the European Union 2023) can be an important step in this direction. In particular, the undervaluation of interactive and emotional work, should be addressed here (see above par. 3.1.1).

In view of labour shortages, it is important to mobilise the hidden labour force of family carers. In many countries, there is a latent tension between public provision of care services and care provided by family members, mostly women (WP2 2024, 9, 138). Member States, in a situation of lack of funding and labour shortages, tend to point to the importance and value of unpaid care in the family.

There are, however, structural risks attached to these policies. Firstly, they often rely on female members of households and families to provide care without pay and adequate financial compensation, thereby not only contributing to gender pay, time and pension gaps, but also reinforcing the stereotypes of care work being women's work that have been such an important factor in care crises in the first place. Secondly, these policies are often promoted with a wish to respect preferences and desires of people in need of care, without considering that such preferences are also shaped by experiences with deficient social services, or public images of social services. This shows that creating better public care and community care is also urgently needed. Community care of good quality could also counteract the social isolation among seniors that has become a major social problem (WP3 2024, 14)

On a more concrete level, in order to attract more men to the sector, gender stereotypes that are linked to the idea of "care" as a supposedly feminine

[36] European Parliament and Council of the European Union 2019a. Our empirical studies show that the conflict between work and private life is above average in all countries of the project partners, especially in Germany, among nursing and healthcare professionals with vocational training or a Bachelor's degree (exception: France, which is slightly below average) (WP4 forthcoming).

concept should be questioned publicly and urgently (European Commission 2022a, 12, 17; 2020a).

It would also be useful to gather more information and systematically collect data on gender inequalities in care occupations, through statistics, surveys, and research (WP3 2024, 23, 30; Mollard et al. 2021, 70–1). A gender perspective should be present in research, including qualitative analysis, in order to capture the full scope of gendered work experiences in care (WP3 2024, 14, 23).

These measures also concern the EU level. In the development of a new Gender Equality Strategy post-2025 in relation to gender, the specific issues of professional care work should be highlighted.

## 8. Funding, Governance and Management

### 8.1 Policy Proposals for Measures on National Levels

#### 8.1.1 Social Clauses in Funding Systems

Implementing the measures we propose is not only complex, but also requires unprecedented budgetary efforts for the national care systems. The funding of care systems does not only have to reflect demographic changes and mirror changes in family structures and ways of living, but also has to contribute to improving job quality and working conditions, in particular reducing workloads for care workers. These objectives are imperative if accessible and high-quality care for everyone is to be guaranteed. For political discussions, it could be helpful to assess the costs of such an investment in comparison to the future costs of a system in crisis.

As our research shows, the national systems have quite diverse funding structures. Nevertheless, in all systems, public expenditures go into two ways: Funding care institutions and in-kind services on the one hand, and on the other supporting families and people in need of care financially to enable them to afford care services, including the employment of care workers as user-employers (WP2 2024, 225, 257).

Both of these funding mechanisms can and should be formally linked and conditioned to working conditions. As far as the funding of social and welfare institutions is concerned, a standard of minimum requirements would have to be set up. Compliance with such standards as well as adherence to collective agreements would have to be introduced by way of social clauses, as a condition for accreditation and/or funding, in particular in the context of public procurement. Some countries have already had experience with such clauses.[37]

As far as financial benefits for people in need of care are concerned, these could also be made conditional on the use of socially responsible services by the

[37] Example from Germany: Since September 2022, service contracts financed by the social insurance institutions can only be concluded with providers that guarantee the minimum standards of a collective agreement (WP2 2024, 258).

introduction of social clauses. Voucher or tax credit systems have already been designed in some countries.[38]

As a precondition for such policies, the introduction of quality certificates for employers and care institutions would be a first step. These should also cover agencies for live-in work, and thereby help inform users about the work standards the agencies have established.

### 8.1.2 Case Management Systems

Our research has analysed in detail how the provision of care services is fragmented in many countries—there are private, public, social and welfare actors, at the least. The same applies to funding which often comes from a variety of public and private sources (WP2 2024, 13, 49, 52, 257, 344). This makes the organisation of decent work in care highly complex.

Nevertheless, organisational environments can and should be designed in a way as to enable people in need of care to access a range of professionals and pay them fairly. This also requires incentives and easy access to information. Some Member States have started experimenting with a measure that can be put to good use in order to guarantee compliance with the minimum standards for decent work in care: Person-centered case management may help establish a reliable mix of care services and a reliable support network for the people in need of care.[39]

A focus on decent work and minimum standards for employment contracts and working conditions should be integrated into such systems. This would be particularly important for live-in care. Case management also allows experiences from individual cases to be used to further develop the infrastructure and analysis of working conditions in care work.

### 8.1.3 Cross-Sectional Policy Approaches

Care work poses particular challenges because it concerns so many policy fields simultaneously: Health, Education, Social Policies, Labour Market, Family Policies, External and Migration Policies, Financial Policies, Regional and International. In most Member States, these policy fields also concern different

[38] Example from France: Act no. 2024-317 of 8 April 2024 on measures to build a society for ageing well and independent living: The law created a professional card by 2025 for home carers working with the elderly and disabled; cf. Canieux 2020.

[39] Example from Germany: Local care support centres (*Pflegestützpunkte*) in accordance with Sec. 7c SGB XI offer advice and support to people in need of care and their relatives. In Sweden, since 2022, there is a requirement that all persons receiving care at home have a fixed care contact, who is a person with special responsibility for the individual receiving care at home (Sikström 2024, 4). Moreover, in 2024, the National Board of Health and Welfare will conduct an investigation following up the introduction of this requirement. In Italy, the "integrated entry gates" facilitate a comprehensive, multidimensional assessment of LTC needs, paving the way for tailored "integrated individual assistance plans" (Antonucci 2024, 4–5).

ministries, governmental agencies, and civil society actors. In order to develop coherent care strategies that are able to effectively establish decent and fair working conditions for workers, cross-sectional and cross-disciplinary councils, advisory boards, working groups etc. have to be designed.

### 8.2 Policy Proposals for Measures at EU Level

The European Union should support Member States in the development of quality assurance systems to be used in funding, as well as monitoring care services; indicators on working conditions and non-discrimination work should be an important part of these (Caritas Europa et al. 2022, 6). The European Labour Authority might be the right forum for these tasks. Social partners should be the primary actors involved in drawing up such indicators.

The Commission should continue to support (and develop) cooperation between Member States to share best practice and pool research and innovation programmes. The EU—in particular, the European Labour Authority—can offer technical assistance and consulting in these processes. It is particularly helpful that the ESF+ funding is also provided for changes of work organisation—these are important for many of the changes envisioned in this paper.

In the EU, as well as in the Member States, cross-sectional approaches should be implemented.

## 9. Summary

The availability of affordable and accessible high-quality care services for everyone who needs them is an objective the importance of which can hardly be overstated. High-quality long-term care empowers people who, as a result of old age, illness and/or disability, depend on help for daily activities, to maintain their autonomy and live with dignity. High-quality jobs with secure and safe working conditions and no-discrimination are a necessary requirement if these goals are to be achieved. This also encompasses addressing the vulnerability of certain groups of workers, such as live-in and migrant care workers, and fighting discrimination based on migration status and gender.

In view of the institutional diversity of care sectors in the Member States and between the Member States, a variety of targeted measures will be necessary to address these problems. Our proposals therefore cover a wide range of issues, among them:

- the promotion of career development and professionalisation,
- standardisation of qualifications and their recognition, in particular in relation to interactive and emotional work,
- the reduction of working time and workloads,
- addressing violence and harassment at work,
- enforcement of labour and social standards,
- opening pathways for third-country care workers into European labour markets,

- protecting migrant workers from discrimination,
- and supporting the building of diverse teams in care work.

Some general issues should be highlighted:

- Firstly, decent work has to be an important factor in any policy concerning decent care. Standards for better job quality and better working conditions should be integral to all definitions and priorities around sustainable and quality care systems. In particular, funding of care services should be made conditional on standards of good working conditions.
- Secondly, all types of care workers (and their representatives) should be acknowledged and recognised, including live-in workers.
- Thirdly, workers' voice, the recognition of social partners from both sides as well as social dialogue are of utmost and cross-sectional importance. The structuring and strengthening of social dialogue paves the way for facilitating the effectiveness of any measure in the care economy.
- Four: the governance of care and care work has to take into account its cross-sectional and cross-disciplinary character.
- And lastly: in order to develop more nuanced measures, and to monitor their implementation, statistics are crucial. To this end, statistical categories that reflect the realities of care sectors, are needed.

Most of the measures needed in order to improve job quality and address undervaluation lie in the competence of Member States, national social partners and care institutions. However, the European Union can support Member States and social actors considerably by setting standards and legal frameworks, and also by organising knowledge exchange. As far as the organisation of labour markets is concerned, the European Labour Authority can be an important actor.

It is our hope that EU actors and actors in the Member States cooperate effectively to address the many aspects of the care crises. Their actions are urgently needed in order to provide affordable, available and accessible care services to everyone who needs them, while at the same time taking care of care workers themselves.

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CHAPTER 15

# Empowering Care through Training. The CARE4CARE Training Programme Model for Trade Unions, Employer Representatives and Families

Agata Ludera-Ruszel, Hubert Kotarski, Giulia Frosecchi

## 1. Wp6 – Training Curriculum: Introduction

This document is an updated version of Deliverable D6.2 and it reflects the results, evaluations, and best practices emerging from the national training sessions carried out between July and October 2025 by the CARE4CARE partners. It complements the original training curriculum with insights from the post-training assessment (Deliverable D6.3), integrating evidence-based feedback on content, methodology, and impact.

The primary goal of WP6 ("Training design and delivery") is designing and delivering training program to empower trade unions, family associations and employers in the sector with knowledge and skills on effective strategies to recognize vulnerabilities of care workers and to improve job quality and contrast discrimination in the care sector. The curriculum specifically aims to: raise awareness within national trade unions and employers' organisations about the realities of care work and the importance of union engagement in this sector; promote an understanding of the multifaceted vulnerabilities experienced by care workers, to support unionisation and improve collective bargaining coverage; develop practical skills, particularly negotiation and conflict resolution skills among representatives of trade unions and employers' organisations ac-

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tive in sectors where care work is prevalent; enhance the ability to prevent and resolve interpersonal conflicts, both within institutional care settings and in the context of family-based care arrangements.

As part of Work Package 6 (WP6), Task 6.2, titled "Design of Training Curriculum", was developed. This task defined the objectives, structure and methodology of the training module developed under Work Package 6 (Training Design and Delivery). The aim of the training module is to strengthen the role of stakeholders in supporting the rights of care workers, improving the quality of work, and counteracting risks in the care sector.

The training was designed for relevant stakeholders, with a particular focus on trade unions and employers' organisations. However, NGOs and other entities involved in protecting care workers and developing a sustainable care sector were also invited to participate if they expressed an interest.

## 2. Methodology and Knowledge Base

The training curriculum has been developed based on the findings and data collected throughout the CARE4CARE project, using both qualitative and quantitative methods to identify specific training needs of stakeholders.

Part A of the training programme draws on the analytical findings presented in the following project reports:

- WP2: Reports on Job Quality and Inclusive Working Conditions.
- WP3: Reports on Discrimination Mapping.
- WP4: Report on Care Workers' Well-being and Rights Awareness.
- WP5: CARE4CARE Policy Paper.
- WP7: CARE4CARE web platform.

The training aimed to disseminate key findings from Work Packages (WPs) 2–5 and 7, enhance stakeholders' understanding of the legal, social and organisational dimensions of the care sector, and promote transnational learning and dialogue. While maintaining these goals, the updated curriculum now includes a specific focus on areas identified as priorities during the training.

Part A of the curriculum had a mini-module structure and was implemented uniformly across all participating countries to ensure conceptual clarity and consistency of approach.

Part B of the curriculum addressed more specific national training needs, as identified in Task.

6.1. Each project partner conducted a contextual analysis using stakeholder interviews, surveys and expert consultations, developing a country-specific component of the training programme to complement the common core.

It is noteworthy that all partners implemented the four common core modules originally outlined in D6.2. The provision of feedback confirmed the modules' relevance and coherence across national contexts. Participants expressed particular appreciation for the sections addressing EU labour law, working conditions, and anti-discrimination principles. The provision of comparative in-

sights across Member States has been demonstrated to enhance understanding and policy reflection.

The CARE4CARE training curriculum has proven to be effective, inclusive, and adaptable across various contexts. The integration of practical experiences, emotional support elements, and hybrid learning has strengthened participant engagement and the long-term impact of the programme. Therefore, the integration that have followed the delivery and assessment of the trainings in the partner countries are minimal. Overall, the evidence gathered through WP6 confirms that this training approach can serve as a replicable model for future EU-level capacity-building initiatives in the care sector.

## 3. Part A: Core Training Modules

### 3.1 Foundations for Improving Job Quality and Combating Discrimination in the Care Sector

#### 3.1.1 Introductory Session

The training begins with a brief introduction to the project, followed by a session in which participants introduce themselves, their affiliations, and their expectations for the training.

#### 3.1.2 Mini-Module 1: Job Quality and Inclusive Working Conditions in the Care Sector

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| Aim | This mini-module aims to:<br>- Provide training on working conditions in the care sector in a national and comparative perspective.<br>- Identify common challenges and potential improvements across different countries.<br>- Highlight the interconnection between labour law and industrial relations in the sector.<br>- Promote the integration of various legal perspectives to enhance job quality and inclusive working conditions for care workers across Europe, as well as across the different professionals of the care sector.<br>- Encourage stakeholder engagement and support a collaborative.<br>- Approach to address key sectoral challenges. |
| Contents | National profiles:<br>- Identification of the pivotal elements of the current national and European legal framework of the care sector.<br>- Focus on the main criticalities of the national legal framework (including norms set by both laws and applicable collective agreements).<br>- Identification of cross-cutting issues affecting various professional roles in the care sector.<br>Comparative profiles:<br>- Presentation and discussion of legal best practices from other countries that may inspire policy innovation.<br>- Analysis of effective collective bargaining practices of other countries that can be of inspiration for the trade union/industrial relations' strategy of the relevant stakeholders. |

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| Methods | Frontal teaching, to introduce the main contents of the mini-module; discussion-based method, to discuss the content and encourage questions, suggestions and the exchange of ideas. Other innovative and inclusive methods (such as "flipped classroom", "gamification" etc.) are strongly encouraged, taking into account each partner's specific expertise and the aptitude of the class. |
| Materials | - WP2 – "Reports on Job Quality and Inclusive Working Conditions", composed by: National Report of France; National Report of Germany; National Report of Italy; National Report of Poland; National Report of Spain; National Report of Sweden; Comparative Report; Comprehensive Report. Available at: Work Packages' Reports and Results \| CARE4CARE.<br>- Legal primary sources, such as normative texts and collective agreements (if accessible), must be made available to the participants. |
| Suggested length | 3 hours. |

### 3.1.3 Mini-Module 2: Discrimination Based on Gender and Migration Status in the Care Sector

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| Aim | This mini-module aims to:<br>- Offer a comparative analysis of discrimination based on gender and migration status in the care sector in six member countries of the Consortium (France, Garmany, Italy, Poland, Spain and Sweden).<br>- Explore how legislation, collective bargaining, case law, public or policy initiatives, activities of institutions, and reports from these bodies address the principle of anti-discrimination concerning care workers.<br>- Share collected data on discriminatory practices.<br>- Analyse how national equality bodies have tackled discrimination within the care sector. |
| Contents | National profiles:<br>- Overview of the pivotal elements of the current national and European legal framework of the care sector.<br>- Analysis of major critical profiles of gender discrimination of care workers.<br>- Analysis of major critical profiles of migration status discrimination of care workers.<br>Comparative profiles:<br>- Presentation and discussion of best legal practices of other countries that that may inspire policy innovation.<br>- Analysis of effective administrative practices (e.g. data collection) and judicial practices (e.g. presence of legal disputes) of other countries that can be of inspiration for the political and legal action of the stakeholders.<br>- Analysis of effective collective bargaining practices of other countries that can be of inspiration for the trade union/industrial relations' strategy of the relevant stakeholders. |
| Methods | Frontal teaching, to introduce the main contents of the mini-module; discussion-based method, to discuss the content and encourage questions, suggestions and the exchange of ideas. Other innovative and inclusive methods (such as "flipped classroom", "gamification" etc.) are strongly encouraged, taking into account each partner's specific expertise and the aptitude of the class. |

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| Materials | - WP3 – "Reports on Discrimination Mapping", composed by: National Report of France; National Report of Germany; National Report of Italy; National Report of Poland; National Report of Spain; National Report of Sweden; Comparative Report; Comprehensive Report.<br>- Legal primary sources, such as normative texts and collective agreements (if accessible), must be made available to the participants. |
| Suggested length | 3 hours. |

### 3.1.4 Mini-Module 3: the Status of Care Workers Well-Being and Rights' Awareness – an Introduction

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| Aim | This mini-module aims to:<br>- Present preliminary results of the study on psycho-social working conditions affecting care workers' well-being and awareness of their rights, conducted by the University of Seville. |
| Contents | National profiles:<br>- Presentation of the main results of the research phase titled "Care workers' well-being and rights' awareness".<br>- Overview of the research methodology and scope.<br>- Indication of the materials that contain the detailed analysis. |
| Methods | Frontal teaching, to introduce the main contents of the mini-module; discussion-based method, to discuss the content and encourage questions, suggestions and the exchange of ideas. |
| Materials | WP4 –"Report on Care workers' well-being and rights' awareness" (first draft). |
| Suggested Length | 1 hour |

### 3.1.5 Mini-Module 4: The Societal Outputs and their Dissemination

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| Aim | This mini-module focuses on two key societal outputs of the project:<br>- The "Policy proposals to improve working conditions for care workers".<br>- The web platform designed to raise awareness of care workers' rights.<br>The session aims to present and discuss these outputs with participants and foster their wider dissemination. |
| Contents | Policy proposal:<br>- Presentation of key policy recommendations to EU institutions.<br>- Explanation of the evidence-based arguments underpinning each proposal.<br>Web-platform:<br>- Demonstration of platform features and functionalities.<br>- Call to action for stakeholders to support dissemination within their networks. |
| Methods | The methods adopted are:<br>- For the policy proposals: frontal presentation, followed by a Q&A session and open debate.<br>- For the web platform: frontal presentation, followed by role play exercises simulating platform use by care workers. |
| Materials | - WP 5 – "Policy proposals to improve working conditions for care workers".<br>- WP 7 – Use of the internet by each participant to connect to the first draft of the Web-platform. |
| Suggested length | 2 hours |

# 4. Part B: Tailored Training Paths

## 4.1 National Priorities and Stakeholder-Driven Focus Areas

### 4.1.1 Preliminary Considerations

Each partner designs Part B based on the specific needs of their national context and the expertise available within their research unit.

This elaboration can be based on prior consultation with relevant stakeholders, conducted through both a survey and a series of focus groups. The aim is to ensure that the content of Part B reflects the concrete training needs and priorities identified at national level, while remaining consistent with the project's overall objectives and its focus on care sector workers.

The topics covered in Part B may include:

- a more detailed assessment of one or more of the profiles addressed in Part A.
- one or more of the following topics listed in the table below.

### 4.1.2 Mini-Module 5: to be Decided by Each Partner According to the Topic(S) Chosen

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| Aim | This part aims to complement the core training with thematic modules tailored to national contexts, allowing partners to:<br>- Explore topics of specific interest of the stakeholders more in depth.<br>- Address additional challenges, opportunities and topics relevant to care workers and to their stakeholders, in line with the partner's specific expertise. |
| Contents | Possible topics:<br>- Subjects covered in previous mini-modules and identified for in-depth study.<br>- "The role of trade unions in the care sector" – Aim: enhancing awareness on the importance of trade unions in the care sector.<br>- "Mediation and negotiation in the care sector" – Aim: providing targeted competencies on mediation and negotiation techniques in the care sector.<br>- "Dealing with difficult situations" – Aim: developing emotional and cognitive competences needed to act in difficult professional situations and manage stress.<br>- "Burnout in the care sector" – Aim: increasing awareness, identifying the symptoms of burnout and acquiring skills to counteract the phenomenon.<br>- "Work-life balance in the care sector" – Aim: sharing techniques to promote work-life balance in the care sector.<br>- "Communication techniques in the care sector" – Aim: developing interpersonal competences<br>- "Working and organising in a multicultural environment" – Aim: addressing the difficulties in working and organising workers in a multicultural environment.<br>- "The patients' perspective" – Aim: raising awareness over patients' rights and ethical aspects.<br>- "Quality Management in Care Services" – Aim: gaining knowledge in the field of quality management systems used in care facilities.<br>- "Inclusion of Informal Carers and Gender Equality" – Aim: to enhance care workers' understanding and practical skills in fostering inclusive and gender-sensitive cooperation with informal carers, promoting equality, mutual respect, and recognition of diverse caregiving roles within the care sector. |

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| Methods | Partners are encouraged to associate "frontal-teaching" and "discussion- based method" with other innovative and inclusive methods, taking into account each partner's specific expertise.<br>These can be, for instance: "flipped classroom", "gamification", "project based learning" and "digital-learning tools".<br>The involvement of scholars with specific expertise in the chosen subject is strongly recommended. |
| Materials | Easy and comprehensible materials, such as summaries, schemes and power point presentations can help fixing the main contents. Legal primary sources, such as normative texts and collective agreements (if accessible), must be made available to the participants. It is strongly encouraged to provide also summaries of the main regulatory sources, which can be easily accessible and intelligible to the stakeholders. |
| Suggested Length | From 3 to 7 hours |

CHAPTER 16

# An Ambitious Multilingual Platform to Improve Care Workers' Rights. The CARE4CARE Web Platform

William Chiaromonte

## 1. Introduction: Care Work, Structural Vulnerability and the Information Gap

Care work—as emerging from the CARE4CARE Project's research activities—constitutes a foundational yet persistently marginalised component of European labour markets. It encompasses a wide range of activities, including personal assistance, long-term care and health-related support, delivered across both public and private sectors and within formal and informal economies.

Despite its essential social function, care work is characterised by chronic undervaluation, weak labour protections and fragmented regulatory frameworks.

A substantial body of research highlights how care workers—predominantly women and increasingly migrants—are exposed to precarious employment conditions, low wages, excessive working hours and limited access to social protection. These vulnerabilities are exacerbated by intersecting inequalities related to gender, migration status, language proficiency and educational attainment. As a result, even where legal protections formally exist, care workers often remain unable to access or exercise their rights effectively.

One of the least visible yet most consequential dimensions of this vulnerability is the information gap. Care workers frequently lack access to clear, reliable and comprehensible information about applicable labour laws, contractual standards and available support mechanisms. Institutional information sources

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tend to be fragmented, overly technical or linguistically inaccessible, reinforcing a situation in which rights remain abstract and distant.

It is within this gap that the CARE4CARE Web Platform (https://app.care-4care.net) positions itself: as a digital tool designed to translate complex regulatory frameworks and research outputs into accessible, practice-oriented guidance tailored to the real needs of care workers. The platform does not merely host legal texts; it reorganises and interprets them according to thematic relevance and user logic, reducing the threshold for comprehension and practical use.

## 2. Digitalisation, Access to Rights and the CARE4CARE Approach

Digital technologies hold significant promise for democratising access to information and enabling rights awareness, but only when they are designed with accessibility, simplicity and user diversity in mind.

The CARE4CARE Project acknowledges this by adopting a user-centred, rights-based and evidence-informed approach, resulting in the development of the CARE4CARE Web Platform. The platform operates as a socio-digital infrastructure mediating between legal knowledge, research evidence and everyday work realities.

Instead of treating digital access as sufficient for empowerment, the Platform was designed on the premise that users must be able to easily understand, navigate and apply digital information in their daily working lives. This position aligns with literature on digital inclusion, which emphasises that technical availability must be accompanied by ease of use, linguistic accessibility, contextual relevance and integration into users' daily practices.

The CARE4CARE Web Platform is therefore conceived not as a static repository, but as an interactive, navigable environment where users can quickly access tailored information relevant to their employment context, national legal frameworks and linguistic preferences.

## 3. Objectives of the CARE4CARE Web Platform: from Awareness to Empowerment

The CARE4CARE Web Platform pursues multiple interrelated objectives.

The primary objective of the Platform is to enhance rights awareness among care workers by providing clear, structured and accessible information on labour rights, social protections and procedural options. By aggregating relevant content and presenting it via an intuitive interface, the Platform seeks to reduce complexity and increase comprehension.

Second, a major barrier to rights awareness is linguistic exclusion. Care workers in Europe often speak multiple languages, and migrant workers may not have proficiency in the official language of the host country. In response, the Platform is available in 13 languages, including languages broadly spoken by migrant care workers. The multilingual architecture of the Platform ensures that users can access information in formats that reflect their linguistic needs.

Third, care work is delivered through a variety of employment arrangements, ranging from formal contracts to informal and undeclared work. The Platform recognises this structural diversity and provides information applicable to different contractual contexts, highlighting both normative standards and practical implications.

Finally, the Platform functions as a bridge between academic knowledge production, public policy development and everyday work practices. It translates empirical findings from comparative research into practical guidance that care workers can apply directly to their lives, thus contributing to both individual empowerment and structural change.

## 4. Translating Research into Digital Content

The CARE4CARE Web Platform's content is grounded in empirical research conducted across six European Union countries. National partners contextualised this research to ensure that legal and institutional differences are reflected in the Platform's information architecture.

The Platform's thematic modules cover key areas such as employment contracts and minimum standards, working time rules and rest periods, occupational health and safety, social security entitlements, including sickness and maternity benefits, complaint mechanisms and access to enforcement.

Each module is designed to prioritise practical relevance over legal formalism, focusing on scenarios and questions that arise in daily work situations. For example, rather than simply citing statutory provisions, the Platform explains how certain protections apply in practice, how to document violations and which local or national institutions can be contacted for further assistance.

This practice-oriented structure distinguishes the CARE4CARE Web Platform from traditional legal repositories. By integrating research with user insights, the Platform translates normative frameworks into actionable knowledge.

## 5. User-Centred Design and Usability: Evidence from Testing

The CARE4CARE Web Platform adopted a user-centred design methodology, incorporating iterative feedback from care workers during multiple stages of development. This approach was validated through systematic usability testing involving care workers across partner countries.

Key findings from usability assessments include high scores for ease of use and intuitiveness when navigating the Platform; positive evaluations for clarity of language and visual layout, which participants reported as supportive in reducing cognitive load; affirmation that content organisation corresponds to practical inquiry logics, enabling users to locate relevant information quickly.

Participants also provided suggestions for improvement, particularly regarding onboarding and navigational orientation, which have informed subsequent refinements to the interface.

Importantly, respondents described the Platform not merely as functional but as reassuring an essential dimension of digital tools meant to support vul-

nerable workers. This affective aspect, while rarely captured in formal usability metrics, is crucial for building trust in digital rights infrastructures.

### 6. Architecture, Accessibility and Technical Functioning

The CARE4CARE Web Platform is built on scalable, secure and mobile-friendly technical foundations. The Platform's architecture includes hosting on a dedicated virtual private server with modular containerised deployment, facilitating updates and recovery; encrypted connections and robust firewall protections to guarantee data security; segregated administrative access with controlled credentials to manage content updates.

An explicit design choice was made to prioritise anonymous access to content, with minimal data collection. Users can navigate the Platform without registration, reducing entry barriers and privacy concerns; and this is an important consideration given the precarious legal status of many potential users.

The user interface follows established accessibility guidelines, with attention to readable typography, logical menu hierarchies and responsive design adaptable to smartphones, tablets and desktops. This is crucial given that many care workers primarily access the internet via mobile devices.

The Platform's multi-language support is facilitated by automated translation workflows, enabling consistent updates across languages while maintaining manageable maintenance demands. Human validation mechanisms are incorporated for content segments where legal precision is critical.

### 7. Content Governance, Quality Assurance and Institutional Anchoring

Ensuring the reliability and relevance of content on the Platform requires systematic governance. Following the project's conclusion, responsibility for content updates and quality assurance has been entrusted to the University of Florence, which coordinates with national partners to reflect legal developments, policy changes and user feedback.

Content governance includes regular review cycles for legislative changes; cross-checking between national partners to ensure accuracy and relevance; integration of stakeholder insights from trade unions, associations and care worker groups.

This model embeds the Platform within a network of institutional and civil society actors, strengthening both its legitimacy and its capacity to respond to evolving realities.

### 8. Sustainability Strategy and Long-Term Operation

Sustainability planning was integral to the Platform's design. Deliverables from the CARE4CARE Project outline a low-cost operational model, with annual expenses for hosting, monitoring and technical support deliberately kept within minimal ranges. This enables the Platform's continuity using institutional resources rather than project funding alone.

Beyond financial sustainability, long-term operation is supported by continuous stakeholder engagement; periodic usability review cycles; integration with dissemination channels such as newsletters and partner networks.

The result is a Platform that is both technically durable and socially embedded; and this is a necessary combination for digital infrastructures aimed at rights empowerment.

## 9. Implications for Digital Rights Tools and Labour Governance

The CARE4CARE Web Platform provides a model for how digital tools can contribute to labour rights awareness in sectors marked by informality, linguistic diversity and structural inequality.

Its strengths include grounding in empirical research; emphasis on usability and accessibility; commitment to multilingual inclusion; sustainable governance architecture; integration with stakeholder networks.

By bridging academic research and practical usage, the CARE4CARE Web Platform exemplifies a holistic approach to digital rights infrastructure.

## 10. Conclusion

The CARE4CARE Web Platform stands as an innovative response to the persistent information gap that undermines care workers' ability to exercise their rights.

By providing accessible, multilingual and empirically grounded information through a user-centred interface, the Platform strengthens care workers' capacity to understand and navigate legal and institutional frameworks.

Its contribution extends beyond the care sector, offering insights into how digital tools can be designed and governed to support empowerment, social justice and inclusive labour markets.

As a socio-digital infrastructure, the CARE4CARE Web Platform represents a valuable intervention in both scholarship and practice, combining rights awareness with participatory design and sustainable operation.

STUDI SUL LAVORO DI CURA – STUDIES ON CARE WORK

TITOLI PUBBLICATI

1. Maria Luisa Vallauri, William Chiaromonte (edited by), *CARE4CARE - We Care for Those Who Care – Vol. I. Care Work and Working Conditions: National Legal Frameworks and Comparative Insights*, 2025
2. Maria Luisa Vallauri, William Chiaromonte (edited by), *CARE4CARE We Care for Those Who Care – Vol. II. Discriminations in the Care Sector: National Legal Frameworks and Comparative Insights*, 2025
3. Maria Luisa Vallauri, William Chiaromonte (edited by), *CARE4CARE We Care for Those Who Care – Vol. III. Building Dignified Care Work in Europe: Critical Reflections, Policy Proposals and Practical Tools*, 2026

This volume collects the theoretical reflections, policy proposals and operational outcomes developed within the CARE4CARE – We care for those who care project. Moving from an interdisciplinary perspective combining labour law, social theory and psychosocial research, the volume frames paid care work as socially essential yet historically undervalued labour, strongly shaped by gender and migration dynamics. Building on comparative findings from six EU countries, it advances proposals to improve job quality, strengthen social dialogue, prevent discrimination and support sustainable care systems, while presenting training and empowerment tools aimed at promoting the dignity and recognition of care work.

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