



Department of Enterprise, Trade and Employment

Labour market impacts of health care assistant employment permits

Final report

KPMG

May 2024

This report contains 62 pages

2024 05 30 Health Care Assistants FINAL



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May 2024

Document review and approval

Revision history

Version	Author	Date	Revision
1	Dr George Jacob	01.03.2024	Initial draft
2	Lawrence Bowles	20.03.2024	Revisions following client and Steering Group feedback
3	Dr George Jacob	29.04.2024	Added sections 2, 4, 6.4 and 7 (and made changes based on client feedback)
4	Dr George Jacob	13.05.2024	Incorporated suggestions of the third steering group. Added section 7.5 (Employment Permit Data + Figure)
5	Dr George Jacob	29.05.2024	Revisions following client and Steering Group feedback

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3	Lawrence Bowles	08.04.2024
4	Lawrence Bowles	17.05.2024
5	Lawrence Bowles	30.05.2024

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Glossary

CSO	Central Statistics Office
DETE	Department of Enterprise, Trade, and Employment
DH	Department of Health
EEA	European Economic Area
ESRI	Economic and Social Research Institute
EU	European Union
HCA	Health Care Assistant
HICP	Harmonised Index of Consumer Prices
HSE	Health Service Executive
HCCI	Home and Community Care Ireland
ILO	International Labour Organization
NHI	Nursing Homes Ireland
NMBI	Nursing and Midwifery Board of Ireland
PHA	Public Health Agency
QQI	Quality and Qualifications Ireland
SIPTU	Services Industrial Professional and Technical Union
SS	Supply
UCD	University College Dublin

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1 Acknowledgements

The authors thank the members of the Health Care Assistants Study – Steering Group. The authors particularly thank Emily de Grae, Linda Kane, Rhodri Lloyd, and Garth Clerkin of the Department of Enterprise, Trade and Employment. The authors are also grateful to Karolina Farrell (Department of Health), Niamh O'Malley (Department of Health), Rachel Simons (Older Persons Policy, Department of Health), and Dr Philippa Witherho (HSE). The authors are also grateful to Neil Bruton (Migrants Rights Centre Ireland), Varghese Joy (Migrants Nurses Ireland), Helen Whitty (Irish Association of Healthcare Assistants), Liam Harvey (Nursing Homes Ireland), Eithne Knox (Nua Healthcare Services), and Michelle Kirwan (Nua Healthcare Services).

2 Executive summary

This report describes the labour market impact of introducing employment permits for non-EEA Health Care Assistants (HCAs), focusing on nursing homes, hospitals, and home care settings. It also sets out a labour market model predicting the supply and demand for HCAs to 2035 to help DETE analyse different growth scenarios.

HCAs provide assistance, support and personal care to patients and residents in nursing homes, hospitals, clinics, and other settings. They generally work to support qualified medical professionals such as nurses. Since June 2021, workers from outside the European Economic Area (EEA) can apply for an employment permit to work as an HCA in Ireland, provided they have an employment offer with an annual salary of €27,000 or higher and they commit to earning a Quality and Qualifications Ireland (QQI) Level 5 qualification within two years.

This report builds on a literature review about how immigration affects wages and unemployment. Studies show imperfect substitution between native and immigrant labour, with education levels playing a role. Theoretical literature suggests educated migrant workers benefit the economy. Studies on immigration across different parts of the world generally reveal mixed effects. Papers and reports published in Ireland and the UK found that low pay and poor work-life balance contribute to high turnover rates for HCAs.

This report is informed by an extensive stakeholder engagement process comprising more than 400 survey responses and interviews with HCAs, representative organisations (such as trade unions and charities representing migrants' rights), and employers.

Stakeholder interviews revealed that introducing employment permits for HCAs had varied impacts. HCAs with employment permits are disproportionately likely to work in private nursing homes. HCA wages are generally low, but private sector wages for HCAs are typically lower than pay in HSE institutions. Survey responses reflected diverse employment settings for HCAs, with a significant portion working in nursing homes, hospitals, and home care. A notable proportion of respondents required employment permits, particularly in nursing home settings. Survey responses revealed indications of potential challenges in staff retention due to ageing, particular amongst Irish/EUC HCAs. Consultations indicate that many HCAs, especially those with permits, transition to new roles after two years. Survey responses suggest that wage differentials between sectors exist, albeit it is not clear the extent to which this reflects different mixes of public- and private-sector workers.

Employers reported a mix of factors influencing HCA employment choices, including pay, location, and flexibility. Substantial levels of open roles were reported across various care settings, with private nursing homes facing higher employee turnover rates and higher numbers of vacancies. Average hourly wages vary between public and private sectors and between settings, which could influence recruitment.

Stakeholder interviews revealed varied impacts of employment permits on HCA supply, with private nursing homes being most affected. HCA turnover patterns differed between sectors, with private nursing homes experiencing higher churn rates. The €27,000 salary

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floor associated with employment permits had mixed effects on wage expectations across sectors, with some stakeholders suggesting it created a “salary ceiling” for workers in private nursing home settings. Private healthcare employers noted that the way Fair Deal Scheme settlements are agreed leaves little flexibility to accommodate increases to minimum salaries.

An expandable employment model, built using data on healthcare needs and demographics, projects a growing gap between needs-based demand for and supply of HCAs. **The growing unmet demand for HCAs and the relatively low share of permit-holding HCAs suggest that employment permits for non-EEA HCAs have not had a material impact on the labour market at current levels.**

Results from the model indicate a growing demand for HCAs due to Ireland's ageing population and healthcare demand trends, with annual growth rates projected at 3.5% to 4.0% over the next 12 years. The supply model estimates the future workforce of HCAs based on existing data and demographic projections. It considers domestic, other EU, and permit-required non-EU HCAs. The baseline scenario predicts an 8% increase in the domestic/EU HCA workforce by 2036.

Comparison of the demand and supply models suggests current unmet demand for HCAs in Ireland, with the shortfall expected to worsen over the next decade. Factors such as population ageing, and healthcare demand outpacing workforce growth contribute to this gap.

We used sensitivity testing to analyse the potential impact of higher minimum HCA salary thresholds on labour supply. Assuming correlation between wages and labour supply at the top of the range suggested by our literature review, testing suggests that raising wage thresholds might reduce the shortage of HCAs in the short term but that this increase in supply does not balance the shortfall of HCA labour supply predicted to develop in the late 2020s and early 2030s.

Following baseline assumptions, the expandable model predicts a growing shortage of HCAs. The shortage of HCAs decreases in scenarios where patients receive less HCA care and increases when more HCA care is needed. In a scenario where patients receive less HCA care and fewer people reside in nursing homes, Ireland would experience an excess of HCAs until 2028 and a shortage afterwards. In contrast, in scenarios where patients receive more hours of HCA care and are more likely to reside in nursing homes, the model predicts the highest shortage, ranging from 22,165 HCAs in 2024 to 62,243 by 2036.

3 Introduction: Health Care Assistants and their role in the Irish healthcare system

3.1 What are HCAs?

According to the International Labour Organisation (ILO), health care assistants (HCAs) “provide assistance, support and direct personal care to patients and residents in a variety of institutional settings such as hospitals, clinics, nursing homes and aged care facilities. They generally work in support of health professionals or associate professionals.”¹

HCAs mostly work under supervision alongside registered nurses, carrying out delegated tasks. Nurses remain responsible for planning, supervising, and reviewing the work HCAs perform.

The ILO definition goes on to clarify that HCAs “do not perform tasks requiring extensive medical knowledge or training, such as administering medications and cleaning and dressing wounds: where tasks of this type are performed, they are of a simple and routine nature.”

3.1.1 HCAs in the Irish health care system

Within the HSE, the staff group Health Care Assistants includes three grade groups: (1) Health Care Assistants/Care Assistants, (2) Health & Social Care Assistants, and (3) Attendant/Aide. These healthcare roles include assistants, aides, interns, and specialists across various medical disciplines and support services (e.g., Care Assistant - Disability Services, Cardiac Aide, Audiologist - Assistant, Multi-Task Attendant etc).²

Multi-Task Attendants perform HCA tasks as well as assisting with cleaning and catering in healthcare settings. While they do not exclusively perform HCA tasks, we have included them in our definition of HCA for this study as they have the skills and training necessary to act as HCAs where needed.

3.2 HCAs and the employment permit system

Evidence within the healthcare sector suggests increasing competition for skilled candidates in several healthcare roles. Despite increased efforts to recruit from the Irish and European labour markets, including through engagement with the Department of Social Protection, supply has not sufficiently met demand. With increases in the ageing

¹ <https://www.ilo.org/public/english/bureau/stat/isco/docs/health.pdf>

² From the Health Service Personnel Census, we identified all HCAs - including Health Care/Care Assistants, Health & Social Care Assistants, and Attendant/Aide. We made sure that this figure is used in our model.



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population and consequent increases in demand for services, significant extra HCAs will be required to provide sufficient long-term residential care for older people into the future.

Non-EEA nationals, unless they are exempted, must hold a valid employment permit to work in Ireland. The employment permit system is managed by the Department of Enterprise, Trade and Employment. The system operates by a list of occupations classified as critically important to Ireland's economy (critical skills list) and a list of occupations for which employment permits are not issued (ineligible occupations list). Occupations not falling into either category are generally eligible for a General Employment Permit.

In June 2021, the role of HCA was removed from the ineligible occupations list, thereby allowing non-EEA HCAs to apply for a permit and work in Ireland. To be eligible for the general employment permit, prospective HCAs must have attained an employment offer with a minimum annual remuneration of €27,000 and a relevant QQI Level 5 qualification after two years employment in the State.

As part of the announcement of this Statutory Instrument in June 2021, a public commitment was made to review the changes after an initial period to ensure the new framework meets the needs of the sector and to identify any issues arising. This study provides stakeholders in the sector with evidence of the labour market impacts of giving HCAs working in the nursing home and hospital sectors access to Employment Permits.

4 Study methodology

The methodology of this study comprises several integrated qualitative and quantitative elements. This includes a concise literature review, based on which a data gathering exercise was performed through interviews and surveys with employees, employers, and representative organisations. Publicly available data along with insights gained from the stakeholder engagement were used to create an expandable employment market model for Health Care Assistants, which also included scenarios analysis and the effect of varying wage thresholds.

This study builds on a concise literature review on topics of immigration, labour market outcomes, and healthcare sector (summarised in Section 5 and Appendix B). Research on immigration's impact on local job markets shows early evidence of potential wage decreases for low-skilled workers, but recent studies suggest local wages might stay the same or even rise slightly if immigrants have different skills and capital is flexible. Most recent evidence internationally indicates that immigrants generally do not harm local job markets. Immigration may not have a significant effect on jobs because immigrants and locals often do different types of work due to language differences. Studies related to healthcare show factors affecting medical labour supply vary by context. HCAs are in high demand across the EU (including in Ireland), as indicated in the European Employment Services (EURES) 2022 report³. Studies on turnover and job satisfaction among HCAs in Ireland highlight issues like low pay, poor management relations, and limited training.

Section 6 of the report includes lessons learned from talking to HCAs and the organisations that hire or represent them. These insights helped the authors to create the employment model and scenarios explained later in the report. This section is based on consultations (interviews and surveys) with 440 people, including HCAs, employers, and organisations like unions and charities. Seven interviews were conducted, and 433 individuals responded to the survey. Approximately a quarter of the HCAs surveyed needed work permits, primarily those employed in private nursing homes. HCAs with permits in nursing homes earned less than those without permits, and they were typically younger than Irish/EEA HCAs. Also, nursing homes hired the most HCAs with permits. Many HCA positions remained vacant, especially in nursing homes and care facilities, and turnover rates were high, particularly in private nursing homes.

Section 7 provides a brief analysis of the existing wage structure, based on the data gathered from consultations.

Section 8 describes and analyses publicly available data, which was used as building blocks to develop the model (see model in section 9 and Appendix A). The data sources used in this report includes the 2011, 2016 and 2022 Censuses, the CSO's population projections, HSE's Health Service Personnel Census, and DH published data on hospital

³ <https://www.ela.europa.eu/sites/default/files/2023-09/ELA-eures-shortages-surpluses-report-2022.pdf>

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procedures. This was used to create different variables including the population share of age cohorts and propensity to use hospitals/nursing homes by age cohorts.

Section 9 describes the expandable employment market model for HCAs. As seen in section 9.1, the need-based demand for HCAs is modelled by calculating HCA requirement by hospitals, nursing homes, and other settings. Parameters are identified using the above-mentioned data sources, previous studies, and insights learned from the consultations. In section 9.2, the supply of HCAs is modelled with the help of HSE data, employment permit data provided by DETE, and using assumptions supplied/confirmed through stakeholder engagement (see appendix A.1 and A.2 for a detailed explanation of the demand and supply model).

Section 10 sets out various scenarios and explores how the demand and supply of HCAs in Ireland changes accordingly. These scenarios included changing the required HCA burden and propensity to access different healthcare settings. A shortage of 17,500 - 60,000 HCAs was predicted by 2036 depending on each of the scenarios. Appendix A.3 shows the effect of increasing the wage thresholds. The future projected shortage of HCAs persists even if the thresholds are assumed to be increased. Inflation and wage elasticity are taken into consideration to interact with the wage thresholds.



Figure 4-1: High-level graphical overview of the methodology

5 High-level findings from the literature review

This section summarises the findings from our literature review. The full literature review and bibliography are available in Appendix B.

Existing literature explores how immigration affects wages and job availability for the local population. Some early evidence suggests that it can lower wages for low-skilled workers. But more recent extensive studies argue that if immigrants have different skills and capital is flexible, local wages might remain unchanged or rise slightly. Most of the international evidence show that immigrants generally do not harm local job markets.

Immigration may not have a big impact on jobs since local and immigrant workers are not interchangeable. Immigrants and the local population often do different kinds of work because of language differences. Evidence shows that immigrants doing specialised tasks help businesses, while locals move into jobs needing good language skills. So, when there are more immigrant workers, locals often go for better-paying jobs that need good language skills, which helps keep wages up for less educated locals. Also, an increase in immigration for low-educated workers has a positive impact on wages for local, high-educated workers. For example, this may manifest in the HCA labour market by non-EEA workers filling junior HCA positions and Irish/EEA HCAs moving to supervisory or more specialised positions.

There are a few studies that looked at big changes in visa programs. Evidence based studies in the US shows that such changes bringing temporary immigrants to the US for science and engineering jobs did not have a big effect on things like how many jobs there were, average wages, or unemployment rates. Research also revealed that high skilled immigrants helped in innovation in their field.

There is some research revolving around the healthcare labour market. Factors affecting the number of medical workers, especially nurses, vary depending on the situation. Evidence based in the UK suggests that an increase in wages for nurses only led to a minor decrease in nurses leaving their jobs. Similar studies in the US and Norway show that nurse's wages do not have a big impact on their job decisions in the short term.

Health Care Assistants play a crucial role in the healthcare system. The 2022 report by the European Employment Services (EURES) on labour shortages and surpluses includes Health Care Assistants in the list of occupations where there is a shortage (including in Ireland)⁴.

Studies have been done on turnover and job satisfaction among Health Care Assistants (HCAs) in Ireland. Although some were not published in peer-reviewed journals they are included because it relates directly to the research question. Evidence suggests that turnover among nurses and HCAs in Ireland is linked to low pay, poor relationships with management, limited training opportunities, few chances for career

⁴ <https://www.ela.europa.eu/sites/default/files/2023-09/ELA-eures-shortages-surpluses-report-2022.pdf>



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growth, and work-life balance issues. Studies highlighted concerns about skills and training, suggesting a need for a standard set of skills for HCAs and carers nationwide.

The Department of Health's 2022 report focused on challenges in the care industry, noting a shortage of qualified workers, especially as many are getting older⁵. The report suggests improvements in pay, contracts, and training to attract and retain workers.

⁵ <https://www.gov.ie/pdf/?file=https://assets.gov.ie/237210/448892b3-36b4-4b7a-a41e-90368ff2345c.pdf#page=null>

6 Stakeholder engagement

This section of the report summarises the results of our engagement with HCAs and the organisations that employ or represent them. The conclusions from this engagement inform the figures and assumptions used to construct the expandable employment model and scenarios, described in the following sections.

We have engaged with 440 individuals, employers, and representative organisations (such as trade unions and migrant workers' charities), including seven interviews and 433 survey responses.

The table below shows the breakdown of these interactions by type (see Table 6-1). A substantial proportion of survey responses from employers or representative organisations were not completed. This is likely because people from these organisations clicking through the survey to familiarise themselves with the questions before collaborating with colleagues to prepare a full response.

Table 6-1: Stakeholder engagements by type and completeness

Type of engagement	Respondent type	Total responses	Complete responses
Survey	Health Care Assistants	325	313
	Employers	251	112
	Representative Organisations	23	8
	Total surveys	599	433
Interview	Employers		4
	Representative Organisations		3
	Total interviews		7
Grand total			440

In summary:

- About one quarter of HCAs surveyed required an employment permit. Most of these HCAs worked in private nursing homes.
- There is no evidence to indicate any changes in HCA vacancy rate since the introduction of employment permits.
- Employment permit-holding HCAs in nursing homes earn less than their counterparts who do not require permits.
- More experienced/older HCAs tend to earn more than less experienced/younger HCAs.
- Permit-holding HCAs are often younger compared to Irish/EU HCAs.
- Nursing homes hire the most HCAs with permits.
- Many HCA roles are vacant, especially in nursing homes and care settings.

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- Many HCAs leave their jobs, especially in private nursing homes.
- HCA wages are higher in the public sector.
- Permit holding HCAs tend to start in private nursing homes and then move to hospitals for better pay and conditions.

6.1 Survey

6.1.1 Health Care Assistants

The HCAs who completed the survey represented a wide range of different employment settings. Out of 313 total HCAs who reported their employment setting, 119 (38%) worked in a nursing home, 88 (28%) worked in a hospital, and 54 (17%) worked for a home care provider (see Figure 6-1).

Most (59%) HCAs who responded to the survey work in the public sector. The distribution of public and private sector workers varied widely between different work settings, with 73% of nursing home respondents working in the private sector. By contrast, all the hospital HCA respondents work in the public sector.

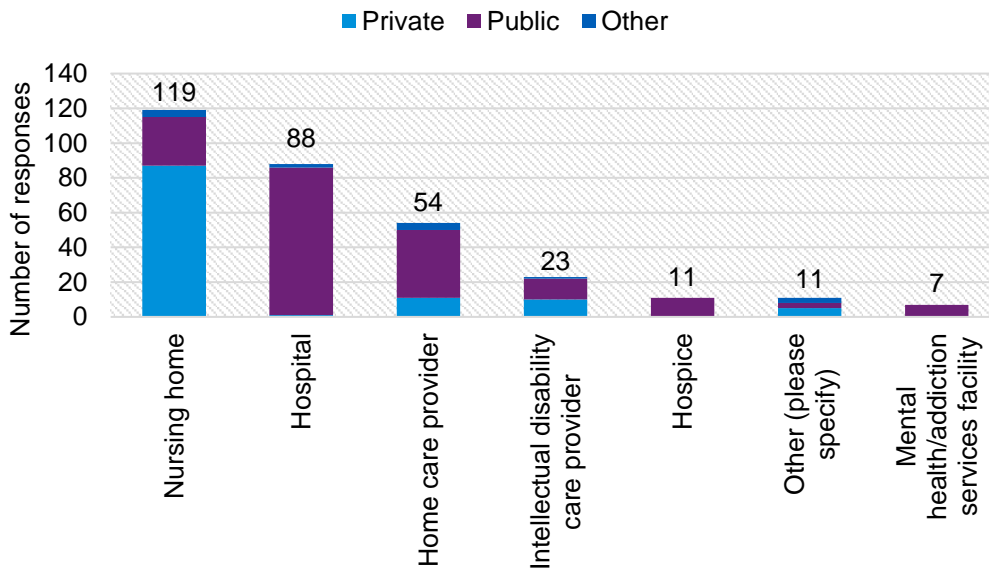


Figure 6-1: Number of HCA survey respondents from different work settings

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A little under a quarter (79 out of 313) HCAs who responded to this survey reported needing an employment permit to work in Ireland. Most of these HCAs, 85%, said they intended to renew their permit (see Figure 6-2).

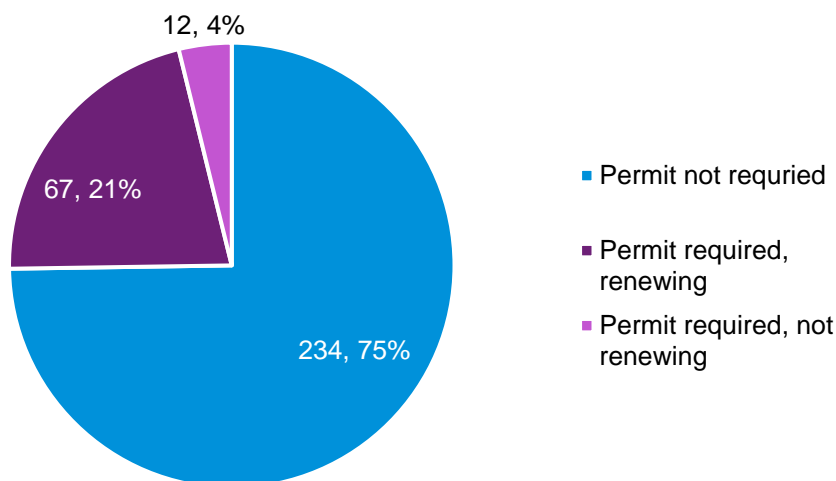


Figure 6-2: Number of HCA survey respondents who require employment permits and intend to renew them

Almost three quarters (58 out of 79) of the HCA respondents who need an employment permit work in a nursing home setting, with 53 of them working in private sector nursing homes. A further 10 HCAs work in HSE hospitals⁶, 4 HCAs work for home care providers, and 7 HCAs work in other work settings (see Figure 6-3).

⁶ Data provided by DETE suggests that no employment permits have been issued for HCAs working in HSE hospitals. These ten survey responses may represent HCAs who initially worked in another setting before transferring to a hospital.

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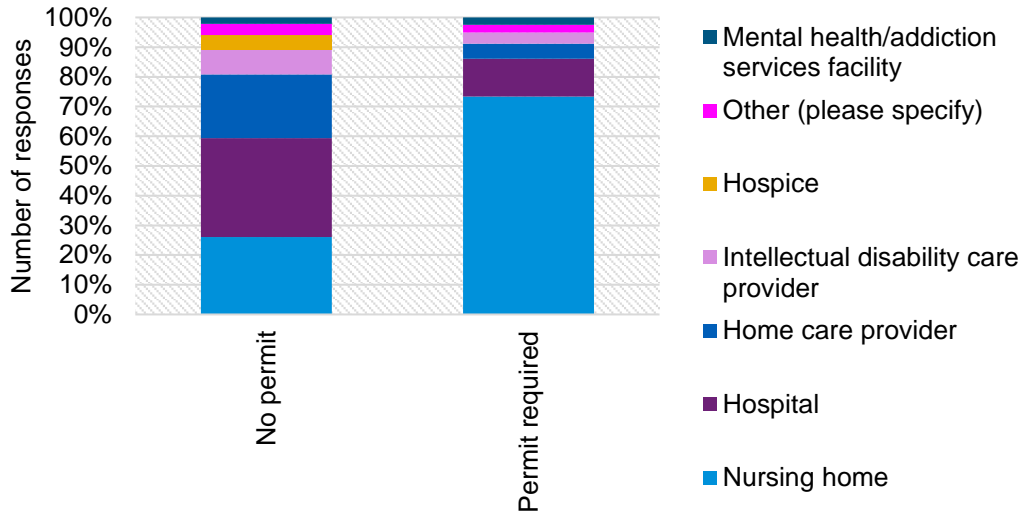


Figure 6-3: Breakdown by sector and permit requirement

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Just under a third (94 of 309, 30%) of HCAs said they had started a new job in the last year. For 48 of these respondents, this was because they had taken up their first HCA role in Ireland. Twenty-six HCAs had moved from one work setting to another (e.g., from a nursing home to a hospital) and 15 moved between HCA roles in the same setting (e.g., from a nursing home to another nursing home)⁷.

Almost half (47%, 36 out of 76) of those HCA with permits reported that they had started a new job in the last year (see Figure 5-4). This was the first HCA role in Ireland for majority of these respondents (26 of 36, 72%). Six HCAs had moved from one work setting to another (e.g., from a nursing home to a hospital) and 2 moved between HCA roles in the same setting (e.g., from a nursing home to another nursing home).

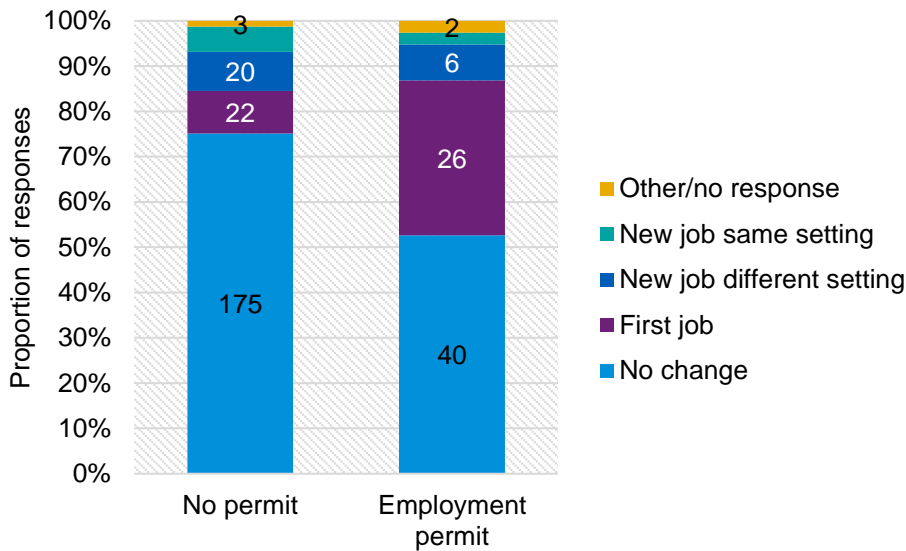


Figure 6-4: Reasons for job change and permit requirement

The average hourly wage for HCAs in a nursing home setting was higher for those without employment permits than for those working with a permit. The average hourly wage for nursing home HCAs with an employment permit is very slightly higher than the €27,000 salary floor.

The average wage reported in hospital settings was slightly higher for HCAs with employment permits than for those without. However, this conflicts with employment permit data recorded by DETE, which reports the average annual salary of non-EEA HCAs working in hospital settings at €32,637. This may be due to respondents reporting an hourly wage inclusive of overtime or unsociable hours supplements.⁸

We received fewer than five responses on average wages from HCAs with employment permits working for home care providers and in other settings. However, the wage data

⁷ Members of the Steering Group observed that domestic HCAs (non-Permit required) are also moving out of the healthcare sector.

⁸ Employment Permit Data records salary at time of application. Any changes/increments accrued while on a permit will not be reflected in the DETE data.

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for HCAs without employment permits working in home care suggest that wages are higher than in nursing home settings but lower than in hospitals.

Table 6-2: Annualised hourly wages by work setting and permit requirement ⁹

	Maximum Annualised Wage		Average Annualised Wage	
	No Permit	Permit Required	No Permit	Permit Required
Nursing home	€79,092	€32,448	€31,333	€27,337
Hospital	€42,588	€68,952	€35,916	€37,396
Home care provider	€40,560		€32,245	
Other	€52,728	€38,532	€37,437	€32,063

HCAs working with an employment permit tend to be younger than Irish/EU HCAs. Just 21% of HCAs with employment permits were aged 45 or older, compared to more than half (54%) for HCAs working without employment permits (see Figure 6-5).

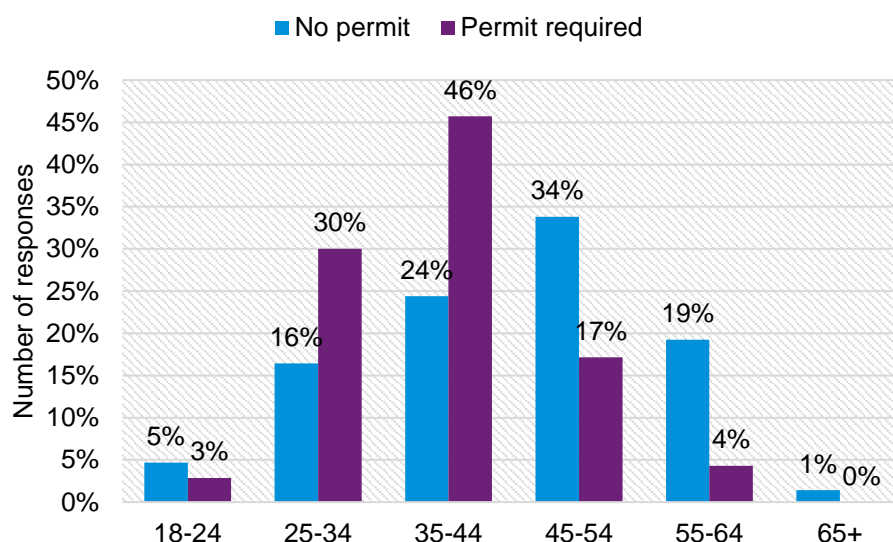


Figure 6-5: Age distribution of HCAs by permit requirement

The age profile of HCAs suggests that the sector may face growing challenges with staff retention as a rising proportion of HCAs reach retirement age. Opening the sector up to younger employees through the employment permit scheme may help to support the long-term sustainability of the sector.

⁹ 52 weeks of 39 hours each is assumed for calculations. Average and maximum wages for categories with fewer than five responses have been suppressed.

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6.1.2 Employers

A total of 112 employers responded to the survey. Sixty-three of these, 56%, represented nursing homes, with a further 14 responses each from home care providers and hospitals (see Figure 6-6).

The nursing homes and home care providers who responded to the survey were predominantly private sector. All hospital respondents were from either HSE or Section 38 hospitals.

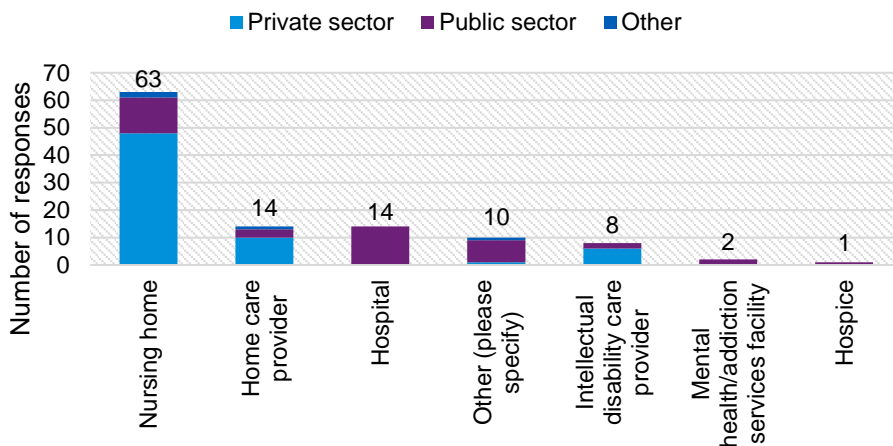


Figure 6-6: Number of employer survey responses by setting and public/private sector

The employers responding to this survey employ a total of 15,634 HCAs. Most employed HCAs work in nursing homes (6,886 of 15,634, 44%) and are predominantly in private nursing homes (6,040 of 6,886) (see Figure 6-7). The next biggest employer types are Intellectual Disability Care Providers (17%), Home Care Providers (16%), and Hospitals (14%).

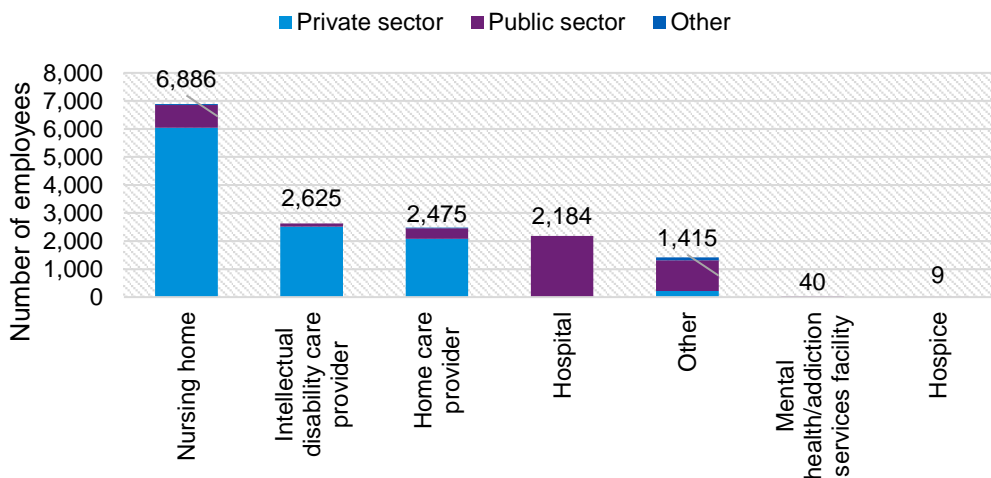


Figure 6-7: Number of employees in survey respondents by setting and public/private sector

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Nursing Homes employ the greatest share of HCAs who require an employment permit, followed by Intellectual Disability Care Providers, Home Care Providers, and Hospitals. On average one third of employed HCAs in Nursing Homes need an employment permit. Around 15%-20% of HCAs in other care settings and hospitals are reported to need an employment permit (see Figure 6-8).

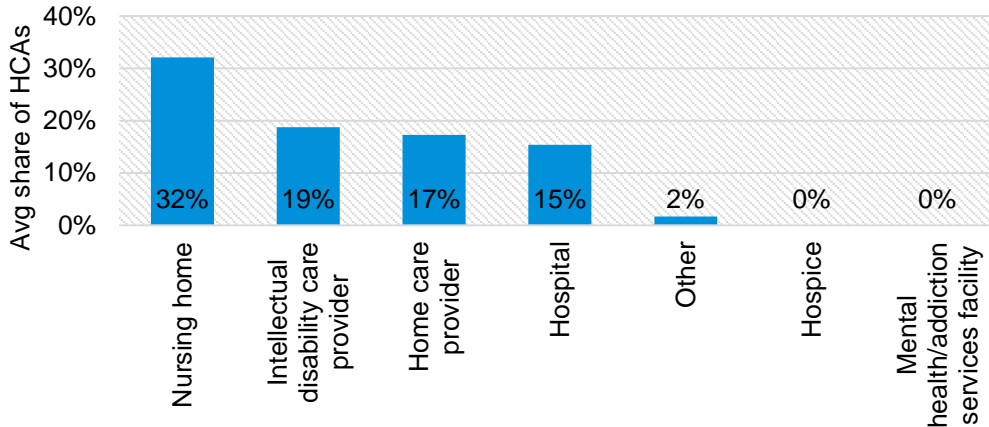


Figure 6-8: Average share of employed HCAs who require a permit by setting

Employers offered a range of reasons when asked why HCAs choose to work for them. However, good pay, convenient location, flexible hours, and training access were all commonly cited reasons to work as an HCA in public and private sectors (according to employers) (see Figure 6-9).

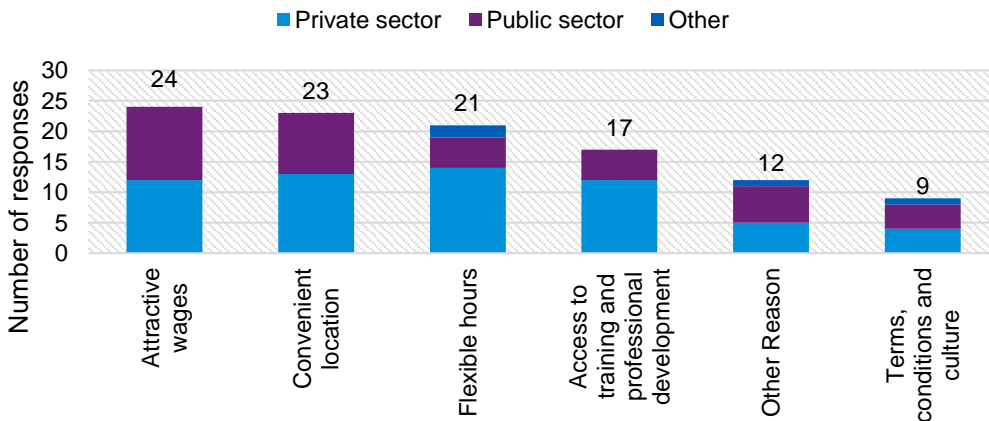


Figure 6-9: Reasons HCAs choose to work by public/private sector

Employers who participated in the survey reported a total of 1,196 open HCA roles. The highest open HCA roles are within the Intellectual Disability Care Providers (329), Nursing Homes (310) and Home Care Providers (229). More than a third of reported open roles were in the public sector, dominated by hospitals (157) and other public

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settings (82). These results suggest there are still widespread vacancies for HCA roles, even following their addition to the employment permit scheme (see Figure 6-10).

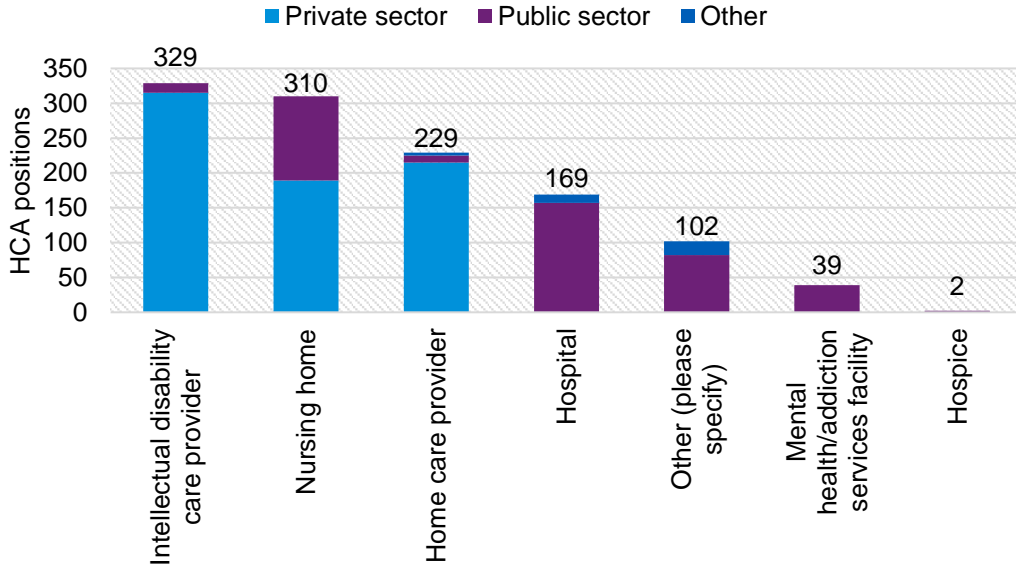


Figure 6-10: Open HCA positions at the time of survey by setting and public/private sector

According to the employers surveyed, 2,161 HCAs left their employment in 2023. The bulk of the HCAs that left employment were from the private sector (1,854 of 2,161) and predominantly from Nursing Homes (see Figure 6-11). This corroborates feedback from interviews and research quoted in the literature review, which identified high turnover rates for HCAs in nursing home settings.

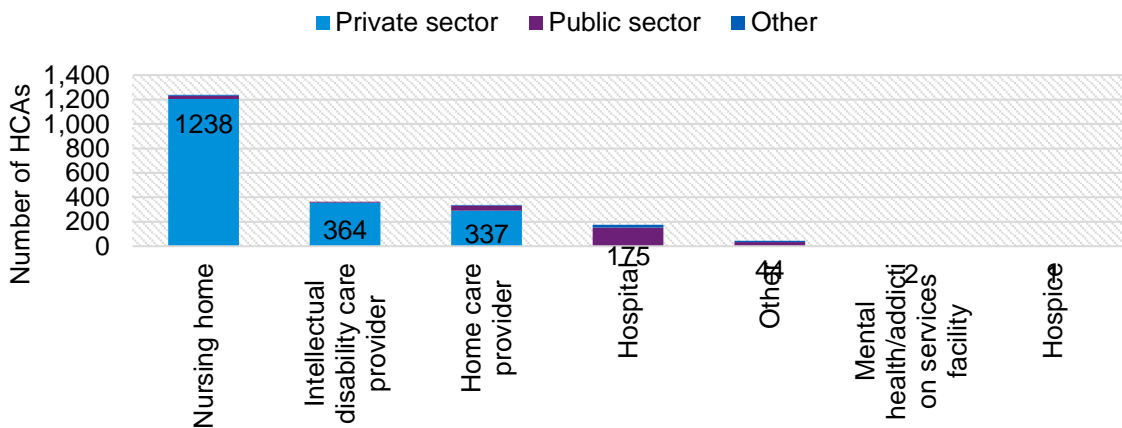


Figure 6-11: Number of HCAs that left employment in 2023 by setting and public/private sector

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Average hourly wages for HCAs are higher in the public sector.

Most private employers pay less than 17 Euros an hour to HCAs with more than 5 years of experience. In contrast, experienced HCAs in the public sector are mostly offered an hourly wage rate over 19 Euros an hour. The pattern in the difference in pay between HCAs in public and private sectors remains largely similar for those with less than 2 years of experience (see Figure 6-13).

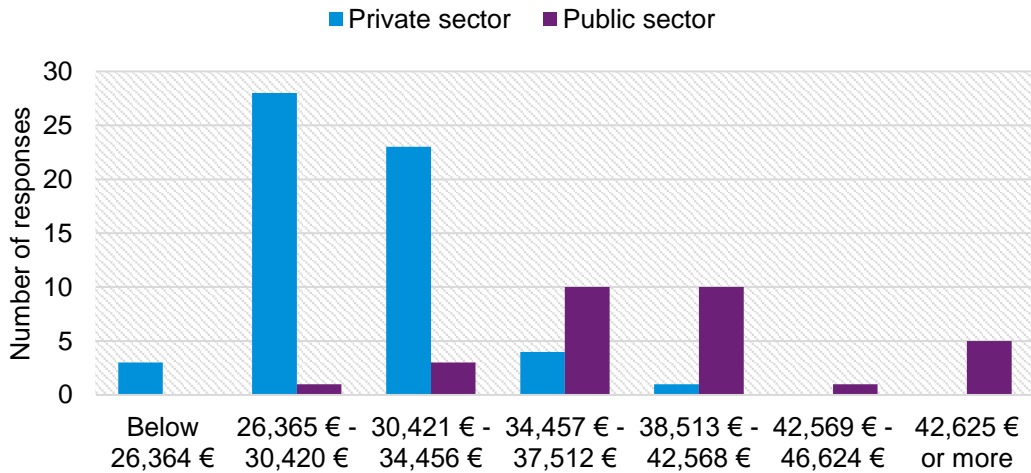


Figure 6-12: Average annual wages of HCAs with more than 5 years of experience by setting and public/private sector

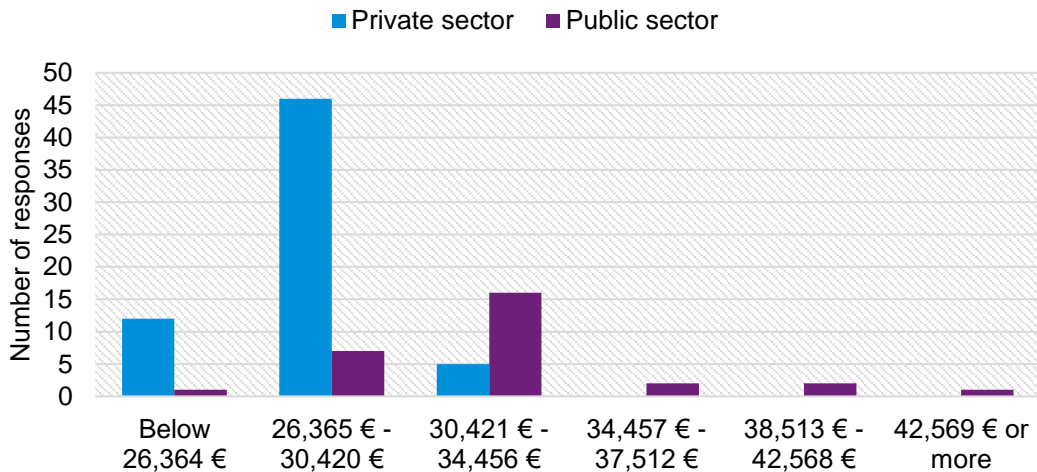


Figure 6-13: Average annual wages of HCAs with under 2 years of experience by setting and public/private sector

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According to the surveyed employers, recruitment over the years appears to be increasing over time. From 2021-2023, employers that recruited no HCAs and up to five HCAs decreased by 14% and 22% respectively. In the same period those employers who recruited more than 20 HCAs increased by 23% (see Figure 6-14).

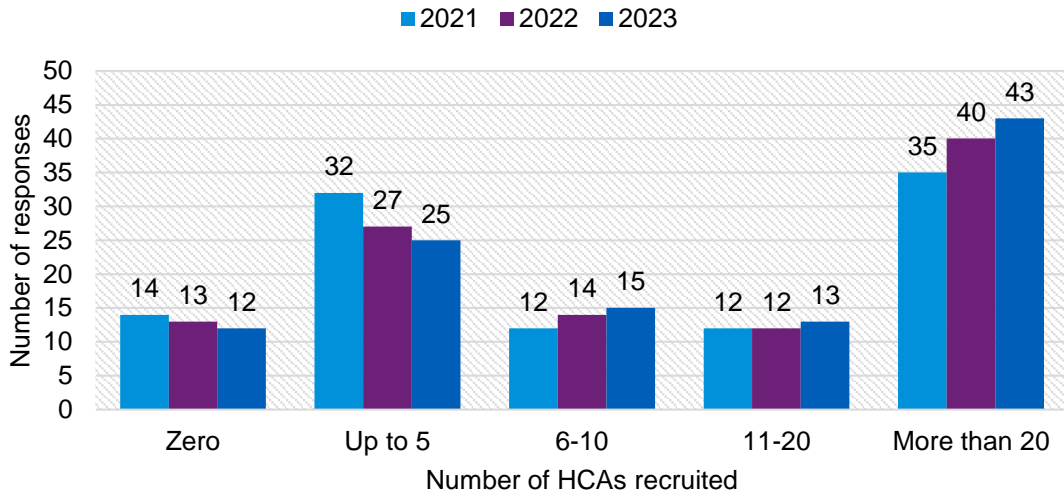


Figure 6-14: Overall recruitment in 2021, 2022, and 2023

6.1.3 Representative organisations

Out of the seven organisations that responded to the survey, four of them have up to 100 HCA member, two have between 100-999 HCA members, and one has more than 10,000 HCA members (see Figure 6-15).

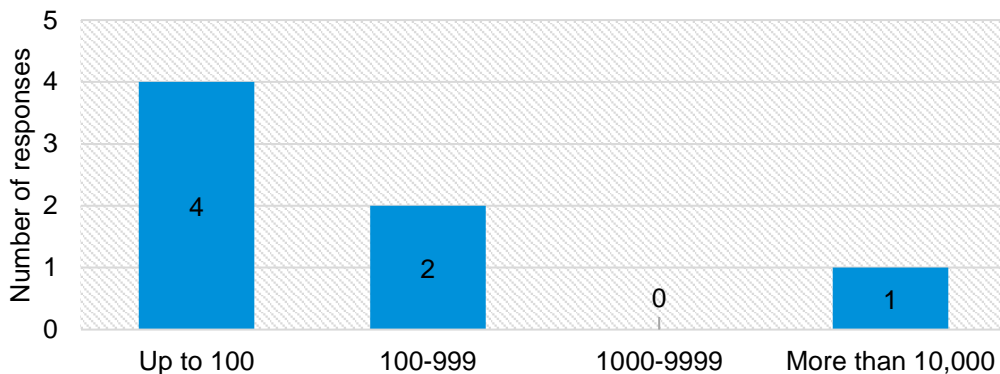


Figure 6-15: HCA members represented by organisations

There were two organisations that had no HCA members with permits. Almost half of the members of two organisations were HCAs who required employment permits. Out of the 7 surveyed organisations, the proportion of HCA members who needed a permit were

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85% in one organisation and 100% in another two organisations. In most organisations which responded, most of their HCA members required employment permits (see Figure 6-16).

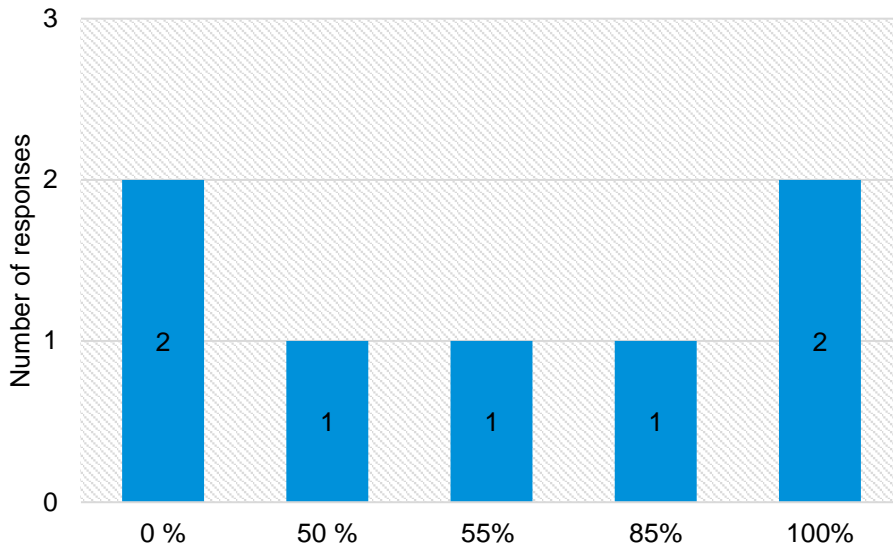


Figure 6-16: Proportion of HCA members that require employment permits

The average of hourly wages reported by organisations suggest that wages increase by years of experience. At lower levels of experience, i.e., under 2 years, HCAs members in hospitals get paid more (on average 15 €/hour) compared to nursing homes (on average 11 €/hour). But the gap closes at higher levels of experience where HCAs with 5 years of experience earn on average 25 €/hour in both hospitals and nursing home. It is not clear if the same holds true for those with employment permits, as the role was established in 2021 and has not yet been eligible for 5 years (see Figure 6-17).

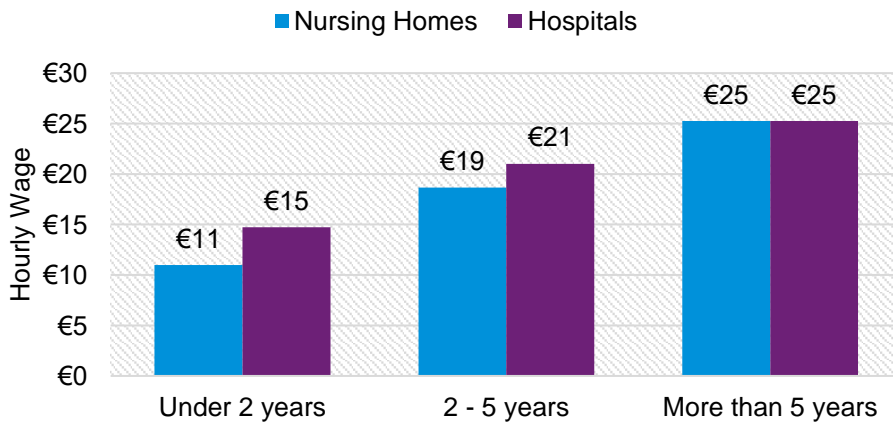


Figure 6-17: Average hourly wages of member HCAs by experience and setting

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6.1.4 Overall response

HCA, employers, and representative organisations answered the survey regarding how HCAs can be attracted to Ireland. Most cited required changes to attract HCAs in Ireland revolved around topics of pay (wages), recognition, work-life balance, family reunification visa issues, etc (see Figure 6-18).

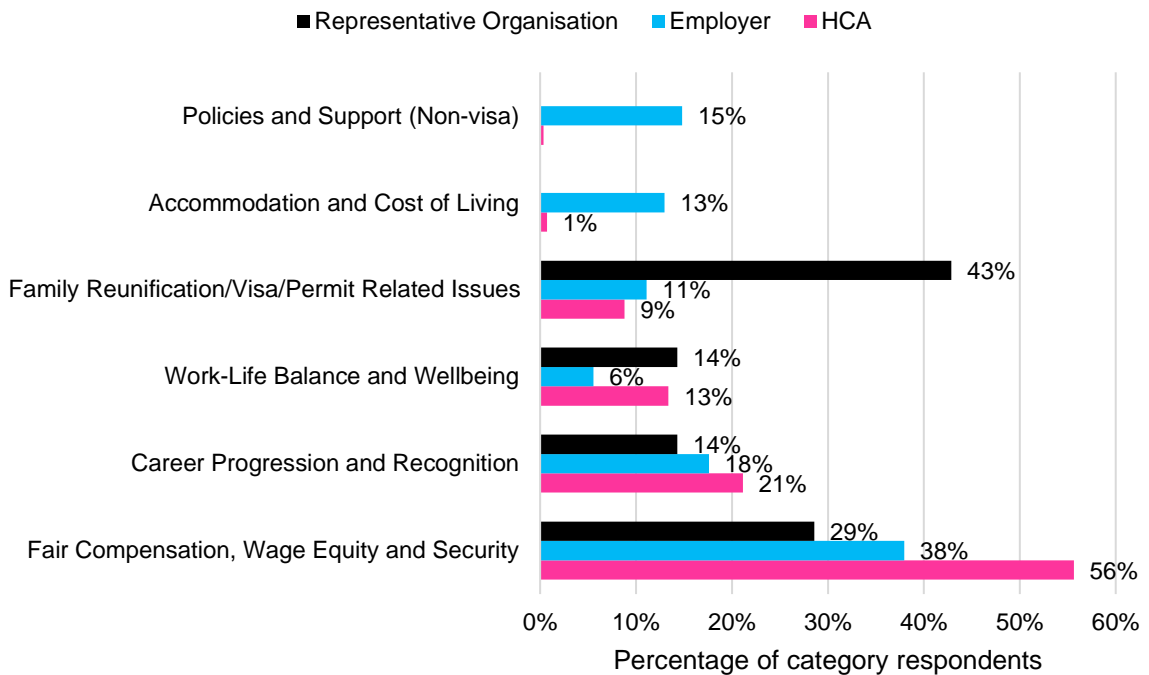


Figure 6-18: Changes required to attract more HCAs in Ireland

6.2 Interviews

We conducted interviews with seven organisations representing the sector and migrant labours.

The organisations interviewed were:

- SIPTU;
- Migrant Rights Centre Ireland (MRCI);
- Irish Association of Healthcare Assistants (IAHA);
- The HSE;
- Nursing Homes Ireland (NHI);
- Home and Community Care Ireland (HCCI); and
- The Private Hospitals Association (PHA).

6.2.1 HCA supply

We asked each interviewee whether they had observed any change in the availability of HCAs following the introduction of employment permits.

NHI reported that the employment permit scheme was significant and critical for private nursing homes to remain operational. By contrast, HCCI reported that the proportion of HCAs/home care assistants using employment permits was much lower and the impact had been much less significant. The Private Hospitals Association and HSE also reported that employment permits had had a limited impact on the supply of HCAs.

These responses align with the survey responses, which suggested that a high proportion of HCAs using employment permits work in private nursing home settings.

None of the interviewees reported noting a significant change in HCA vacancy rate since the introduction of employment permits. This could be because of the compensation packages offered to HCAs with permits. Low salaries offered to HCAs in the Irish private sector was frequently brought up in the interviews. According to HCCI, poor wages and inconsistent working hours makes the private sector unattractive for prospective home carers, especially compared to the competitive terms and conditions offered to them elsewhere in Europe. For example, HCCI remarked that in Germany, HCAs can avail of subsidised accommodation and German language lessons.

6.2.2 HCA employee flows and churn

NHI reported observing a consistent pattern of HCAs starting work in private nursing homes (either with or without employment permits), before transitioning to work in acute hospital settings. According to NHI this was due to the greater number of open roles available for HCAs in nursing homes, while roles in hospitals are more competitive because they can afford to offer higher salaries and better employment conditions.

Other interviewees acknowledged that they may have seen less impact from the introduction of employment permits for HCAs because they are more likely to work in the private nursing home sector. There may be a more widespread impact in future as HCAs renew their employment permits and seek to move from private nursing homes to other settings.

Employee churn was a much greater issue for private nursing home operators than for hospitals. However, hospitals noted challenges with HCA retention, particularly for staff who have recently received qualifications or completed training.

MRCI highlighted the lack of contract flexibility for HCAs on employment permits. These HCAs are effectively tied to their original sponsoring employer unless they can find an alternative employer willing to repeat the recruitment and sponsorship process.

6.2.3 HCA salaries

Interviewees were asked whether the €27,000 salary floor associated with the HCA employment permit had impacted salary expectations or growth in the sector.

The HSE noted that this salary floor falls below the bottom of its pay scale for HCAs and had therefore had no impact for them. The pay scales for HCAs in the HSE starts from €32,473.¹⁰ The PHA reported a similar lack of impact, as its members pay salaries at similar levels to the HSE to attract and retain staff.

HCCI remarked that the salary floor may fall above typical salaries for HCAs in a home care setting, but that this was highly unlikely to have affected salary expectations for this sector as the proportion of workers using employment permits is currently so low. However, they acknowledged that this situation may change as the scheme matures and more non-EEA HCAs begin working in the home care sector.

NHI reported that the €27,000 salary floor had effectively set a new salary expectation for all HCAs across the sector, increasing costs for private nursing homes. These higher wages do not appear to have attracted additional local talent. They remarked that the way nursing homes negotiate funding means it is critical that any increase in HCA salary thresholds is well signposted well in advance.

SIPTU suggested that the €27,000 salary threshold was acting as a ceiling rather than a floor and was in fact suppressing wage growth for HCAs in the private sector. They noted that the discrepancy between HCA pay in the private and public sectors existed before the introduction of employment permits and has not changed substantially since 2021. The discrepancy between HCA pay in the private and public sectors was also reported by IAHA.

MRCI contrasted the €27,000 salary floor against the minimum threshold for reunification of families, €30,000. They also noted that migrant HCAs face delays of several years before being able to have their spouses or children join them, as they need a minimum two years' income over the €30,000 threshold and the application and approval process for family reunification can last a year or more.

6.2.4 HCA skills, training and experience

Different settings reported different expectations for new HCAs. In HSE and private hospitals, HCAs must typically have completed a QQI Level 5 qualification in healthcare

¹⁰ This was reported by the HSE. €32,473 is for grade code 6075 (as of October 2023). As mentioned above, the staff group *Health Care Assistants* includes various roles. The team leader HCA salary starts at €37,697 whereas salaries for Care Assistants and Multi-Task Attendants, which are also included in this staff group, start at €30,755 and €32,473 respectively.

https://assets.hse.ie/media/documents/FINAL_Pay_Scales_for_1_October_2023-_V2.pdf



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or have a nursing qualification not recognised by the Nursing and Midwifery Board of Ireland (NMBI)¹¹.

By contrast, for nursing home and home care settings HCA candidates may not hold any healthcare qualifications, though they must show they are working towards achieving one.

Several interviewees highlighted the importance of HCAs also having strong verbal and written English skills, particularly in settings working with vulnerable or older patients.

IAHA also pointed out the lack of a clear pathway of learning/progression for HCAs with different qualifications.

¹¹ According to Section 22 of the Health Act 2004, prospective HCAs in the HSE must hold relevant health skills QQI (formerly FETAC) level 5 qualification OR relevant health care qualification/a comparable healthcare qualification as outlined in the Quality and Qualifications Ireland (QQI) NARIC Ireland framework OR be currently employed as an HCA/comparable role. See [230421 EC Health Care Assistant \(Apr 2023\) MS \(hse.ie\)](#).

7 HCA wages

One of the objectives of this report is to contextualise the current and projected salary thresholds for HCAs with employment permits.

Stakeholder consultations reveal that the average annual wages for HCAs are generally low especially in private nursing homes. Annual wages for HCAs are approximately €35,000 in Hospitals and around 30,000 in nursing homes. Permit holding HCAs in private nursing home are much lower at around €27,000 per annum. This threshold of €27,000 is aligned with the minimum wage prescribed by DETE to issue general employment permits to HCAs (see Table 6-1). Most of the consultations indicated that lower wages offered to HCAs make the role unattractive and leads to many HCAs move to other roles in the healthcare sector or other sectors (like retail).

In December 2023, the Minister of State for Business, Employment and Retail announced changes to the employment permit system. These changes include plans to increase the salary floor for HCAs to €30,000 in 2025, eventually rising to €39,000¹² by 2026¹³.

The current wage floor of €27,000 translates to €13.31 per hour. For comparison, the overall average hourly wage in the Irish economy in Quarter 1 2022 was €27.41¹⁴. At a sectoral level, the average weekly wage in the same period was €17.95 in Retail Trade and €14.90 in Food & Beverage Service Activities¹⁵. Competition from the retail sector was pointed out during the consultations.

The low wage floor under current and future expected inflationary pressures will make the role of HCA more unattractive.

Consultations also revealed the desire and wish of permit-holding HCAs to bring their families – family reunification. General employment permit holding HCAs with the current minimum yearly salary of €30,000 are allowed to bring their spouses to Ireland after waiting an initial 12 months. The current legislation prescribes them to have much higher salaries for their children to join them in Ireland¹⁶.

¹² Using year-on-year inflation rate and assumes the rate in 2026 is the same as 2025. Please refer https://economy-finance.ec.europa.eu/economic-surveillance-eu-economies/ireland/economic-forecast-ireland_en

¹³ In 2026, after considering inflation (HICP), this will be around €34,500.

¹⁴ <https://www.cso.ie/en/releasesandpublications/ep/p-ire/irelandsretailleconomy2022/keyfindings/>

¹⁵ Average weekly wages were €484.53 in Retail Trade and €378.52 in Food & Beverage Service Activities. In the same period, average number of weekly hours worked was 27.0 hours in Retail Trade and 25.4 hours in Food & Beverage Service Activities.

¹⁶ Members of the Steering Group representing the private sector noted difficulties in implementing the proposed salary increment for HCAs.

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Table 7-1: Minimum salary requirements for reunification and comparisons for different wage floors

Type	Minimum Requirement for Reunification		Minimum Wage Comparisons			
	Weekly (net) ¹⁷	Annual (gross)	Sector/ Role	Annual (gross) ¹⁸	Weekly (net)	Reunification with children Eligibility
Only Spouse	-	€30,000 ¹⁹	HCA (2023 level)	€27,000	€491	No
Spouse + 1 child	€645	-	HCA (higher)	€30,000	€537	No
Spouse + 2 children	€746	-	HCA (2024 level)	€34,000	€592	No
Spouse + 3 children	€847	-	HCA (2026 level)	€36,000	620	No
Spouse + 3 children	€938	-				
Spouse + 4 children	€1064	-				

¹⁷ Levels of income used for qualifying for Working Family Payment are used to determine the required salary. <https://www.citizensinformation.ie/en/social-welfare/families-and-children/working-family-payment/>

¹⁸ The approximate weekly net salary assumes a married individual aged 30 in 2023 with dependent children, paying a full PSRI rate, with no employee contributions, no rental income, spouse not earning, and no additional tax credits/reliefs.

¹⁹ <https://enterprise.gov.ie/en/what-we-do/workplace-and-skills/employment-permits/permit-types/general-employment-permit/>

8 Data analysis

This section describes the data we collected and analysed to inform construction of the expandable HCA model.

The data sources used include 2011, 2016 and 2022 Censuses, the CSO's population projections, HSE employee census, DH published data on hospital procedures, and Census data on nursing home residents.

In summary,

- Based on the population levels from 2016 and 2022 Censuses, the share of older people in Ireland is going up.
- The proportion of people in each age group living in nursing homes decreased slightly between 2011 and 2016, but it is not clear whether this trend has continued.
- In-patient hospital bed days for older cohorts are decreasing slightly over time.
- The employment of HCAs in the public sector is growing.

8.1 Population projections

Population levels by age are an important input into both the demand and supply sides of the expandable HCA employment model.

We extracted historical data on population by age band from the 2016 and 2022 Censuses. For simplicity, we assumed linear population growth between these two points.

The CSO published its latest population projections in 2016 covering the period from 2017 to 2036. In the baseline model, we have used the CSO's "M2F2 Dublin Inflow" projection scenario. The expandable model allows testing of alternative population growth scenarios.

To reconcile the CSO's population projections with the 2022 Census, we have taken the Census population in 2022 as a starting point and applied the annual growth rates from the CSO's projections to those figures in subsequent years (see Figure 8-1).

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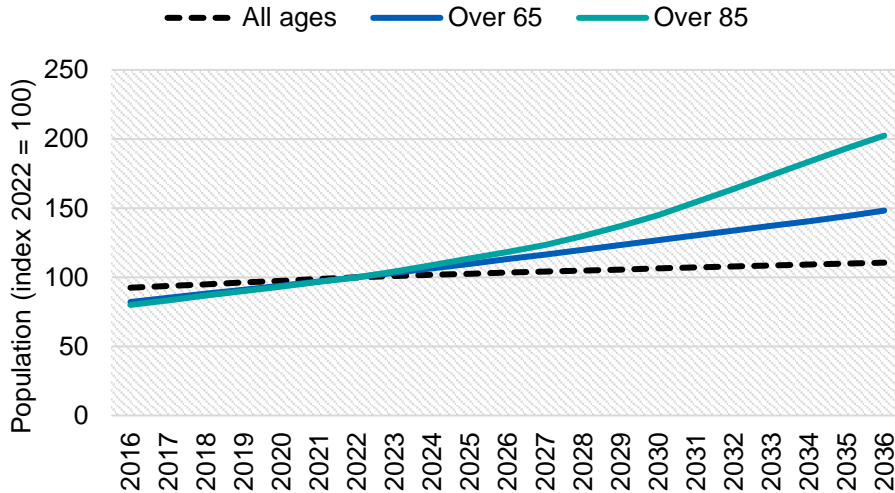


Figure 8-1: Population growth projections by age band²⁰

8.2 CSO: nursing home residents

The CSO has not yet published data on the number of people aged 65 and over with a nursing home as their primary residence. We have therefore used data from the 2011 and 2016 Censuses to estimate a 2022 population living in nursing homes.

The 2011 and 2016 Censuses provide a breakdown of nursing home residents by single year of age (from 65 years to 100 years). We categorised this data into three age bands: 65-74, 75-84, and 85+ and calculated the proportion of people in each age band living in a nursing home. We then applied these propensities to the 2022 population to estimate nursing home residents in that year (see Table 8-1).

This analysis suggests that in 2022 there were 29,781 older adults (aged 65 or above) living in nursing homes. Among them, 4,161 were aged 65 to 74, 10,589 aged 75 to 84 and 15,031 aged 85 and above.

²⁰ Source: KPMG Future Analytics using [CSO population projections](#).

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Table 8-1: Nursing Home residents aged above 65 years and the propensity to be in a Nursing Home by age category²¹

	Nursing Home Residents			Propensity of being in a Nursing Home		
	65-74	75-84	85+	65-74	75-84	85+
2011	2,879	7,669	10,254	1.0%	4.6%	18.5%
2016	3,367	7,941	11,454	0.9%	4.2%	17.8%
<i>Average</i>				1.0%	4.4%	18.2%
2022	4,161	10,589	15,031	1.0%	4.4%	18.2%

8.3 Department of Health: in-patient bed days

The Department of Health publishes data on In-Patient and Day case Procedures and Average Length of Hospital Stay. Data from 2016 to 2021, categorised into various age groups was used to identify the number of in-patient bed days for individuals across different age groups, including those under 65, aged 65 to 74, 75 to 84, and over 85. Population projections are then used to calculate the average number of bed days per person for various age groups (see Table 8-2). On average less than one bed day (0.3) is required per person if they are below 65, whereas more than 6 bed days (6.2) is required for older people (those aged above 85).

Table 8-2: In-Patient Bed Days related to all procedures (DH, 2016-2021).

	In-Patient Bed Days				In-Patient Bed Days per person			
	Below 65	65-74	75-84	85+	Below 65	65-74	75-84	85+
2016	1,294,540	562,032	710,461	444,059	0.314	1.505	3.616	6.573
2017	1,297,508	572,986	716,727	459,343	0.311	1.489	3.487	6.528
2018	1,311,397	597,775	747,902	481,386	0.312	1.509	3.485	6.578
2019	1,310,520	608,591	766,001	493,024	0.308	1.494	3.425	6.487
2020	1,178,774	551,937	672,930	424,819	0.275	1.319	2.891	5.390
2021	1,248,316	564,633	709,327	447,087	0.288	1.314	2.934	5.477
<i>Average</i>					0.301	1.438	3.306	6.172

²¹ Source: KPMG Future Analytics using CSO Census 2011, 2016 and 2022. Source: KPMG Future Analytics using [CSO population projections](#).

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8.4 Health Service Personnel Census (HSPC)

The number of HCAs employed through the HSE²² are reported every month in the Health Care Service Personnel Census Reports from 2019 to 2023. HCAs employed through the HSE includes those working in acute and community settings. HCA employment did not see much change in 2019 whereas it increased for the most part in 2020, 2021, and 2023. As of December 2023, almost two thirds of the HCAs employed through the HSE were working in the community sector (13,505 of 20,255). The rest were employed in Acute services (6,736 of 20,255) (see Figure 8-2).

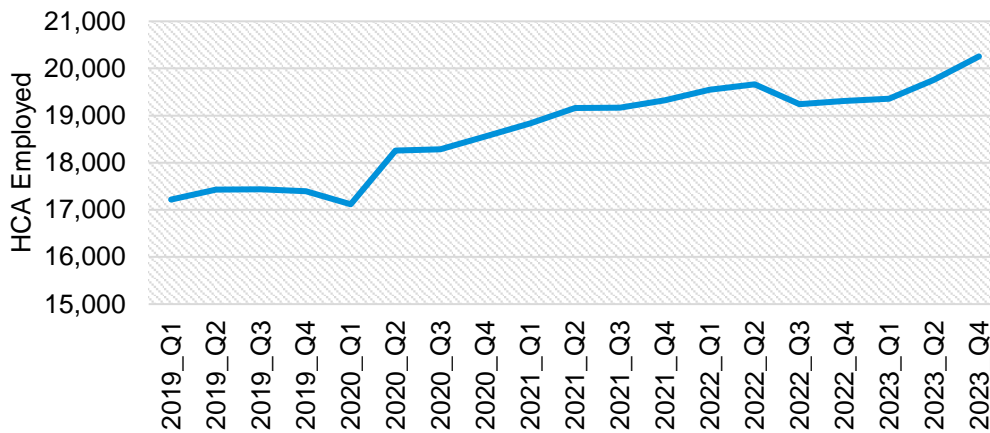


Figure 8-2: HCA employment by HSE, Section 38 Hospitals, and Voluntary Agencies

²² This includes HCAs employed by the HSE, Section 38 Hospitals, and Voluntary Agencies

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8.5 Data on HCA employment permits

Employment permit data provided by DETE (from October 2021 to April 2024) shows that almost three quarters of the HCA permits issued in this period were for HCAs in nursing homes.²³ Around 20% were issued for HCAs working in disability support.²⁴ The data also suggests there are fewer than 30 HCAs working with employment permits in HSE settings and 347 working in voluntary settings and agencies, representing 1.9% of all HCAs recorded in the Health Service Personnel Census (see Figure 7-3).

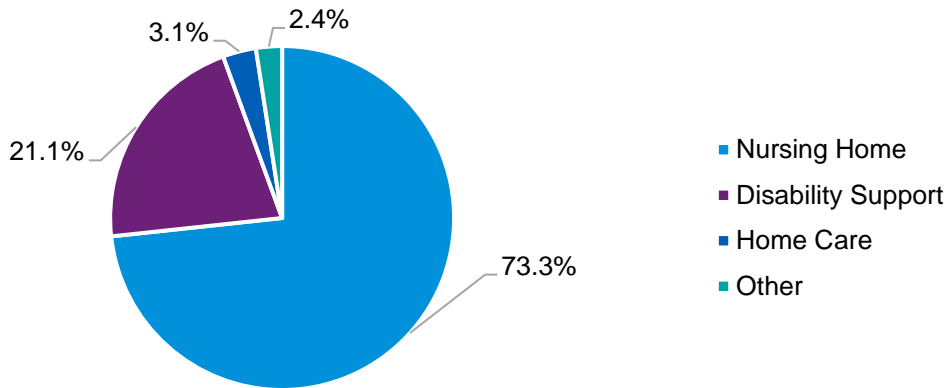


Figure 8-3: Percentage of employment permits issued to HCAs by healthcare setting (October 2021 - April 2024)

²³ 73.3% permits were for HCAs working in Nursing Homes. The breakdown of this is as follows: 67.9% in the private sector, 5.1% in the voluntary sector, and 0.4% in the public sector.

²⁴ 3.1% of permit issued HCAs worked in Home Care. Also 2.4% permit issued HCAs worked in other setting (this includes 0.1% working in acute hospital setting).

9 Expandable employment market model

In this study, we have developed an employment market model that predicts the supply and demand for HCAs to 2035, to help DETE understand the impact of different population growth and policy scenarios.

The model is “expandable” in that it has the flexibility to accommodate additional variables and assumptions. For example, the model can be adjusted to account for updated population projections when these are published by the CSO.

The model comprises two main components, predicting the demand for HCAs and the supply of native/EEA HCAs.

9.1 Demand model

The figure below shows the structure of the model we have constructed for projecting HCA employment need-based demand. Throughout the report, this need-based demand is referred to as “*demand*”. The model comprises the following elements:

- Calculate demand for HCAs in hospital settings by taking the population segmented by age and multiplying by the propensity for each age group to be hospital in-patients and the number of HCAs required per in-patient;
- Calculate demand for HCAs in nursing home settings by taking the population segmented by age and multiplying by the propensity for each age group to reside in nursing homes and the number of HCAs required per resident; and
- Calculate demand for HCAs in other settings (such as disability care and home care) by assuming this is a fixed percentage of demand in hospital and nursing home settings.²⁵

²⁵ The study assumes residual demand for HCAs from other settings to be fixed at the 2020 levels (see <https://www.drugsandalcohol.ie/32885/>). An increase in the population of older cohorts could change this share. The model does not capture substitution between hospitals/nursing homes and other care settings, i.e., the study assumes those who need to be admitted to hospitals or resided at nursing homes will not switch to other healthcare settings. Even if older cohorts substitute between these settings, they are still going to need HCA assistance – hence the demand for HCAs persists.

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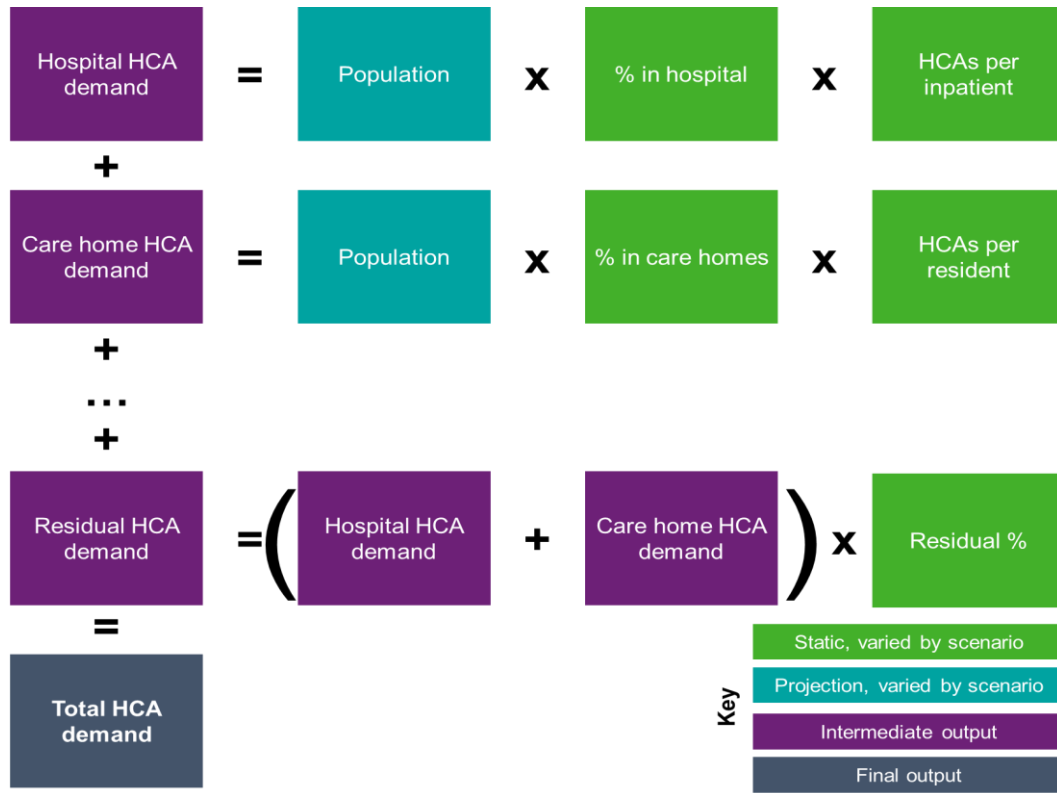


Figure 9-1: Illustrative structure of the expandable HCA employment demand model

This model effectively assumes that:

- The propensity for people in each age group to spend time in hospital or residential care/demand home care does not substantively change over time²⁶;
- The number of HCAs required per in-patient/nursing home resident/home care user does not change over time; and
- The proportion of HCAs working in hospitals, nursing homes, and home care as a percentage of all HCAs remains the same over time.

We have the option of varying each of these assumptions in scenario testing later if desired. In particular, it may be helpful for DETE to consider alternative scenarios where the propensity for different age groups to require care in hospital or nursing homes falls

²⁶ For each of the age cohorts, the number of residents in different health settings (Hospitals, Nursing Homes) are separately identified using the Census data. The corresponding population figures are also taken from the Census. For example, for nursing homes, dividing these two numbers for the age cohort above 85 will give the propensity – meaning how many out of 100 individuals aged above 85 will reside in nursing homes. Calculations based on Census 2011 and 2016 shows that these propensities for age cohorts do not change much over time. For example, the propensity for those aged 85+ to be residents of a Nursing home is 0.18 (in 2011) and 0.17 (in 2016). Research published by the ESRI in 2017 suggested using a “Dynamic Equilibrium” assumption for modelling long-term care residents, which decreased the propensity for over-65s to live in long-term care from 4.5% in 2015 to 4.4% in 2030; given the very small difference in propensity here we have opted to use a static propensity assumption for simplicity.

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as people age more healthily or where the number of HCA care hours required per patient/resident rise due to increasing complexity of care.

Please refer to Appendix A (page 48) for further detail on the demand model’s construction and underlying assumptions.

9.1.1 Demand model results

The results of the demand model indicate an upward trend for the demand for healthcare assistants (HCAs) over the coming years. The model predicts that 65,272 HCAs (FTE) were required to cater to the Irish population in 2023, with demand rising exponentially in line with older population growth to 104,196 by 2036 (see Figure 9-2).

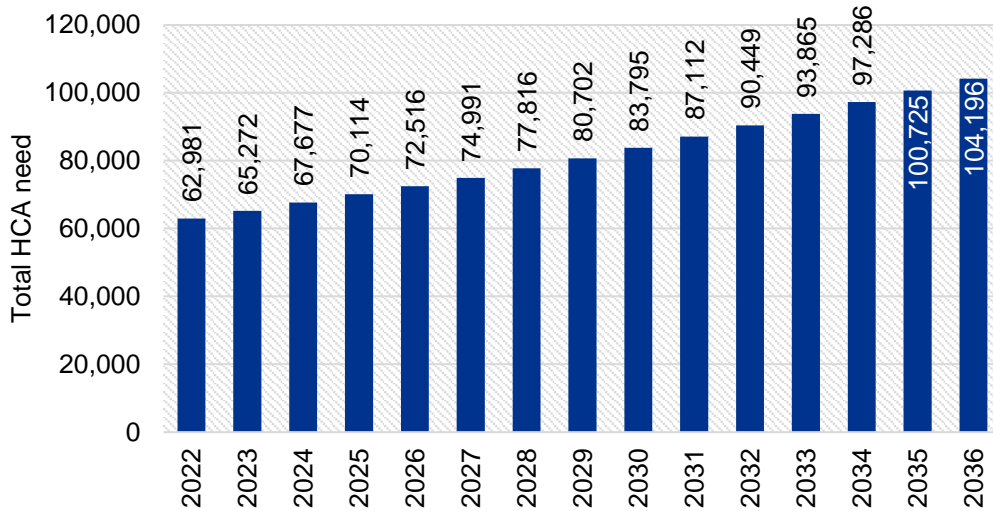


Figure 9-2: Projected HCA demand

The predicted HCA demand in 2023, 65,272, is higher than the number of HCAs working at that time, which was 59,707. This discrepancy reflects a shortfall in HCA supply, implying some combination of:

- HCAs working overtime, and/or
- Patients/residents receiving informal care from family members or friends, and/or
- Patients/residents receiving fewer hours of HCA care than they would like.

The model results suggest that HCA demand will grow annually by 3.5% to 4.0% for the next 12 years. This corresponds to an average annual growth of 4.1% of HCAs in Nursing Homes and 2.3% HCAs in Hospitals until 2036 (see Figure A-2 in Appendix A).

This projected increase in demand for HCAs in Ireland takes in account of Ireland’s ageing population and the demand for healthcare at the 2021/22 levels. In addition to demographic factors, there are other factors that could impact the demand for HCAs (e.g., advances in medical technology, evolving healthcare policies, increasing complexity of care, etc). These are not incorporated in the model.

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The upward trend in HCA requirements suggests several underlying factors influencing healthcare services. Population growth, an ageing population requiring increased care, and evolving healthcare policies are among the contributing elements. As the population expands and life expectancy rises, there is a corresponding rise in the demand for healthcare services and support staff.

9.2 Supply model

Figure 9-3 below summarises the structure of the model we have used to estimate the supply of HCA employees. The model comprises the following elements:

- Calculate and/or model the current HCA workforce across different settings using data published by the Health Service Personnel Census and gathered in interviews with Nursing Homes Ireland, the Private Hospitals Association, and Home and Community Care Ireland; and
- Project the supply of domestic and EU HCAs with reference to working age population projections.

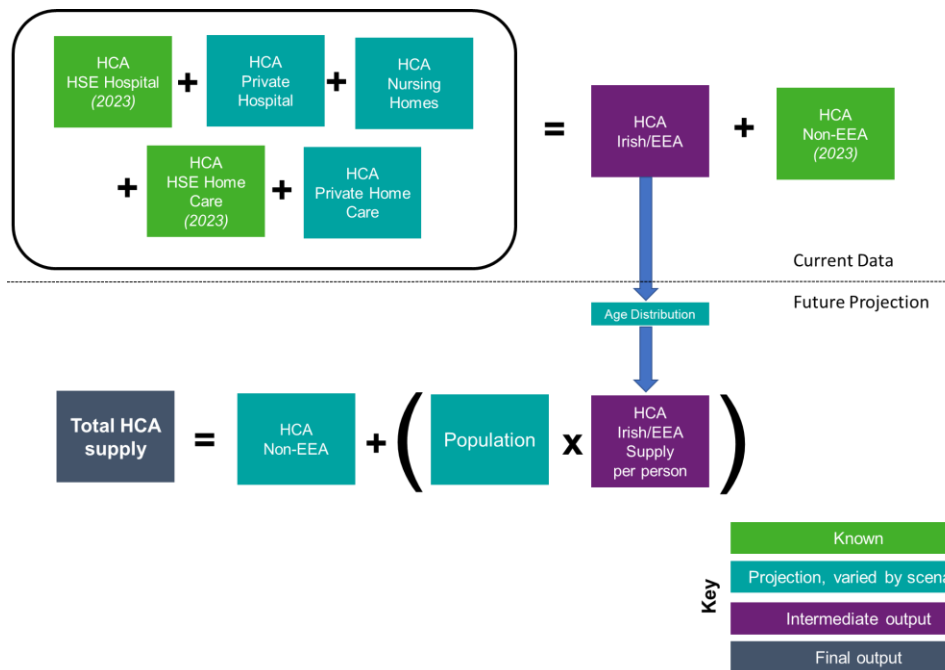


Figure 9-3: Illustrative structure of the HCA employee supply model

We have used this model to estimate a value for total current HCA supply (i.e., in 2023) and to project the supply of HCA employees from domestic and EU sources to 2036.

This model assumes that the proportion of the working-age population choosing to work as HCAs remains constant over time.

We also assume that the availability of non-EEA HCAs through employment permits is determined by other factors such as migration policy and competition for talent from other

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states. The supply of HCAs with employment permits is therefore set and can be varied to reflect different scenarios.

9.2.1 Supply model results

The supply model suggests that a total of 59,707 HCAs were employed across the State in 2023, comprising approximately 5,656 with employment permits and 54,051 without (either Irish/EU nationals or working in the State with other visas).

The number of HCAs increased by 28% between 2019 and 2023, representing a compound annual growth rate of 6.3%. Excluding HCAs with employment permits, total HCA employment growth was 16% and compound annual growth was 3.7%.

In our baseline scenario we have assumed that the proportion of the working age population choosing employment as HCAs remains constant, i.e. that the supply of Irish/EU national HCAs will increase in line with the projected growth in working age population. This suggests the domestic/EU HCA workforce will increase by 8% between 2023 and 2036, which represents annualised growth of just 0.6% (see Figure 9-4).

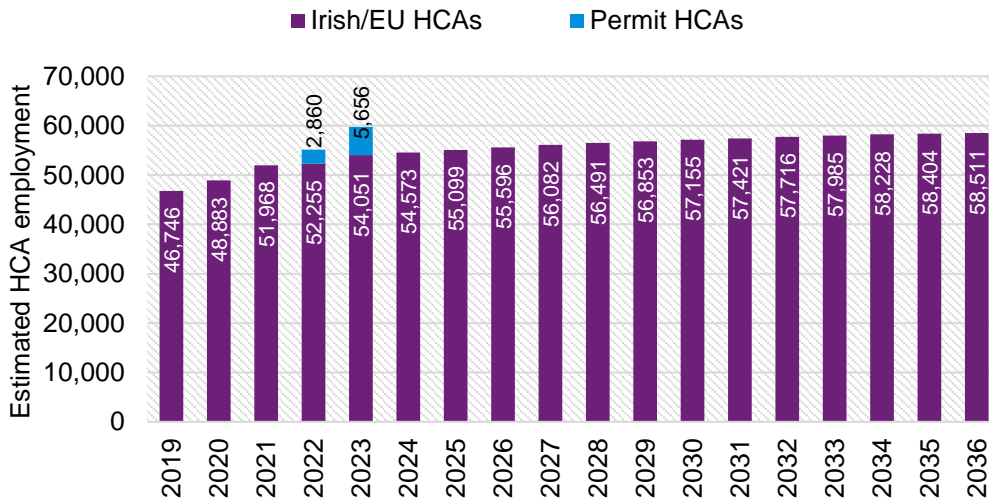


Figure 9-4: Historical and projected supply of HCAs

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9.3 Demand and supply compared

Comparison of our baseline models of HCA need and supply suggest there is unmet demand for HCAs in Ireland. The difference between HCA supply and demand is likely to grow over the coming decade (see Figure 9-5).

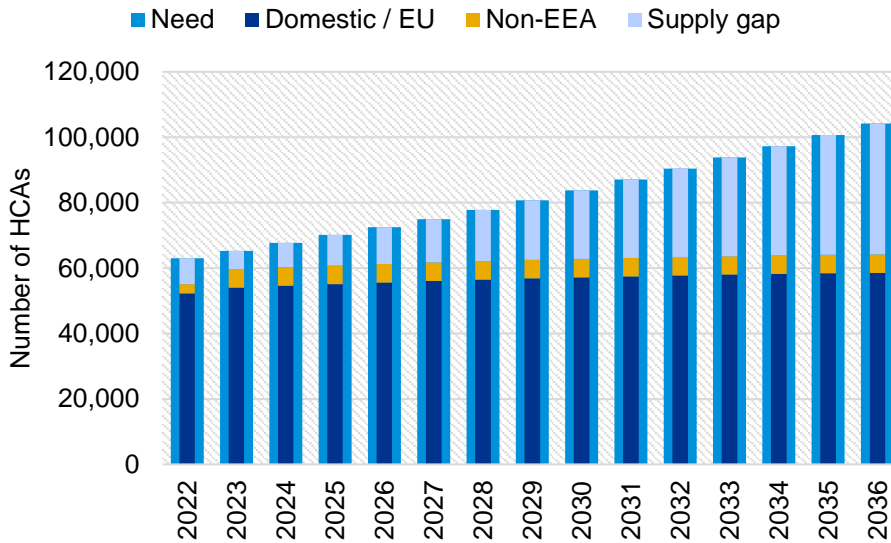


Figure 9-5: Projected demand and supply of HCAs by origin

9.4 Wage sensitivity testing

The expandable model suggests that Ireland will experience a growing shortfall of HCAs at current levels of recruitment domestically and from overseas. Higher wages for HCAs may help to mitigate this in the short run, but the effect would gradually diminish in the long run.

Increasing wage thresholds to levels that are still competitive will encourage people to work and increase their supply of labour.²⁷ This will also depend on the level of employment (i.e., full employment or not) and on wage elasticities of labour.²⁸ For this analysis we considered wage elasticities of 0.5 (moderately wage elastic) and 0.9 (highly wage elastic) are considered for this analysis.²⁹

Even when applying the simplifying assumption that HCA salaries rise immediately from €27,000 to €39,000 in 2024, the increase in labour supply does not completely mitigate the current shortfall and a more significant shortfall still emerges later in the

²⁷ <https://docs.iza.org/dp3150.pdf>

²⁸ If wage elasticity of labour is at 0.5, then a 10% increase in wages will lead to a 5% increase in labour supply. A comprehensive review on wage elasticities can be found at <https://d-nb.info/1190747154/34#:~:text=The%20first%20empirical%20effort%20known,his%20Theory%20of%20Wages>.

²⁹ Note that these figures represent relatively high wage elasticities.

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forecast period. The extent to which wage increases mitigate the shortfall of HCA labour depends on the strength of the relationship between wages and labour supply. Even at high elasticity levels, the effect diminishes gradually and results in a shortfall of more than 32,000 HCAs in 2036 (see Figure 9-6).

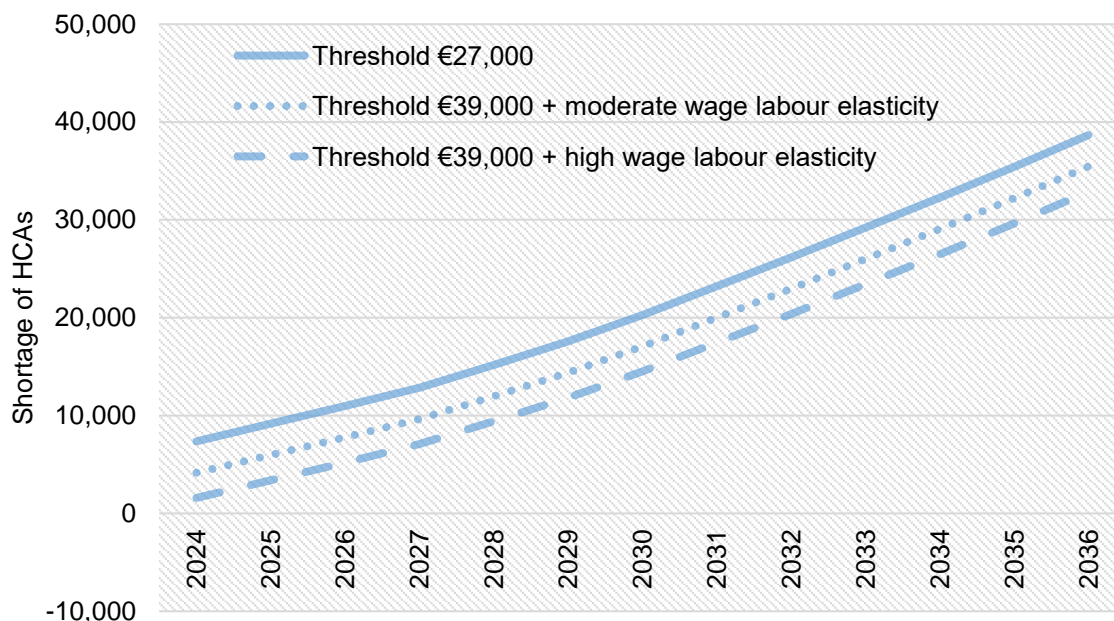


Figure 9-6: Impact of increasing wage thresholds in 2024 at different wage elasticities of labour³⁰

The model took a more optimistic approach by assuming that there is a significant supply of available EEA workers ready to work as HCAs at higher wages. The model also assumes that not all available jobs are currently filled (not in full employment). In the case of full employment, the reduction of the shortage of HCAs in the short run might not be feasible without employees from other sectors moving to the healthcare. The model also assumed relatively high wage elasticities of labour for HCAs.

However, wage/labour supply sensitivities are only valid over a small range of wage changes. For more substantive wage increases, the effects may be different. For example, when average HCA wages exceed typical wages in retail or hospitality by some threshold, we might see a step change in labour supply. This will also change the nature of the labour pool and will also have implications on the wage elasticities.

³⁰ Except for the wage threshold assumption, refer to the start of section 7 for all other assumptions that were considered.

10 Sensitivity analysis

All the scenarios have the following common assumptions:

- Population³¹
 - Total fertility rate is assumed to decrease from 1.8 in 2016 to 1.6 by 2031 and to remain constant thereafter to 2036 (F2)
 - Mortality rates for males and females are assumed to improve at 2.5% and 2.0% per annum respectively to 2036.
 - 2016 internal migration flow of -4,400 per annum from Dublin is assumed to revert to a pattern of +2,100 inflows from other regions to Dublin per annum by 2021 and remaining constant thereafter (Dublin Inflow).
 - High net migration of +30,000 per annum to 2036 (M1)
- 22% of EU HCAs are assumed to work in private nursing homes and care homes, where salaries are comparatively lower.³²
- Non-EU recruitment of HCAs is assumed to remain constant at the 2023 level.
- Year-on-year inflation (HICP) is assumed to be 2.2% in 2024 (Economist Intelligence Unit) and 2.0% for the period 2024-2036 (ECB target).
- Wage elasticity of labour is assumed to be 0.5 (i.e., a 10% increase in wages will lead to a 5% increase in labour supply).³³
- Wage threshold is assumed to be a minimum of €27,000.³⁴

Demand scenarios were determined in consultation with DETE. These scenarios are intended to illustrate how the model's results vary with respect to different input assumptions, and should not be interpreted as forecasts.

³¹ Sensitivity tests for different population projections did not make a material difference in the model projections.

³² This is guided by the survey results.

³³ Sensitivity tests at different wage elasticities of labour supply did not make a material difference in the model projections.

³⁴ Sensitivity tests indicate no material differences in projections when thresholds are increased (see in appendix). As per the Employment Permits Bill 2022 (https://data.oireachtas.ie/ie/oireachtas/bill/2022/91/eng/ver_b/b91b22d.pdf), the wage threshold will at minimum increase at the same rate as average weekly earnings as reported by the CSO.

10.1 Scenario 1: S1 (Baseline)

In addition to the common assumptions, the baseline scenario assumes that each patient in a hospital receives 4 hours of care from HCAs, while each patient in a nursing home receives 3.5 hours of daily HCA care. It also assumes that the likelihood of someone living in a nursing home remains at the average level between 2011 and 2016.³⁵

This scenario projects an increasing shortage of HCAs – a shortage of 7,359 HCAs in 2024, rising to 38,657 in 2036 (see Figure 10-1).

10.2 Scenario 2: S2 (Streamlined Care)

In addition to the common assumptions, the S2 scenario assumes that each patient in a hospital/nursing home requires 10% less care time compared to the baseline. It also assumes that the likelihood of someone living in a nursing home remains is at the average level between 2011 and 2016. This scenario projects an increasing shortage of HCAs – a shortage of 587 HCAs in 2024, rising to 28,195 in 2036. Compared to the baseline the shortage of HCAs is smaller when less HCA care is required in the healthcare sector.

While we have labelled this scenario “Lower Care Burden” for the sake of brevity, it is important to note that the change in assumptions merely reflects a reduction in the number of hours of HCA care received per patient/resident per day. This may come as a result of efficiency improvements, for example through investment in new technology or innovative new care techniques. However, it may alternatively be used to represent a scenario where patients and residents receive a lower standard of care (see Figure 10-1).

10.3 Scenario 3: S3 (Streamlined Care + High Propensity to be in a NH)

In addition to the common assumptions, the S3 scenario assumes that each patient in a hospital/nursing home requires 10% less care time compared to the baseline. This scenario also assumes that the likelihood of someone living in a nursing home (NH) increases by 15% compared to the baseline.

This scenario projects an increasing shortage of HCAs – a shortage of 7,160 HCAs in 2024, rising to 38,933 in 2036. The reduction in the need for HCA services because of fewer care hours is mostly balanced by the increase in demand through the higher likelihood of being in a nursing home (see Figure 10-1).

³⁵ The HCA care requirement hours are based on information gathered during the consultations.

10.4 Scenario 4: S4 (Streamlined Care + Low Propensity to be in a NH)

In addition to the common assumptions, the S4 scenario assumes that each patient in a hospital/nursing home requires 10% less care time compared to the baseline. This scenario additionally assumes that the likelihood of someone living in a nursing home (NH) decreases by 15% compared to the baseline.

This scenario projects an excess of HCAs from 2024-2028 followed by an increasing shortage of HCAs for the remaining period – an excess of 5,986 HCAs in 2024, transitioning to a shortage of 17,458 in 2036. The reduction in the need for HCA services and the lower likelihood of being in a nursing home results in an overall low demand for HCAs in the sector. This scenario projects the smallest shortage (see Figure 10-1).

10.5 Scenario 5: S5 (Enhanced Care Burden)

In addition to the common assumptions, the S5 scenario assumes that each patient in a hospital/nursing home requires 10% more care time compared to the baseline. It also assumes that the likelihood of someone living in a nursing home remains is at the average level between 2011 and 2016.

This scenario projects an increasing shortage of HCAs – a shortage of 14,131 HCAs in 2024, rising to 49,119 in 2036. Compared to the baseline the shortage of HCAs is bigger when more HCA care is required in the healthcare sector (see Figure 10-1).

10.6 Scenario 6: S6 (Enhanced Care + Low Propensity to be in a NH)

In addition to the common assumptions, the S6 scenario assumes that each patient in a hospital/nursing home requires 10% more care time compared to the baseline. This scenario additionally assumes that the likelihood of someone living in a nursing home (NH) decreases by 15% compared to the baseline.

This scenario projects an increasing shortage of HCAs – a shortage of 6,097 HCAs in 2024, rising to 35,995 in 2036. The greater need for HCA services because of more care requirements is mostly balanced by the decrease in demand through the lower likelihood of being in a nursing home (see Figure 10-1).

10.7 Scenario 7: S7 (Enhanced Care + High Propensity to be in a NH)

In addition to the common assumptions, the S7 scenario assumes that each patient in a hospital/nursing home requires 10% more care time compared to the baseline. This scenario additionally assumes that the likelihood of someone living in a nursing home (NH) increases by 15% compared to the baseline.

This scenario projects an increasing shortage of HCAs – a shortage of 22,165 HCAs in 2024, rising to 62,243 in 2036. The greater need for HCA services and the higher

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likelihood of being in a nursing home results in an overall high demand for HCAs in the sector. This scenario projects the highest shortage (see Figure 10-1).

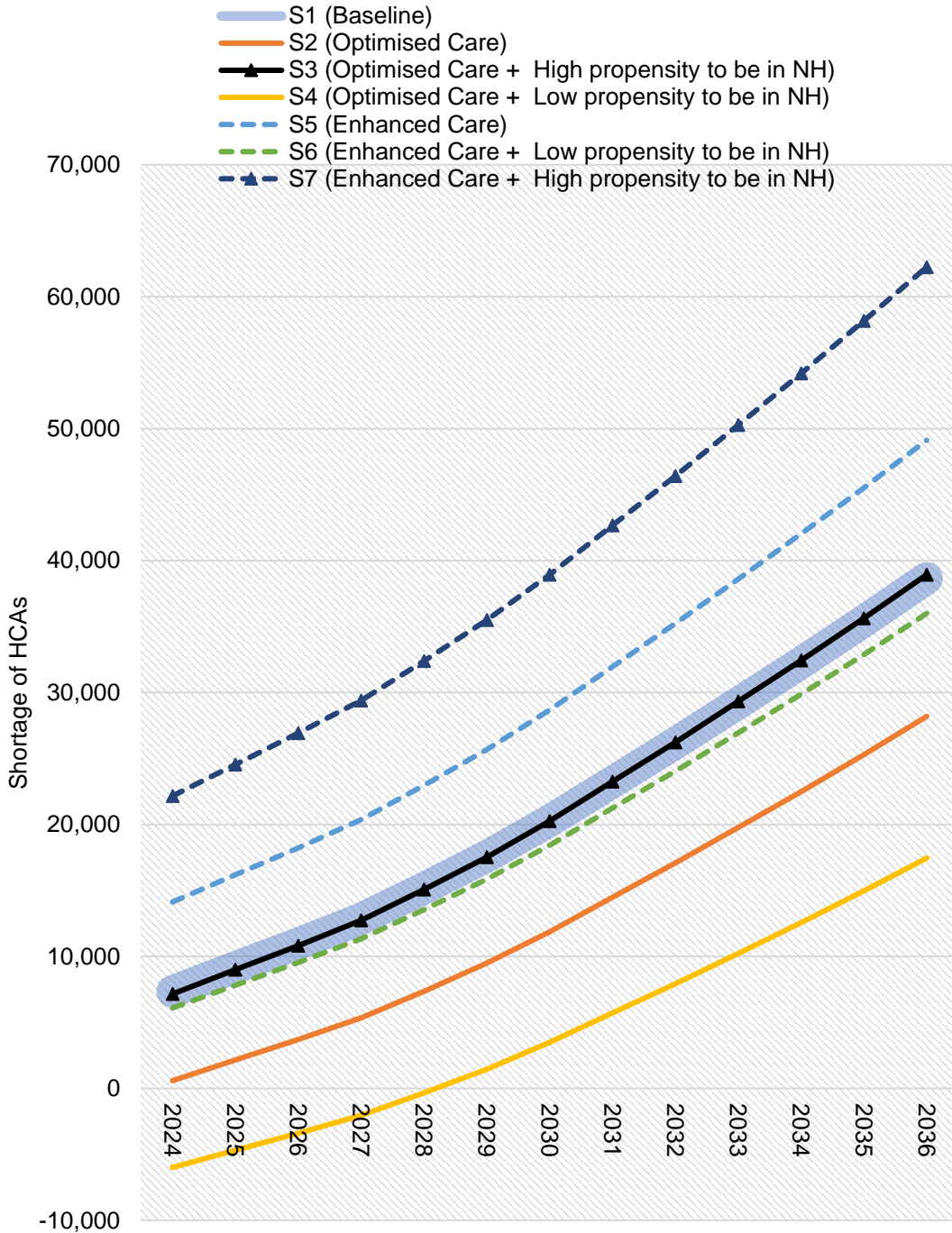


Figure 10-1: Projected shortage of HCAs by scenarios

A Appendix: model structure and assumptions

A.1 Demand model

The following section describes the model used to estimate the demand³⁶ for Health Care Assistants (HCAs). We assume that the demand for HCAs originates from Nursing Homes, Hospitals, and other settings. We calculate the propensity for each relevant age group to require care in each of these settings to estimate the number of residents and patients. We then estimate the total number of HCA hours needed to satisfy their care needs and use this figure to estimate total HCA employee demand.

In the baseline case, demand for HCAs varies primarily with reference to population projections, especially the anticipated growth in the older population.

A.1.1 Nursing homes

Let $\Pr(\text{NursingHome}_{Age_i})$ be the probability of a person belonging to age category Age_i being a resident of a Nursing Home³⁷. The various age categories for Age_i are 65-74, 75-84, and above 85. These probabilities can be calculated using the 2011 and 2016 Census. It gives data on the number of people aged 65 & above living in Nursing Homes (as their usual Residence) by single year of age³⁸.

$\text{Population}_{Age_i}^Y$ is the estimated population of people in age category Age_i in year Y ³⁹. These estimated population projections are from the CSO's M2F2 Dublin Inflow population projection scenario.

$$\text{Residents}_{Age_i}^{\text{Nursing Homes}} = \Pr(\text{NursingHomes}_{Age_i}) * \text{Population}_{Age_i}^Y$$

$\text{Residents}_{Age_i}^{\text{Nursing Homes}}$ gives the estimated number of people belonging to age category Age_i who will be a resident of a Nursing Home in year Y ⁴⁰.

If $HCA_{\text{Daily Hours-per resident}}^{\text{Nursing Homes}}$ is the daily hours of work per-resident required by an HCA⁴¹ and if they work on average 8 hours a day, then the demand for HCA in Nursing Homes as full time equivalents can be written as:

³⁶ As mentioned before this is the *need-based demand*.

³⁷ This is based on the 2022 Census data.

³⁸ It must be noted that similar probabilities from Censuses 2011 and 2016 were used as robustness checks.

³⁹ Estimated years are from 2022-2036.

⁴⁰ Assume that the age-specific probability of being a resident in a Nursing Home remains constant.

⁴¹ Value based on stakeholder consultations.

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$$Demand_{HCA}^{Nursing\ Homes} = \sum_i \frac{HCA_{Daily\ Hours-per\ resident}^{Nursing\ Homes} * Residents_{Age_i}^{Nursing\ Homes}}{8}$$

A.1.2 Hospitals

Let $Beds_{Age_j}^{PerPerson}$ be the average number of in-patient beds in hospitals occupied by individuals belonging to age category Age_j ⁴². The various age categories for Age_j are below 65, 65-74, 75-84, and above 85. These numbers can be calculated using the 2021 data of the Department of Health⁴³. It gives data on the in-patient bed days in Hospitals (for all procedures) by single year of age.

$Pop_{Age_j}^Y$ is the estimated population of people in age category Age_j in year Y ⁴⁴. These estimated population projections are also from the CSO's M2F2 Dublin Inflow population projection scenario.

$$DailyBeds_{Age_j}^{Hospitals} = \frac{Beds_{Age_j}^{PerPerson} * Pop_{Age_j}^Y}{365}$$

$DailyBeds_{Age_j}^{Hospitals}$ gives the estimated number of daily beds (in-patient daily beds) for each age categories (Age_j) in Hospitals in year Y ⁴⁵.

If $HCA_{Daily\ Hours-per\ bed}^{Hospitals}$ is the daily hours of work per-bed (patient) required by an HCA⁴⁶ and if they work on average 8 hours a day, then the demand for HCA in Hospitals as full time equivalents can be written as:

$$Demand_{HCA}^{Hospitals} = \sum_i \frac{HCA_{Daily\ Hours-per\ bed}^{Hospitals} * DailyBeds_{Age_j}^{Hospitals}}{8}$$

⁴² This is based on the 2021 Health Department Data

⁴³ DHA42 - In-Patient and Day case Procedures and Average Length of Hospital Stay, Department of Health

⁴⁴ Estimated years are from 2022-2036.

⁴⁵ Assume that the age-specific average-bed days in a hospital remains constant.

⁴⁶ Value based on stakeholder consultations.

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A.1.3 Total demand

If the demand for HCAs from other sectors are assumed to be $n\%$ ⁴⁷, then the total demand for HCAs can be written as:

$$HCA_{Demand}^{Total} = \frac{Demand_{HCA}^{Nursing\ Homes} + Demand_{HCA}^{Hospitals}}{1 - n}$$

Research published by UCD in 2020⁴⁸ suggests that 43% of HCAs work in hospital or nursing home settings, with the balance (57%) working in home care and other settings. Following these results, we have assumed in this model that $n = 43\%$.

The backbone of the model which estimates the demand for HCAs mainly depends on:

- Probabilities of various age groups residing in Nursing Homes and being an in-patient in hospitals. The main assumption is the static nature of these probabilities⁴⁹.
- Population Projection values of various age groups from the CSO.
- Share of “non-Nursing Home” and “Non-Hospital” HCA requirement in the Irish context.

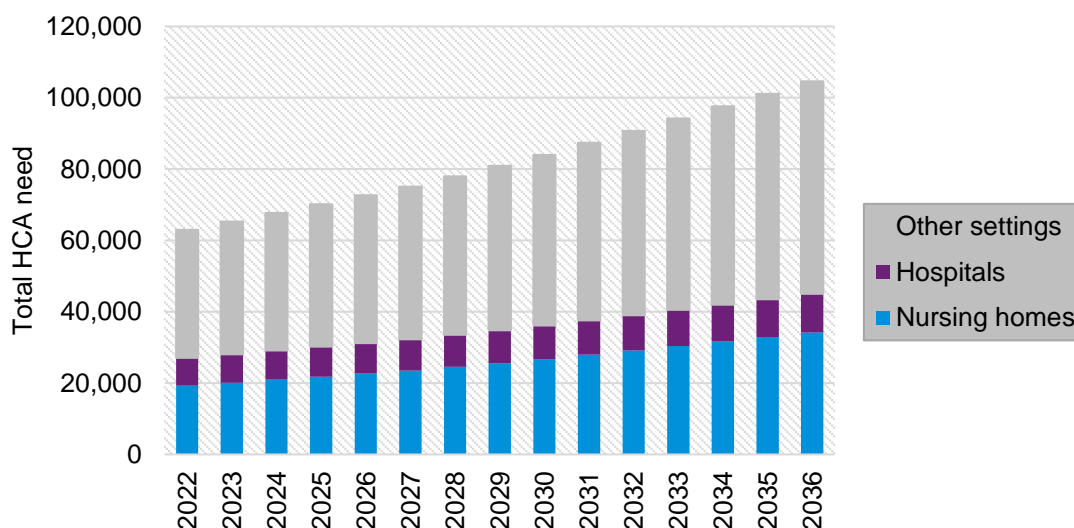


Figure A-2: Projected demand for HCAs by healthcare settings

⁴⁷ n must be written as a decimal out of 100, i.e., 40% written as 0.40.

⁴⁸ Healthcare assistants and qualified carers, a trained, but untapped underutilised resource: a population-based study in Ireland of skillset, career satisfaction, wellbeing and change across all sectors and care settings, 2020. <https://www.drugsandalcohol.ie/32885/>

⁴⁹ These probabilities are calculated from the Census and Department of Health data.

A.2 Supply model

The supply of HCAs originates from those who do not require an employment permit (Irish/EEA Nationals) and those who require employment permits (non-EEA Nationals). HCA were only removed from the ineligible list in 2021 (hence employment permits for HCAs were only provided from 2021).

HCAs are employed by the public (HSE) and private sector. Lack of publicly available historical data on HCA employment in the private sector is a major constraint to model the supply of HCAs in the Irish context. Available data on HCA employment in HSE, permits data (by DETE), assumptions on the private sector, and additional assumptions on population distribution are used to forecast yearly supply of HCAs in Ireland until 2036. The assumptions of the model are based on consultations with various stakeholders (2.1 Survey) and survey results (2.2 Interviews).

A.2.1 Model ingredients

Let HCA_{SSY}^{HSE} be the supply of HCAs in the HSE including HCAs in both Hospitals and Home Care services in Year Y.

$$HCA_{SSY}^{HSE} = HCA_{SSY}^{HSE\text{Hospitals}} + HCA_{SSY}^{HSE\text{Home Care}}$$

If $k\%$ ⁵⁰ of total HCAs in hospitals belong to private hospitals, one can calculate the number of HCAs in the private sector as

$$HCA_{SSY}^{Hospitals\text{Total}} = \frac{HCA_{SSY}^{HSE\text{Hospitals}}}{1 - k}$$

Additionally, if assumptions were made on the ratios of HCAs working in All Hospitals to Nursing Homes to Private Nursing Homes to other sectors, then the number of HCAs working in all these sectors can be teased out.

Let $HCA_{SSY}^{Hospitals\text{Total}} : HCA_{SSY}^{Nursing\ Homes} : HCA_{SSY}^{Home\ Care\ Private} : HCA_{SSY}^{Other} = a : b : c : d$

Then the following can be calculated.

$$HCA_{SSY}^{Nursing\ Homes} = \frac{b}{a + b + c + d} * HCA_{SSY}^{Hospitals\text{Total}}$$

$$HCA_{SSY}^{Home\ Care\ Private} = \frac{c}{a + b + c + d} * HCA_{SSY}^{Hospitals\text{Total}}$$

⁵⁰ k must be written as a decimal out of 100, i.e., 40% written as 0.40.

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$$HCA_{SSY}^{Other} = \frac{d}{a + b + c + d} * HCA_{SSY}^{HospitalsTotal}$$

Finally, the total supply of HCAs in all sectors can be calculated as the following:

$$HCA_{SSY}^{Total} = HCA_{SSY}^{HospitalsTotal} + HCA_{SSY}^{HSEHomeCare} + HCA_{SSY}^{NursingHomes} + HCA_{SSY}^{HomeCarePrivate} + HCA_{SSY}^{Other}$$

This total supply of HCAs can be disaggregated to Irish/EEA nationals and permit required non-EEA nationals.

$$HCA_{SSY}^{Total} = HCA_{SSY}^{EEA} + HCA_{SSY}^{NonEEA}$$

A.2.2 Linking to population

Additional assumptions on the age distribution of Irish/EEA HCAs allows to model the number of HCAs who do not require a work permit (Irish/EEA nationals) as a function of projected population by age. If p is the age category of each Irish/EEA HCA and if the number of permits issued to HCAs in year Y is available, then the total projected supply of HCAs in year Y can be written as:

$$HCA_{SSY}^{Total} = \sum_p HCA_{SSY}^{EEA_{Age_p}} + HCA_{SSY}^{NonEEA_{Projected}}$$

A.3 Sensitivity test (wage thresholds)

Different wage thresholds do not seem to have a material impact on the HCA shortage. Wage elasticity of labour is assumed to be 0.5 (see Figure 9-3 and Figure 9-4).

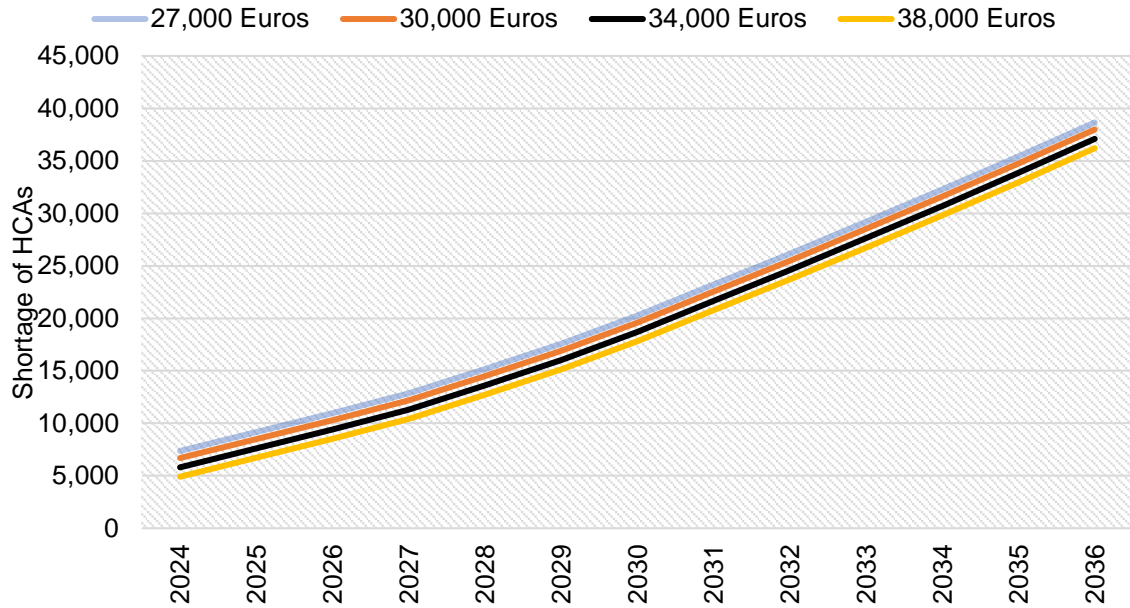


Figure A-3: Projected shortage of HCAs by wage thresholds - S1 (Baseline)

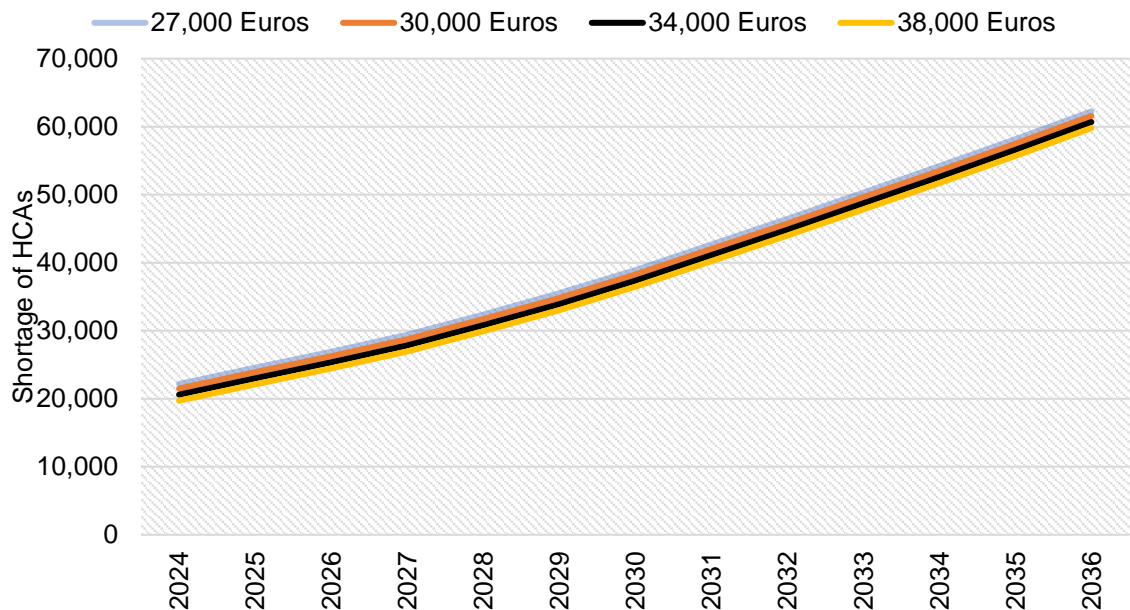


Figure A-4: Projected shortage of HCAs by wage thresholds - S7 (Enhanced Care + High Propensity to be in NH)

B Appendix: literature review

In this section we present the conclusions from our review of literature relevant to the opening of employment access to the broader labour market. We have divided this chapter into sections representing the primary themes we identified in the research.

These themes are immigration's impact on residents' wages and unemployment, substitution between resident and immigrant labour, the factors affecting the supply of medical sector labour, and turnover and job satisfaction for health care assistants in Ireland.

Further to these themes, we have also researched the scope, design, and conclusions of the Economic and Social Research Institute's (ESRI's) Hippocrates model, which aims to estimate and project healthcare demand in Ireland for the period 2015-2030.

B.1 Appendix: review of existing literature

B.1.1 Impact of immigration on resident wage growth and unemployment

Card (2001) is a seminal paper that investigates the effects of immigrants on the local labour market. Even though the study focusses on immigration rates (and not on employment permits), it puts the whole question of immigration and labour markets in a logical framework: *immigration that increases the share of the population in a particular group would be expected to put downward pressure on wages and employment rates in that group, whereas balanced immigration that does not change the relative population shares is not expected to affect the relative wage structure*. The empirical evidence in the study suggests that immigration had a negative effect on the wage structure of the low-skilled natives in the US in the 1980s. Moving away from this approach, Dustmann et al., 2012, developed a theoretical approach that included different factors of production (including skill types). They show that *“when the immigrant skills composition differs from the native labour force, and if capital is elastic in supply (not fixed supply of capital), the effect on average wages of native workers should be zero or even slightly positive”*. The authors empirically estimate the wage effects (a parameter of the model) for the UK, which experienced an increase in its foreign-born population between 1997-2005. The results reveal that immigration has negative effects on wages below the 20th percentile and has a positive effect on wage growth above the 20th percentile. Importantly, the average effect of immigration on wages are shown to be positive.

Studies on correlations between immigration and labour market have been done in several countries including USA, Poland, and Norway. Basso & Peri, 2015 in the context of the USA shows correlation evidence that local economies absorb immigrants without negative effects on native labour demand. Using data from the Census and American Community Survey over the period 1970-2010, they use simple correlations and regression analysis with several controls for observed and unobserved factors. They also investigate the part of the correlation that captures the causal link from immigrants to native labour outcomes. Estimates obtained with two least squares

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regression using the shift share instrument suggests that the net growth of immigrant labour has a zero to positive correlation with changes in native wages and native employment. Duszczyc & Matuszczyk, 2018 show that the increase in the presence of foreigners in the Polish labour market (through work permits and employer declarations/simplified procedure from 2007 to 2016) was not correlated with the rise in unemployment, increase in the rate of economic inactivity and availability of seasonal jobs in Poland. Using the spatial correlation method, Elstad & Heggebo, 2021 revealed that an increase in the immigrant (born abroad by parents with no Norwegian ancestry) share of the regional population in Norway was associated with better employment outcomes for all. The authors also show a slightly negative correlation between lower educated immigrant population and wages/employment for low educated natives and earlier immigrants.

In summary, these studies tend to show that there is either weakly positive or no correlation between increases in immigrant labour and native wages and employment.

B.1.2 Imperfect substitutability (between native and immigrant labour) and comparative advantage

One of the reasons why immigration might not affect the labour market is the imperfect substitutability between native and immigrant labour. The effect of immigration depends upon whether native and immigrant workers with similar observable characters are imperfect substitutes in production. There is evidence that immigrants and natives with comparable educational backgrounds and skills specialise in different jobs, and this makes sure that native wage rates remain relatively higher (Ottaviano & Peri 2006, 2008). Language barriers for the immigrant workforce plays a role, creating an advantage for native-born workers in jobs demanding communication skills. Immigration encourages workers to specialise. Less educated natives leave physically demanding occupations for language-intensive ones (managerial positions). Importantly, language-intensive tasks tend to earn a comparatively higher return. This eventually leads to productivity gains from specialisation coupled with the high compensation paid to communication skills together imply that foreign-born workers do not create large adverse consequences for wages paid to less educated natives (Peri & Sparber, 2009).

In summary, these studies suggest that native and immigrant workers are not interchangeable because they have different skills, particularly language skills. Increases in immigrant labour tend to encourage native workers to seek more language-intensive, typically managerial, jobs.

B.1.3 The role of education

Regardless of the migration route, there is consensus in the literature on the general effect of migration on wages: there is no significant negative effect for educated natives. If workers are differentiated only by their education level, and if production technology and productivity of each type of labour are given, the migration of less education people will lead to a) an increase in wages paid to educated natives and b) a

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decrease in wages paid to less educated natives (Borjas, 2003; Borjas & Katz, 2007). Other studies suggest that immigration will have almost no effects on less educated natives (Card, 2007; Lewis, 2005).

In summary, these studies suggest that an increase in immigration for low-educated workers has a positive impact on wages for native, high-educated workers. There is mixed evidence for the impact on native, low-educated workers.

B.1.4 Overall effects on the economy

If immigration is relatively high among workers with high education levels (college or higher), then these types of immigrants may compete with highly educated natives. On the other hand, there is evidence to suggest that it will lead to an increase in total factor productivity and competitiveness of the country and essentially have a positive effect on the economy, so their overall wage impact on native workers is likely to be positive (D'Amuri & Peri, 2014). Complementing to this the study of Ortega & Peri, 2014 found a positive significant relationship between openness to immigration of a county and long-run income per-capita of its inhabitants.

The 2006 ESRI paper that focusses on the labour market effects of immigration in Ireland suggests a similar story. According to this study, if immigrants in Ireland (who arrived between 1993-2003) are employed at a level fitting their education, this would increase the national GNP by 3.5% to 3.7%. Immigration would reduce skilled wages, and this would increase the competitiveness of the country leading to an increase in GNP. Longhi et al. (2005) also suggest that the impact of migration on labour markets depend on the type of modelling approach.

Fundamentally, to understand the effects of opening up the labour market of a specific sector through employment permits requires a tailor-made model (not a general equilibrium model) with only one sector, and different levels and skills.

B.1.5 The Swiss case

There are studies that exploited policies that resulted in a quasi-natural experiment in Switzerland - opening its labour market to workers from the EU- to understand the effects of migration on the labour market. Even though this route of migration is very different compared to issuing employment permits/visas, the general insights on the effects migration on labour markets is useful.

Beerli & Peri, 2015, used the difference in the timing in implementing this policy on the various geographical regions in Switzerland. Using the difference-in-difference approach they found that opening the border had no significant impact on average native wages and employment. Using the same setting Basten & Siegenthaler, 2019, provided evidence to suggest that immigration of foreign workers reduced unemployment of natives and had limited adverse effects on their wages and employment. Pregaldini & Backes-Gellner, 2023, showed that inflow of immigrants led to an increase in the employment of native middle-skilled workers with highly specific

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occupational skills. Gatti et al, 2022 suggests that migrant workers contributed to a reduction in wages for young natives, as opposed to the older native workers.

These studies that use the Swiss natural experiment in migration suggest that opening up employment to foreign workers generally has either positive or no impact on employment and wages for native workers, although one study found that they reduced wages for younger natives entering the workforce.

B.1.6 Effect of changes in visas

Most studies in economics that investigate the effects of immigration use spatial variation in immigration or variation over a long time (e.g., using Census data). One paper (Kerr and Lincoln, 2010) exploited large changes in the H-1B visa program in the US. The H-1B visa program admits temporary immigrants into the US for employment in science and engineering. The authors did not find any substantive effect of allowing immigrants through H-1B program on various labour market outcomes like employment levels, mean wages, and unemployment rates. They also suggest that inventions in the sector through the visa program increased through direct contributions of immigrants.

B.1.7 Factors influencing medical labour supply

Literature suggests that wage elasticities of medical professionals (mainly nurses) are context specific. Frijters et. al, 2007 used the instrumental variable approach to estimate that a 10% increase in wages for nurses in the UK would reduce the annual exit rate by 0.7%. Policy reforms in the US are used as natural experiments to understand nurse wage elasticity in the short run. Staiger et al, 2010 used such a reform as a regional policy shock in the US to suggest that nurse wage elasticity is inelastic. There is similar evidence in the Norwegian context where policy reforms are used as exogenous shocks (Mas & Pallais, 2017).

Migration is also discussed in the literature that covers the medical labour market. Using US data, Cortes & Pan, 2014 looks at the effects of immigration of foreign-born registered nurses on the long-run employment and occupational choice of native nurses. The authors use historical geographical distribution of migrants as an instrument for the number of migrant nurses. The results suggest that an increase of foreign-born nurses lead to native nurses leaving the profession. There is no evidence to suggest that this is caused by changes in wages. They also report suggestive evidence that dependency on foreign nurses may have fewer incentives to increase the capacity of nursing schools in the state. Cortés & Pan, 2014, exploited a staggered adoption of a policy change that made it substantially easier for nurses to work and move across state lines in the US. They found no effect for the policy on labour market outcomes of nurses such as labour force participation, employment levels, hours worked, and earnings.

Research from the UK (Ruttena & Reed, 2009) also found that recruiting foreign workers into the medical labour force had a greater positive impact on patient welfare than an equivalent increase in budget.

B.1.8 Health care assistants

The 2022 report by the European Employment Services (EURES) on labour shortages and surpluses includes Health Care Assistants (HCA) in the list of occupations where there is a shortage (including in Ireland)⁵¹. The reports also mentions that the educational profile for Health Care Assistants is mostly medium (ISCED 3-4). Migrant workers account for an important share of the labour force, including in critical sectors like healthcare (2021 ILO Global Estimates on International Migrant Workers). This could place Health Care Assistants, especially migrant HCAs, as vulnerable. According to the UN, “*vulnerable employment is often characterized by inadequate earnings, low productivity and difficult conditions of work that undermine workers’ fundamental rights*”.

B.1.8.1 Health care assistants - turnover and job satisfaction

We have identified three master’s degree theses specifically on the topics of turnover and job satisfaction for health care assistants working in Ireland. While some of these studies do not meet the quality criteria set in our search strategy, we have elected to include them in this review as their findings are directly relevant to the research question.

Mbyehuzya, 2021 found that high turnover rates for nurses and HCAs in Ireland were correlated with low pay, relationships with management, access to training and development, opportunities for career progression, and work-life balance. The qualitative study used survey data of 70 respondents suggests that poor career progression prospects were highlighted as a reason for HCA staff moving positions. Conway, 2021 also identified work-life balance, low rates of pay relative to other sectors, and a lack of access to learning and development opportunities as reasons for high HCA turnover in Ireland. The author used survey data with more than 100 observations. Boatamsete, 2019 focused on HCA turnover in private nursing homes, finding that employees were dissatisfied with the balance of work and responsibility they faced relative to their pay. Using data from conducting interview, the author concluded that high turnover in the HCA workforce may lead to lower productivity due to a more disengaged workforce, low morale, and the associated impacts on employee health.

In general, these three studies suggest that job satisfaction among HCAs in Ireland is poor due to low pay relative to the job’s responsibilities and limited options for professional development and advancement.

B.1.8.2 Health care assistants – the Irish context

The 2020 (UCD) Irish population-based study on various care workers revealed several trends. It examined 1,846 caregivers in Ireland, mostly females (92.3%), revealing patterns in demographics and employment. According to this study, private hospitals pose challenges for Healthcare Assistants (HCAs) due to unhelpful management, while

⁵¹ <https://www.ela.europa.eu/sites/default/files/2023-09/ELA-eures-shortages-surpluses-report-2022.pdf>

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those in private home care face fewer hindrances. The study also addresses skillsets, training concerns, and discrepancies between reported and practiced skills, stressing the necessity for a standardized competency framework for Healthcare Assistants and Carers across Ireland. It highlights the need for clarity in the scope of practice for Healthcare Assistants and Carers, advocating a standardized national competency framework to comprehensively define their roles across sectors.

The Department of Health's 2022 Report on Home Carers and Nursing Home Healthcare Assistants focussed on the challenges faced by the industry in Ireland.⁵² According to the report the shortage of qualified care-workers is severe and is worsened by an ageing workforce - 63% of home-support workers are over 55, leading to a decline in experienced staff. Ireland competes with EU countries for recruitment, and the removal of HCA from the Ineligible Occupations List helps hiring non-EU/EEA citizens. The report mentions that care-workers experience problems with poor pay, insecure contracts, and financial instability because of unpredictable working hours. It also focusses on the need for a competency framework for career development, linking training, qualifications, employment grades, and pay-rates.

B.1.9 The Hippocrates medical labour market model

In 2017, The Economic and Social Research Institute (ESRI) published its Hippocrates model, funded by the Department of Health.

The Hippocrates model estimates and projects Irish healthcare demand and expenditure for the period 2015-2030 based predominantly on population projections and assumptions regarding the proportion of the population in each age band requiring medical care.

It uses sex-specific population projections for age groups and activity rates. Activity rate measures healthcare use, like hospital stays or home help hours. Healthcare demand for an activity in a year is the rate (from the base year) multiplied by the projected population is treated as healthcare demand. Assumptions consider various scenarios of population growth, healthy ageing, and unmet needs. The model aims to predict health needs but is not suitable for understanding policy effects.

The 2020 version of the model, which estimates workforce requirement for public acute hospitals in Ireland in the period 2019-2035, includes grade mix distributions, estimating the workforce supply along with demand from population projections. Grade mix is a ratio that shifts tasks between different grades. The model explores three scenarios with varying ratios of Staff Nurses to Healthcare Assistants (70:30, 75:25, and the 80:20 ratio recommended by the 2018 *Framework for Safe Nurse Staffing*⁵³) and suggested a projected average annual growth for HCAs from 2.8% to 0.2%.

⁵² <https://www.gov.ie/pdf/?file=https://assets.gov.ie/237210/448892b3-36b4-4b7a-a41e-90368ff2345c.pdf#page=null>

⁵³ <https://www.gov.ie/pdf/?file=https://assets.gov.ie/10011/e1a93e955329405694bb7b16aea50b98.pdf>

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