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THE EUROPEAN CARE STRATEGY

A CHANCE TO ENSURE INCLUSIVE CARE FOR ALL?

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Today Europe might be standing at the crossroads of a new care paradigm shift as the European Commission has presented its 'European Care Strategy' in September 2022. A particular focus is laid on childcare and long-term care (LTC) through two Council Recommendations on the revision of the Barcelona targets on early childhood education and care (ECEC) and on access to affordable high-quality long-term care.

By taking leadership in this under-explored policy area, the EU may take a more proactive approach to rebalance persisting inequalities attributable to the neglect of care. The true question lies, however, in how this recognition translates into wide-reaching answers addressing the challenges faced by women whose individual situations are as diverse as Europe itself. The EU plays a crucial responsibility in initiating transformative policies towards a change of social and gender norms and incentivising public investment in care.

That is precisely why this policy study seeks to feed and guide the discussion by critically assessing whether the European Care Strategy can be seized as an opportunity to trigger a new approach to care that is truly inclusive and fair for all. In other words, this publication explores whether the EU is sufficiently equipping itself to live up to the claims that European values "can only flourish in a caring society".

To this end, the present policy study takes a closer look at the European Care Strategy as it currently stands. The aim pursued is two-fold. On the one hand, it offers an analysis of the positive developments welcomed by the key stakeholders. On the other hand, it also serves to better understand the remaining blind spots of the Strategy. Care being such a complex and multifaceted policy field, each chapter thus dives into a different dimension relevant to understand how the Strategy can give itself the means to ensure that care-givers and -receivers do not fall short of the EU's fundamental values and the fulfilment of social rights.

By gathering a diverse set of voices from academia, civil society and policymaking, this policy study thus makes the case for strengthening care policies across the EU. The last chapter provides an overview of the policy recommendations put forth by this policy study.

ABBREVIATIONS

AI	Artificial Intelligence
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
ECEC	Early childhood education and care
ECS	European Care Strategy
EESC	European Economic and Social Committee
EIGE	European Institute for Gender Equality
EPRS	European Parliamentary Research Service
EPSR	European Pillar of Social Rights
EPSU	European Federation of Public Service Unions
EU	European Union
GDPR	EU General Data Protection Regulation
ILO	International Labour Organization
ISCED	International Standard Classification of Education
LTC	Long-term care
OECD	Organisation for Economic Co-operation and Development
PA	Personal assistance
PHS	Personal and household services
PPE	Personal protective equipment
TFEU	Treaty on the Functioning of the European Union
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization

DEFINITIONS[1]

Care work

According to the ILO, care work consists of two overlapping activities: direct, personal and relational care activities, such as feeding a baby or nursing an ill partner; and indirect care activities, such as cooking and cleaning.

Community-based care

Long-term care provided and organised at community level, for example in the form of adult day services or respite care.

De-institutionalisation

The European Disability Forum refers to the process of closing institutions in favour of community-based alternatives as 'de-institutionalisation'. Alternative community-based forms of care and support must be up and running before the closure of institutions, but, in this view, this does not take away from the urgency required to set the transition in process and should not be used as an excuse to delay it. De-institutionalisation also refers to the process of creating conditions for the prevention of institutionalisation, and banning the building or renovation of new institutions.

Early childhood education and care (ECEC)

Refers to any regulated arrangement that provides education and care for children from birth to compulsory primary school age, which may vary across the EU. To qualify as ECEC, the relevant facilities must meet five criteria of quality mandated by the International Standard of Education (ISCED) 2011 classification: 1) adequate intentional educational properties; 2) institutionalisation; 3) an intensity of at least two hours per day of educational activities and a duration of at least 100 days per year; 4) a regulatory framework recognised by the relevant national authorities; and 5) trained and accredited staff. For simplicity, this report may sometimes refer to 'childcare' interchangeably with 'early childhood education and care (ECEC)'.

Formal homecare

Long-term care provided in an individual recipient's home, by a professional long-term care worker.

Independent Living

According to article 19 of the UN CRPD, to which the European Union has become a party in 2010, independent living/living independently means that individuals with disabilities are provided with all necessary means enabling them to exercise choice and control over their lives and make all decisions concerning their lives. Personal autonomy and self-determination are fundamental to independent living, including access to transport, information, communication and personal assistance, place of residence, daily routine, habits, decent employment, personal relationships, clothing, nutrition, hygiene and health care, religious, cultural and sexual and reproductive rights. These activities are linked to the development of a person's identity and personality and are an essential part of the individual's autonomy and freedom, and does not necessarily mean living alone.

Informal carer

Informal care refers to care for persons with disabilities or older people with care and support needs that is carried out by relatives, friends, acquaintances or neighbours, often without a contractual agreement or formal payment.

Live-in carer

Domestic care worker who lives in the care recipient's household and provides long-term care.

Long-term care

A range of healthcare and social care services and assistance, for people who, because of mental and/or physical frailty and/or disability and/or old age, over an extended period of time depend on help with daily living activities, and/or need some permanent nursing care.

Paid care work

Work performed for pay or profit by care workers. They comprise a wide range of personal service workers, such as nurses, teachers, doctors, and personal care workers. Domestic workers, who provide both direct and indirect care in households, are also part of the care workforce.

DEFINITIONS

Personal assistance

According to article 19 of the UN CRPD, to which the European Union has become a party in 2010, personal assistance refers to person-directed/'user'-led human support available to a person with disability and it is a tool for independent living. Although modes of personal assistance may vary, there are certain elements which distinguish it from other types of personal assistance, namely: (i) funding for personal assistance must be provided on the basis of personalised criteria and take into account human rights standards for decent employment; (ii) the service is controlled by the person with disability, meaning that he or she can either contract the service from a variety of providers or act as an employer; (iii) personal assistance is a one-to-one relationship; and (iv) self-management of service delivery.

Pre-primary education

A programme intending to prepare children for primary education. It typically starts one year before the compulsory school age, which in most EU countries is set at six years old.

Personal and household services

Personal and household services (PHS) cover jobs and services carried out to support households. Amongst them, 63% are direct care activities (excluding healthcare) such as childcare, assistance to the elderly, dependent or disabled and 37% are indirect care activities such as cleaning, laundry, meal preparation, gardening, small house repairs and private lessons. These two activities are highly intertwined: while indirect care support allows people to spend more time caring for their parents or children, direct care support generally includes a large component of indirect care. This concept of personal and household services was developed in 2012 in the framework of the employment package.

Unpaid care work

Care work provided without a monetary reward by unpaid carers, often family members. Unpaid care is considered as work and is thus a crucial dimension of the world of work.

1. INTRODUCTION

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Caring lies at the heart of everything people do in their lives. But in spite of its pervasiveness and its enormous importance for human well-being and survival, it has remained very heavily unregulated, unmeasured and underestimated. This lack of policy attention is inextricably linked to the idea that care is a private matter not deserving public intervention. Yet, the pervasiveness of care has long been well encapsulated by the definitions adopted in feminist literature conceiving of it as: 'an activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web'.[2] Pushing care to the private sphere ignores the central role of care and the care economy in realising a sustainable economic recovery and creating a social market economy in line with gender equality.

The reality is that we are all inherently interdependent and vulnerable. The countless accounts from the pandemic lockdowns have been the greatest reality check proving our deepest reliance on caring relationships and demonstrating how all our other activities depend on them. They also highlighted that all across Europe, care is in a state of crisis which is set to aggravate along with the EU's demographic ageing. The same applies to the precarious working conditions in the care sector, which is chronically understaffed and marked by low pay.

If addressed in policy-making at all, care has all too often been considered of secondary importance and ascribed to the national, not European, level. Despite the slowly emerging engagement of the EU with care policy and carers, the development has been rather fragmented and has lacked the underpinning of a cohesive strategy.[3] Today, however, Europe might be standing at the crossroads of a new care paradigm shift. In September 2022, the European Commission presented its 'European Care Strategy'.[4] A particular focus is laid on childcare and long-term care (LTC) through two Council Recommendations on the revision of the Barcelona targets on early childhood education and care (ECEC)[5] and on access to affordable high-quality long-term care.[6] Both recommendations were adopted by the Council at the end of 2022.[7] It may thus seem that recent events have had the effect of a wake-up call for the EU which appears to finally give care the political weight it deserves.

By taking leadership in this underexplored policy area, the EU may take a more proactive approach to rebalance persisting inequalities attributable to the neglect of care. Gender inequalities in the distribution of care work – whether paid or unpaid – are widely documented. In the EU, women with children under the age of 7 namely spend an average of 20 hours per week more than men on unpaid work, including domestic tasks and care.[8] In line with promises to "support men and women in finding the best care and the best life balance"[9], the Commission already acknowledged that as a result of uneven care responsibilities, women are particularly disadvantaged and hindered from economic empowerment. The true question lies, however, in how this recognition translates into wide-reaching answers addressing the challenges faced by women whose individual situations are as diverse as Europe itself from the live-in migrant care worker in Spain to the single mother in Bulgaria. Here, the EU plays a crucial responsibility in initiating transformative policies towards a change of social and gender norms and incentivising public investment in care.

Overall, the European Care Strategy should thus serve not as an endpoint in itself but rather as the very start of the EU's journey towards the development of solid and encompassing policies acknowledging the centrality of care whilst protecting and valuing all those needing or providing it.

That is precisely why this policy study seeks to feed and guide the discussion by critically assessing whether the European Care Strategy can be seized as an opportunity to trigger a new approach to care that is truly inclusive and fair for all. In other words, this publication explores whether the EU is sufficiently equipping itself to live up

to the claims that European values "can only flourish in a caring society".[10] To this end, the present policy study takes a closer look at the European Care Strategy as it currently stands. The aim pursued is two-fold. On the one hand, it offers an analysis of the positive developments welcomed by the key stakeholders. On the other hand, it also serves to better understand the remaining blind spots of the Strategy. Care being such a complex and multifaceted policy field, each chapter thus dives into a different dimension relevant to understand how the Strategy can give itself the means to ensure that care-givers and -receivers do not fall short of the EU's fundamental values ranging from solidarity to well-being, human dignity and gender equality, and the fulfilment of social rights.

By gathering a very diverse set of voices from academia, civil society and policymaking, this policy study thus makes the case on how to strengthen care policies across the EU. The last chapter provides an collective overview of the policy recommendations made throughout the authors' contributions.

2. CARE AS A DRIVER OF SUSTAINABLE GROWTH

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Cecilia Navarra and Meenakshi Fernandes[11]

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1. INTRODUCTION: STATUS QUO - THE VICIOUS CYCLE

In the EU (and beyond) both professional carers and people caring for relatives and dependents in households face a systematic under-evaluation of their work, despite the fact that care work is what allows people to live in dignity and allows all other works to take place.[12] This under-evaluation occurs for both paid and unpaid care work, i.e. for the work of professional carers (in childcare, in residential elderly care, in domestic settings, ...) and of carers within household who take care of relatives, especially with regards to dependents.

We consider this under-evaluation as being the *trait d'union* between weaknesses of the care sector and gender inequalities in households and the labour market. On the one hand, a 'low investment model' in the care sector is the main driver of the under-supply of affordable quality care services and of the prevailing poor working conditions. On the other hand, the invisibility of unpaid work and the vulnerability of paid care workers put pressure especially on women, since women are much more likely to be carers, both as family members and as workers.

If we put this in the context of structural gender gaps in the labour market[13], this reinforces a vicious cycle of gender inequalities. Women earn on average less than men and are more likely to drop out of the labour market when a care need arises in the household. In economic terms, we could say that the 'opportunity cost' of staying at home and taking up care tasks is usually lower for women than for men. In other words, they pay a higher effective price to pay for care than men do due to their lower earnings and gender stereotypes. According to the Labour Force Survey, **16% of women outside the labour force and wanting to work said that the main reason they were inactive was due to caring responsibilities**.[14] **The percentage in the case of men is 2 %. Among workers working part-time, 26% of women indicated that family care was their main reason for it**[15] **as compared with 6 % of men**. This amplifies the vicious cycle of lower earnings of women.

> *We consider this under-evaluation as being the trait d'union between weaknesses of the care sector and gender inequalities in households and the labour market. On the one hand, a 'low investment model' in the care sector is the main driver of the under-supply of affordable quality care services and of the prevailing poor working conditions. On the other hand, the invisibility of unpaid work and the vulnerability of paid care workers put pressure especially on women, since women are much more likely to be carers, both as family members and as workers.*

On the other end of the vicious cycle there is a supply of care services that falls short of the needs, both as regards childcare (0-3 years) and long-term care (LTC). As shown by EIGE,[16] several member states have not reached the Barcelona target of 33% of children up to 3 years of age enrolled in childcare and in 2016 14% of EU households reported an unmet need for childcare, most for affordability or direct availability issues. The same report shows that only 35% of elderly in need receive long term care either home-based or in an institution. When a care need arises, the possibility to find accessible and quality services is low, and therefore to 'externalise' care outside the household remains a challenge. This brings us back to the 'low investment approach' to care: this has often led to the outsourcing of care services to private providers and cost-cutting (see Chapter 5 by Tuscany Bell). This, together with limited monitoring and oversight, has contributed to a situation of often limited access and quality for recipients are coupled with low wages and poor working conditions for care workers.

Care workers are more likely to be in the bottom third of the wage distribution, more likely to have temporary contracts, and more likely to be undeclared, therefore deprived of legal guarantees and social protection. Drawing on data from the European Labour Authority[17], we consider that **36% of care workers work in undeclared conditions[18]**, while this share in the private sector is considered to be 8%.[19] The likelihood of under-declared work is also higher, but it is even more difficult to find figures on this phenomenon.

To reinforce the vicious cycle, these conditions also fall disproportionately on women: 9 out of 10 care workers are women.[20] The under-valuation of care work and of feminised sectors go hand in hand. An indicator of this low-valuation is the invisibility and poor recognition of care workers. Estimating the number of professionals working in the care sector is not an easy task. Not only because of the different possible definitions of the boundaries of the sector[21], but especially because the high share of undeclared workers. Accounting for these, **we estimate around 12 million care workers in the EU**. **Around 3.1 million of these workers are migrants** (out of which, **2.8 million migrant women**), that indicate the relevance of the intersectional dimension of inequalities and vulnerabilities of workers (see Chapter 9 by Elisa Chieregato on the intersectional dimension of care).

> *Several member states have not reached the Barcelona target of 33% of children up to 3 years of age enrolled in childcare and in 2016 14% of EU households reported an unmet need for childcare, most for affordability or direct availability issues. The same report shows that only 35% of elderly in need receive long term care either home-based or in an institution.*

2. WHY THE EU SHOULD ACT?

The undervaluation of care work both within households and in the labour market implies the **need for public intervention to recognise its full value for society**. Doing so could help to ensure that supply of care work is sufficient to meet **the demand without creating distortions and reinforcing gender inequalities**.

At present, member states have different policies and laws in place concerning the provision and access to care. For example, with regards to long-term care, a 2021 study from the European Commission reports wide variation in institutions, regulations and social traditions across member states.[22] The laws and policies in place primarily affect who has access to long-term care services, the type of long-term care services provided, and the extent

to which recipients of long-term care are exposed to the full costs of the services. Figures 1 and 2 illustrate the variation across member states in spending on long-term care and the share of the population estimated to be in need of long-term care. Figure 2 highlights the significant variation across member states with respect to long-term care and how there is variation by gender. In all EU member states, women aged 65 and higher are more likely to face limitations and would thus have a higher need for long-term care.

> *The under-valuation of care work and of feminised sectors go hand in hand. An indicator of this low-valuation is the invisibility and poor recognition of care workers*

Figure 1 - Share of women ages 65 and higher with some or severe self-reported limitation in relation to long-term care expenditure as a share of GDP

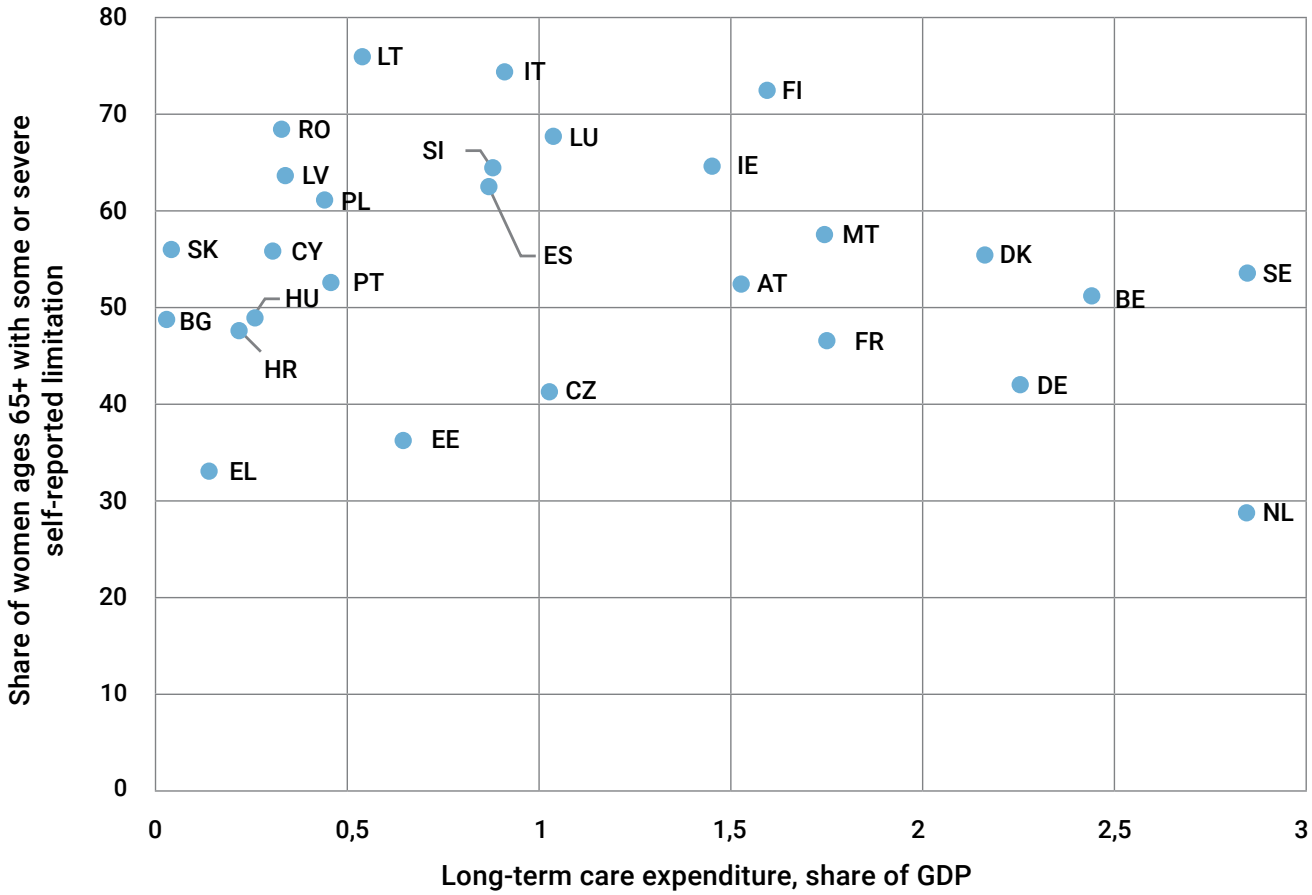
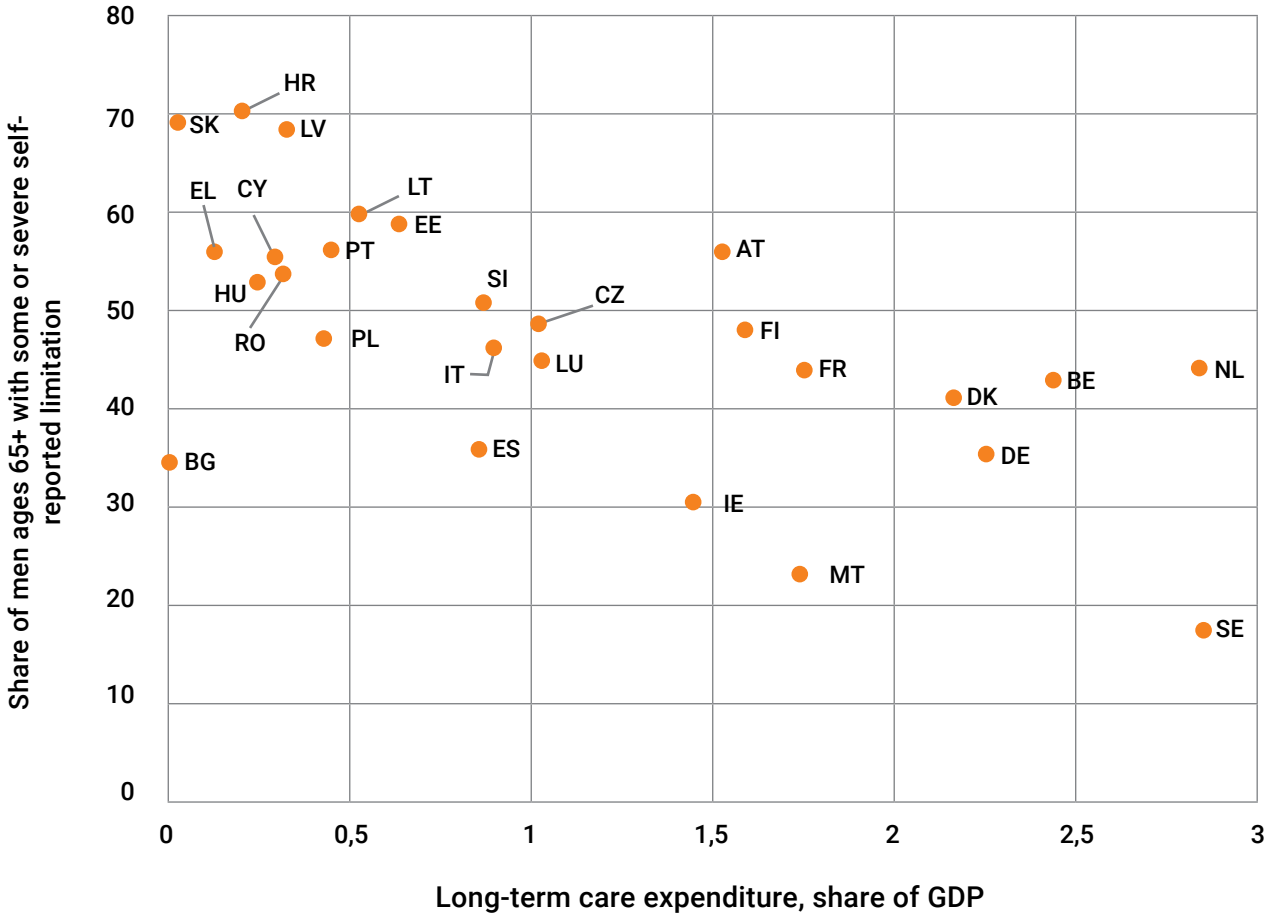


Figure 2 - Share of men aged 65 and higher with some or severe self-reported limitation in relation to long-term care expenditure as a share of GDP



Source Figure 1 and 2: Eurostat, 2019 data Long-term care (health) expenditure [TPS00214] and Self-perceived long-standing limitations in usual activities due to health problem by sex, age and degree of urbanisation [HLTH_SILC_20]

The EU has already taken important steps to promote the care economy. It began with the introduction of the **Barcelona targets in 2002**, which called for the **provision of childcare for 90% of children between three years old and the mandatory school age in the country, and for 33% of children under three years of age**. The primary objective of the Barcelona targets was to promote women's engagement in the labour market and their work-life balance. The EU recognised the right to receive care in the **European Pillar of Social Rights (EPSR)** put forward by the European Commission in 2017. It **specifically recognised the right of children to affordable early childhood education and care of good quality, and the right of everyone to affordable and good quality long-term care services**. The EPSR also recognised the right to fair working conditions, although not specifically for the care sector where conditions are particularly precarious, limiting the attractiveness of the sector to draw workers. In 2019, the EU introduced the **Work-Life Balance Directive**, which introduced the rights to paternity leave (up to 10 days), carer leave (up to five days a year) and to flexible working arrangements for carers and parents of children up to eight years of age. The Covid-19 pandemic raised attention to the care sector due to school closures and the poor conditions in long-term care facilities, including the high number of deaths. **An estimated 10 percent of funds in national recovery plans following the Recovery and Resilience**

> *The need for care is projected to grow with the aging of the EU population. The share of people in need of care to those who could provide care is expected to reach 76 % by 2050. EU action is needed to anticipate this demographic trend.*

Facility were allocated to health, economic and institutional resilience, which may include investment in the care sector.[23]

Moreover, the **need for care is projected to grow with the aging of the EU population**. The share of people in need of care to those who could provide care is expected to reach 76 % by 2050.[24] EU action is needed to anticipate this demographic trend. As care is a public good, EU action in the form of policies, programmes and investment could potentially have high added value. Also, gender inequalities have a transversal dimension across member states, and are not specific to some cases. The overall gender earning gap, that accounts for hourly wage gap, number of hours worked, and employment gap, is between about 20% and 40% in EU member states. Observing the three components shows the structural and pervasive problem more than just focusing on a single dimension.

Lastly, **we observe a high extent of workers mobility in the care sector.** The share of migrant workers is relatively higher in the care sector than in the overall economy, as indicated by the evidence collected during the Covid 19 pandemic of the relevance of migrant workers in essential sectors. This applies also to intra-EU mobile workers. For example, a survey estimates that **98% of live-in elderly care workers in Austria are migrants, mostly from Slovakia and Romania** (see also Chapter 5 by Tuscany Bell on building a resilient care sector).[25]

3. EUROPEAN PARLIAMENT'S RECOMMENDATIONS

Ahead of the introduction of the European Care strategy, the **European Parliament put forward a motion for a resolution entitled 'towards a common European action on care'** in June 2022.[26]The report was jointly developed by the Committee on Women's Rights and Gender Equality and the Committee on Employment and Social Affairs under the co-leadership of elected Members, Milan Brglez and Sirpa Pietikäinen. It was adopted with 436 votes in favour, 143 votes not in favour and 54 abstentions.

The 47-page report calls for a range of EU measures that could serve to modify disparities in the sharing of care responsibilities between women and men, mobilise external provision of care, and modernise and regulate the care sector.

Overall, it calls on member states to recognise the right to care and it calls for a dedicated investment package directed to the care sector to guarantee equal access for those in need of care at critical periods over the life course, while promoting the profession and career opportunities for carers. In doing so the EU could follow the ILO's 5R framework for decent care work (recognise, reduce and redistribute unpaid care work, reward paid care work).[27]

It also calls on member states to leverage available European funds including instruments such as the ESF+, the Recovery and Resilience Facility and the EU4Health Programme and the European Commission to ensure that EU funds can facilitate the transition from institutionalised care to community and family-based care. With regard to childcare, the European Parliament calls for upward convergence across the member states while raising the level of ambition of the targets. It also calls for a new target for the provision of childcare after school hours. It moreover calls on the member states to reform their social services and social protection systems to reflect different employment models to respond to care needs. The European Parliament also calls on member states to establish national registers of care service providers and to monitor their compliance with legal requirements and quality controls including the provision of whistle-blower channels.

The European Parliament resolution addresses both unpaid and paid care work. With regards to the former, the European Parliament calls on the European Commission to present a European **Informal Carers programme** that could define support measures to recognise the skills of unpaid informal carers and to support their reintegration in the labour market including care or pension credits. With regards to working conditions in the paid care sector, the European Parliament calls on member states to **ratify and implement ILO Convention 189 concerning decent work for domestic workers and ILO Convention 190 on violence and harassment in the world of work and ILO convention 149 on nursing personnel**. It also calls for setting minimum standards for live-care work that covers issues such as working time, remuneration and accommodation of carers, and to promote social dialogue, collective bargaining and collective agreements in the care sector. The occupational health and safety of

live-in care workers, particularly those who are mobile and migrant workers and employed through complex chains of agencies posting workers, should also be better protected via improved coordination between the European Agency for Safety and Health at Work (EU-OSHA) and the European Labour Authority.

Interestingly, the European Parliament also calls for these priorities for the care economy to apply also to the external dimension of EU policies including in pre-accession and official development assistance, and for better statistics to measure the economic contribution of care in European economies, and how it is financed through EU and national budgets.

Members of the European Parliament stressed several of these positions following Commissioner Dalli's presentation of the Care Strategy in the plenary session of the European Parliament on 12 September 2022 in particular the rights and working conditions of domestic workers, and the need to regulate care service providers particularly in the context of the commodification and privatisation of the sector.[28] **Members raised other questions such as the possibility of introducing targets on long-term care similar to the Barcelona targets for early childhood education, the need for a framework of investments, and the need to address the psychological well-being of women due to current shortcomings in the care sector**.

> *"Improper valuation of care work is not only limiting access to social rights, but leads also to an economic loss."*

4. THE ECONOMIC CASE FOR EU INTERVENTION

Addressing the vicious cycle described in the first chapter through a comprehensive EU policy and a renewed investment in the care sector could have a number of positive social impact that translate into economic gains. Improper valuation of care work is not only limiting access to social rights, but leads also to an economic loss.

The European Parliament's approach suggests that this requires addressing problem both on the demand and the supply sides of care services, and valuation and recognition of care work is key. Its approach of modifying the disparities in the sharing of care responsibilities between women and men, mobilising external provision of care, and modernising and regulating the care sector, together with an important investment effort, can lead to important economic gains.

Potential benefits of an ambitious EU action, which are actually foregone benefits today and could represent the 'cost of inaction' can be found at least in three different areas: 1) the realisation of women's potential on the labour market, 2) the promotion of an attractive sector, with creation of good employment, and 3) the potential for the development and independence of the people who are cared of, due to the increased quality of care services.

Care tasks at home affect women participation in the labour market, the number of hours worked and the choice of occupation, driven by the need to combine work and care duties. This has consequences on the probability of being employed, the probability of working part time and the hourly wage (due to occupational segregation). As discussed in the first subsection, Eurostat Labour Force Survey data shows that care duties at home impact differently labour market outcomes men and women. EIGE estimates also the hourly wage loss that can be explained by difference in unpaid care duties at home.[29] Based on this evidence, in our work for the European Parliamentary Research Service (EPRS)[30], we simulate what would occur to women's overall earning if care tasks impacted their employment choices as this occurs for men and this results in an **average increase in women's earning of about 340 euros per week, for a total of 242 billion euros per year.** Despite being an average estimate based on simplifying assumptions, this can give the idea of the relevance of the cost of the status quo as what concerns labour market outcomes of women in the EU.

> *"Investing in the care sector would improve the ability of EU society to respond to the care needs: currently, only 35% of elderly in need receive long-term care"*

An ambitious action to modernise and regulate the care sector, improving both working conditions and quality, could have moreover further positive economic spillovers.

These would be first of all the creation of an attractive sector capable of creating good employment. Reducing the prevalence of undeclared employment, increasing the number of formal jobs, and improving wages and working conditions could have a number of positive impacts, including on the mental health of care workers. On sole economic terms, the overall labour income generated by an increase in employment to cover 50% (which is a relatively conservative assumption) of the current needs of long-term care and childcare (0-3 years) would be of about **68 billion per year.** If, on top of this, **we assume improved working conditions represented by an increase in wages[31] we get to more than 96 billion per year**.

Another positive economic spillover could be generated by the impacts on persons who are cared for. Investing in the care sector would improve the ability of EU society to respond to the care needs: currently, only 35% of elderly in need receive long-term care (see also Chapter 7 by Jean-François Lebrun on long-term care).[32] The increase of both quality and affordability of care services would increase autonomy and independence of the elderly, cognitive development for children and overall social inclusion of the dependents. Based on the US estimated impact of pre-school enrolment on GDP, we can estimate that halving the unmet needs of 0-3 children in the EU could lead to a positive impact on GDP between 25 and 64 billion per year.[33]

> *Care is a public good and could benefit from public intervention in particular at the EU level due to the structural nature of the problems on the supply and demand sides.*

Such an improvement in the sector would require an important investment, but we know from the existing literature that investment in the care sector has a significant multiplier and tend to more-than-repay themselves. For example, a study on Austrian long-term care sector finds that every euro invested leads to 1.70 euros of domestic value added.[34]

Benefits are clearly not limited to economic ones, but should account for several elements, including dignity of care workers and cared of, gender equality, improved health (including mental health) of professional carers. What we show with this simple projection is that the fulfilment of fundamental rights (such as access to care and gender equality) and social rights (improved working conditions) are both aims in themselves (as enshrined for example in the EPSR), and can bring economic gains.

> *Crucial to reaching the potential social and economic positive impacts, is a holistic approach that tackles the entire vicious cycle. The Care Strategy moves in this direction, but ambitious action is needed to ensure that the potential gains can be reaped and to put the sector on the path towards sustainability.*

5. CONCLUDING REMARKS

Care is a public good and could benefit from public intervention in particular at the EU level due to the structural nature of the problems on the supply and demand sides. An ambitious EU action on care work, as called by the European Parliament, could bring important benefits in terms of social outcomes and protection of social rights and right to an autonomous development of dependent people. They can also bring about economic gains in terms of women's labour market outcomes, of employment and working conditions in a systematically under-valued sector, and in terms of future economic potential.

Crucial to reaching the potential social and economic positive impacts, is a holistic approach that tackles the entire vicious cycle. The Care Strategy moves in this direction, but ambitious action is needed to ensure that the potential gains can be reaped and to put the sector on the path towards sustainability. In this respect, the threefold approach called for by the European Parliament highlight the need to rebalance care work within households between men and women, mobilise external professional provision of care, but in a framework of a regulated and modernised sector that guarantees adequate wages and working conditions. Such a strategy requires investment. Mobilising a 'dedicated investment package to promote the EU care sector' would be a major commitment, as called for by the European Parliament. Care is a public good for which there is potentially a high added value for greater EU action and investment, in supporting a holistic approach.

3. DEMOGRAPHIC CHALLENGES FOR SOCIAL COHESION

3. DEMOGRAPHIC CHALLENGES FOR SOCIAL COHESION

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1. CHILDCARE AND LONG-TERM CARE: TWO ISSUES OF DEMOGRAPHIC SCARCITY

Demographic changes and ongoing trends have radically overturned the balance between needs and resources at both the family and the societal level on which the organisation and division of responsibilities in care had been, and in some countries still are, largely premised. These interact with women's changes in behaviour and expectations on the one hand, and the evolving perception and definition of care needs on the other.

Demographic changes and ongoing trends have radically overturned the balance between needs and resources at both the family and the societal level on which the organisation and division of responsibilities in care had been, and in some countries still are, largely premised.

Demographic ageing has changed the age composition not only of the population, but also of kinship networks, that have become increasingly top-heavy. There are more grandparents and even great-grandparents than grandchildren. And during one's lifetime it is likely that a person (particularly women) will have more or less intensive caring responsibilities for a longer time towards another impaired adult or frail old relative than

towards young children. Demography plays, therefore, a different and somewhat opposite role with regard to care for young children and care for people with disability or the frail old.

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1.1 THE DEMOGRAPHIC CONTEXT OF CHILDCARE NEEDS

The demand for more childcare services is not spurred by their increasing numbers (on the contrary). There is also not, at the demographic level, a decreasing number of grandparents (grandmothers), who – particularly in southern European and in some eastern European countries – have traditionally been the main childcare resource when mothers are employed. It is, however, true that pension reforms that have raised the retirement age may have reduced the time availability of grandparents and particularly grandmothers who, if employed, remain longer in the labour market[35], thus causing a 'scarcity' of full-time grandmothers.

The two main demographic phenomena that drive the need for a care policy are, firstly, the very 'scarcity' of children, coupled with the goal of supporting the choice to have children while encouraging mothers to remain in the labour force; and, secondly, immigration, that spurs the need to integrate linguistically and culturally from start second generation children.

The increasing demand and need for a care strategy with regard to children, however, is spurred by two other phenomena that have changed the perception of needs in this area. One is the request for **time to care as a right for both mothers and fathers**. The other is the **growing importance assigned to early child education,** which frames services for children as merely care and involving only, or mainly, work-family conciliation needs. Recognising the increasing importance of the first years of life, ECEC services are seen as means of investing in children as future citizens and of granting them equal opportunities to develop their capabilities irrespective of the socioeconomic, working and citizenship status of their parents, as well as of having or not a disability. **This perspective requires not only a universalisation of the offer of services for young children, but also a focus on educational quality and the professional profiles of those working on them, thus impacting their cost** (see Chapter 4 by Anna Gromada on universal access to childcare).

Attendance is disproportionately skewed in favour of children from medium-high income households and having higher educated parents, possibly because these are more often dual earners.

Notwithstanding these common trends, there are broad cross-country differences in all the items of the childcare package[36]:

- coverage, duration and compensation of leaves, particularly of that part of leaves that is not directly reserved to mothers;
- coverage by childcare services, particularly for the 0-3 and for the portion of offer that is publicly funded;
- whether services for the under three are framed and organised, with regard to the professional profiles of those working in them, as mainly care or as educational services.

Table 1 shows the range resulting from attendance to formal care limited to only to two dimensions: coverage and number of hours per week. Alongside cross-country differences there are also intra-country differences, particularly in the offer of and access to services, at the regional and sub-regional level[37] as well as at the socio-economic one. Indeed, attendance is disproportionately skewed in favour of children from medium-high income households and having higher educated parents, possibly because these are more often dual earners.[38]

TABLE 1 - Formal childcare, by age of child and duration of care, 2020 (% share of children in each group)

	Aged less than three years			Aged from three years up to the minimum compulsory school age			Aged between the minimum compulsory school age and 12 years		
	1-29 hours per week	≥ 30 hours per week	≥ 1 hour per week	1-29 hours per week	≥ 30 hours per week	≥ 1 hour per week	1-29 hours per week	≥ 30 hours per week	≥ 1 hour per week
EU [1]	12.8	19.5	32.3	29.0	51.5	80.5	41.2	54.1	95.3
Belgium	18.8	35.8	54.6	13.3	83.6	96.9	9.8	89.9	99.7
Bulgaria	89	6.1	15.0	18.5	75.0	93.5	226	77.3	99.9
Czechia	23	25	4.8	28.6	49.6	78.2	37.3	62.1	99.4
Denmark	21	65.6	67.7	2.7	33.9	36.6	13.4	82.2	95.6
Germany [2]	6.0	10.4	16.4	17.6	30.0	47.6	61.1	35.2	96.3
Estonia	9.0	17.7	26.7	13.9	79.6	93.5	53.6	46.2	99.8
Ireland [2]	11.4	11.8	23.2	77.7	14.7	92.4	84.9	14.6	99.5
Greece	11.1	10.4	21.5	45.1	41.0	86.1	32.2	60.4	92.6
Spain	23.9	21.6	45.5	57.7	40.2	97.9	51.3	48.1	99.4
France [2]	20.7	36.5	57.2	30.3	66.7	97.0	27.2	58.4	85.6
Croatia	0.2	20.2	20.4	6.9	47.5	54.4	63.3	32.4	95.7
Italy [1]	7.6	18.7	26.3	16.6	76.6	93.2	11.4	88.6	100.0
Cyprus	3.7	17.0	20.7	34.1	42.2	76.3	71.2	28.8	100.0
Latvia	0.7	25.6	28 3	1.8	76.8	78/6	14.8	84.7	99.5
Lithuania	1.5	14.7	182	6.0	81.1	87.1	39.6	58.1	97.7
Luxembourg [2]	16.5	46.7	63.2	16.9	68.7	85.6	47.2	44.3	91.5
Hungary	1.4	9.1	10.6	11.6	77.9	89.5	23.8	74.9	98.7
Malta	18.2	11.5	29.7	28.1	52.6	80.7	4.5	95.5	100.0
Netherlands	57.9	9.7	67.6	69.4	23.8	93.2	70.8	29.2	100.0
Austria	13.4	7.7	21.1	62.9	24.5	87.4	52.5	46.5	99.0
Poland	2.0	9.2	11.2	19.0	39.1	58.1	43.0	54.3	97.3
Portugal	1.9	51.1	53.0	5.3	82.9	88.2	7.4	91.0	98.4
Romania	6.2	0.6	6.8	48.4	11.0	59.4	81.5	0.9	82.4
Slovenia	2.2	42.1	44.3	5.1	90.7	95.8	23.8	75.8	99.6
Slovakia	0.0	4.8	4.8	10.1	76.7	86.8	31.6	57.8	89.4
Finland	9.5	30.1	39.6	21.5	63.8	85.3	83.3	16.7	100.0
Sweden	18.5	35.6	54.1	27.6	63.8	96.0	51.2	48.8	100.0
Iceland [2]	3.1	58.2	61.3	1.9	96.2	98.1	22.2	75.5	97.7
Norway	5.7	56.4	62.1	6.0	71.8	77.8	73.0	25.8	98.8
Switzerland	25.3	6.1	31.4	45.8	15.4	61.2	47.5	51 6	99.1
North Macedonia [2] [3]	2.7	10.3	13.0				58.5	17.0	75.5
Serbia [2]	6.0	12.1	18.1				62.7	21.7	84.4

[1] Estimated.
[2] 2020 Break in series.
[3] 2019.

Source: Eurostat (2022). 'Living conditions in Europe – childcare arrangements'. Available from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Living_conditions_in_Europe_-_childcare_arrangements#Childcare_arrangements

2. THE DEMOGRAPHIC CONTEXT OF LONG-TERM CARE

Unlike childcare, the demand for adult and frail old care is mainly driven by demographic change: by the increasing number of persons needing long-term care both in society and within kinship networks because of longer life expectancy, in the context of long-term shrinking fertility. In this case, therefore, there is a demographic imbalance between potential care-needers and potential caregivers, which is made more acute by the increasing labour force participation of women and by the rising retirement age. As in the case of small children, the perception of needs and rights of severely disabled adults and frail old people has changed, stressing issues of dignity and personalisation of measures.

> *Population ageing affects the pool of potentially dependent persons and that of potential carers in opposite ways, both at the population and family level. While the number of very old people (80+) and their percentage of the total population (5.6% in the EU28, 2016) is set to increase, the pool of potential men and women carers is likely to shrink.*

Population ageing affects the pool of potentially dependent persons and that of potential carers in opposite ways, both at the population and family level. While the number of very old people (80+) and their percentage of the total population (5.6% in the EU28, 2016) is set to increase[39], the pool of potential men and women carers is likely to shrink. In the long run, there are likely to be fewer people able and willing to provide the required care for the dependent elderly within the family network, as various academics have said already for some time.[40] According to a 2015 estimate[41], the number of women in the EU aged 50-64 years old – those most likely to have a frail or disabled relative in their family network – fell from 2.7 per person aged 80+ in 1990 to 1.9 in 2016. It should be noted that this is the age bracket that it is most likely to be the so-called sandwich generation, having responsibilities both towards a frail old relative (or partner) and one or more (grand-)children.

All European countries except Denmark saw a fall in this ratio in 2016, with a significant convergent trend reducing country differences over the last 25 years. Ireland, Sweden, Cyprus and the Netherlands have seen a slow decline in this ratio, while it was dramatic in Romania (from 5.2 to 2.3) between 1990 and 2016. Many Southern and EU countries – i.e., countries characterised by the most family-oriented and gendered schemes of caring – had also experienced a rapid decline in this ratio. In 2019, the ratio had already fallen to 1,24[42]. Recent data[43]shows that **the share of the age cohorts above 65 years in the EU population is expected to rise from 20% to 30%, with the share of those aged 80 and over doubling from 6% to 13%.** By contrast, the share of the age group 20-64, namely the working-age population, would fall from 59% to 51% of the total population. This change is projected to be particularly acute in Spain, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania and Slovakia, with increases of at least 30 percentual points.

It should be added that the increase in life expectancy also leads to an increase in the burden of specific diseases, such as Alzheimer's disease and other dementias and uterine cancers.[44] These, in turn, negatively impact the quality of life of old people, as well as on the health services and family carers.

The data suggests that, although at present around 52 million Europeans, 14.4% of the population aged 18 to 74, mostly women, provide informal long-term care to family members or friends every week.[45] **In addition to not being always adequate and available, this care resource is set to become increasingly scarce numerically in the face of increasing demand. This scarcity may be further heightened by intra and cross-country mobility, which involves mostly the younger and middle generations**. It may have severe impacts on the frail and old in countries where most, if not all, long-term care is provided informally by family members or, for those who can afford it, privately paid carers, as in most eastern European countries as well as in Greece, Cyprus, Italy and Portugal, and, to a lower degree, Spain.[46] In these countries, cross-country migration plays the opposite role. It acts as a substitute for lacking public services and an integration of family care in the receiving countries, as in Italy and other Mediterranean immigration countries. It strengthens the scarcity of family carers in the emigration countries such as Poland and Romania (and also other non-EU countries such as Ukraine).

The current institutional arrangements for the provision and financing of LTC by the public sector may face pressure in the future, if the availability of informal carers and their propensity to provide care diminish.[47] The degree and direction of the impact, however, depends on whether informal and (publicly funded professional) home care in a given country complement or substitute. The 2021 Ageing Report says that in countries where there is complementarity, a decreasing supply of informal carers might reduce the demand for home care, increasing the demand for residential care. Where, instead, informal care is a substitute for formal home care, a shortage of informal carers could lead to an increase in demand for home care. The prevalence of substitution vs complementarity, however, differs not only across countries, but also by the reasons for long-term care. A study of 12 European countries shows how substitution, rather than complementarity is the general situation when it comes to people with dementia, although there are cross-country differences.[48] Furthermore, particularly in their initial stages, dementia and Alzheimer's are not detected by standard tests and de facto not fully included in the definition of people needing long term care. And the specific needs of people affected by dementia and Alzheimer's (cognitive stimulation, logopaedics, psychological support) are rarely met by usual forms of long-term care, leaving them at their own and their family (also financial) resources.

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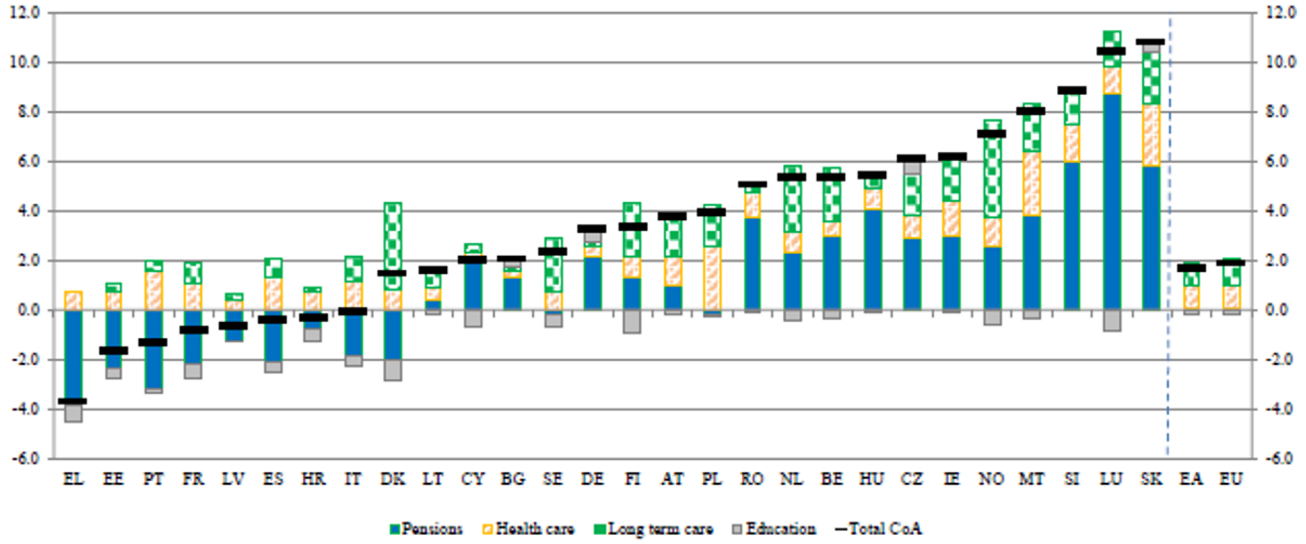
Cross-country differences in LTC policies are even greater than in the case of care and ECEC for young children They concern coverage level by services; the balance between home and institutional care and between payments for care and the provision of services; access rules; formal and informal expectations towards family members; whether or not there is entitlement to a care leave in case of dependent family members and at what conditions; the degree and kind of support offered to informal caregivers; the role played by migrant labour and by the regulation of migration; and women's labour force participation in the age brackets more involved in caregiving demands.[49] In addition, as in the case of services for children, there are often important intra-country differences both in the provision of home services and in the availability of institutional care.

2.1 BUDGETS UNDER STRESS?

Demographic imbalances in the caregiving/care-needing relationship do not just affect the availability of informal, unpaid carers. They also affect the availability of public resources to finance formal care, both for children (including ECEC) and for the frail old and the severely disabled, risking competition between the needs of young children and those of the old. Due to the recent pension reforms, EU pension expenditure is set to increase in the next decades, then level off, with a different timing depending on the country.[50] The largest rise in social expenditure related to the old will be in health and long-term care. But the starting points are very different, as shown in Figure 3, which suggests that the degree of unmet needs and possible tensions and risks from competing needs may vary across countries.

Figure 3 - Projected change in age-related expenditure (2019-70), by expenditure component, PPS. Of GDP



Source: European Commission (2021) The 2021 Ageing Report. Economic and budgetary projections for the 28 EU Member states, Institutional paper 148, May, Luxembourg: Publications Office of the European Union. (graph. 5)

> *The good news is that investing in childcare and long-term care, in addition to improving the well-being of children, people with disabilities, the frail old, and their families, also creates new jobs, thus enlarging the tax base.*

The good news is that investing in childcare and long-term care, in addition to improving the well-being of children, people with disabilities, the frail old, and their families, also creates new jobs, thus enlarging the tax base. Recent research from the International Labour Organisation, cited also by the Commission's Recommendation on child care[51], shows that **investing 1.1% of GDP in ECEC and 1.8% of GDP in long-term care each year would create an additional 26.7 million jobs in Europe by 2035** (although, when budgets are tight, the long-term benefits may seem too far away to be afforded). In countries with long established and more generous policies in the field, this might mean only some reduction at the margins: a decrease in the quantity and quality of services offered. In the case of severely disabled adults or dependent old, the general trend towards the de-institutionalisation of care may also involve a shift towards family provision.[52] In countries where either ECEC or LTC services, or both, are scarce, in the absence of an EU initiative and a mobilisation by interested national groups in favour of more generous care policies, budgetary constraints may mean leaving a large quota of unmet needs left to be answered only through private resources, thus strengthening inequalities.

3. THE IMPORTANCE OF AN EU CARE STRATEGY

One of the European Care Strategy's greatest challenges lies not only in national autonomy in this field, but also in the even larger cross-country differences in starting points. In turn, these underline the differences in resources, as well as in social and political history and family and gender cultures. As the delays by many countries in reaching the Barcelona targets with regard to

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ECEC services indicates, reaching a common minimum level of coverage may prove difficult, particularly for countries that start far away, since it involves a substantial financial effort, a change in priorities and in cultural ideas concerning intergenerational obligations and the well-being of young children and of the frail old.

These difficulties, however, make the present EU initiative even more important and welcome. Putting care on the European agenda furthers and strengthens the action of those social actors and policy-makers in member states who argue that care needing and care providing should be an important political issue since it is at the intersection of demographic, behavioural and cultural changes. It is neither a marginal issue at the private/family nor the societal level, impacting delicate, even fragile demographic, time and budget balances. It must be addressed urgently and with a coherent and integrated approach, where all the pieces of the puzzle are considered. The European Care Strategy offers an 'interpretive pattern'[53] through which needs are identified, and priorities and responsibilities defined. It is particularly important to adopt a life course perspective: care needs and demands for providing care may arise more than once in a lifetime.

> *The European Care Strategy offers an 'interpretive pattern' through which needs are identified, and priorities and responsibilities defined. It is particularly important to adopt a life course perspective: care needs and demands for providing care may arise more than once in a lifetime.*

With regard to childcare and education, the strategy integrates the different initiatives at this level both through recommendations and through directives, up to the 2019 Directive on work-life balance – in other words, the different pieces that make up the care package for children – while highlighting the educational dimension of services for young children. It also goes beyond the needs of children (and parents) below school age, acknowledging that supervision and relational care needs for children can outlast the preschool years and are not always adequately met by school and family.

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Even more important is the inclusion of long-term care. **Unlike childcare, long-term care has barely been part of EU policy discourse**. It has often been limited to the work-family conciliation issue, although demographic ageing has been a concern for some time concerning the increase in health costs. **Although LTC has long been mentioned in various EU documents, it has only formally entered the EU policy agenda with the 2019 Directive on work-life balance**. This Directive introduces the right to protected leave for persons caring for a dependent family member, although in a light way compared to leaves linked to the birth and presence of a young child: a minimum of five days a year, with no minimum statutory compensation. Crucially, the European Care Strategy and the ensuing Recommendation proposal consider the improvement of the situation for both the care needing and the caregivers and, within the latter, for both family caregivers and care workers (in both cases, they are mainly women).

Last but not least, the European Care Strategy and the accompanying Recommendations put a focus on the condition of workers, with regard to professional

requirements, conditions of work and adjournment, and pay. It would be paradoxical if, while putting care and the well-being and dignity of those who need care at the forefront, the needs, dignity and rights of care workers are forgotten or under-evaluated.

Given the cross-country differences in starting points, political and family cultures, and financial resources, there is a risk that the European Care Strategy remains little more than symbolic. To avoid this, the strategy and the recommendations that flesh it out should be accompanied by specific actions at the EU and national level.

4. MOVING FORWARD

Given the cross-country differences in starting points, political and family cultures, and financial resources, there is a risk that the European Care Strategy remains little more than symbolic. To avoid this, the strategy and the recommendations that flesh it out should be accompanied by specific actions at the EU and national level.

The instrument of a Recommendation (rather than a Directive) is appropriate, and in any case, the only one available for the time being in this area. It offers guidelines for shared goals that may be achieved progressively, depending on the starting points. However, specific actions and results with regard to the care policies spelled out in the two Recommendations should become part of the evaluation of the content of national budgets and of the guidelines for the use of the European Regional Development Fund, the European Social Fund plus, and its Employment and Social Innovation strand, the Just Transition Fund, Horizon Europe, the Digital Europe Programme and the Recovery and Resilience Plans. In addition to 'gently nudging' countries to develop their care strategies, explicitly including the goals and principles of the European Care Strategy in the guidelines for these funds and in their ex-post evaluation would help in public debates and in negotiations with their governments. At the same time, in order to avoid fragmentary measures with little or no impact, coherent and integrated planning should be required when using the diverse resources provided to the different bodies at national level. This implies setting up a complex governance arrangement where, depending on the country, more than one ministry might be involved, as well as both national and regional and/or municipal level bodies. The appointment of a national coordinator for the care strategy, as suggested by the Commission, might be useful.

In this process, it is not only important to stress coverage percentages at the national level, but also the need for a certain uniformity within each country. In countries where there are great regional disparities, national averages may hide enormous regional and municipal differences in provision. It is, for instance, the case in Italy both for ECEC services for the under three and for LTC services.

4.1 ECEC SERVICES

It is important and welcome that the recommendation highlights their educational, not exclusively care, dimension, and, following the principles of the Child Guarantee, identifies, among its goals, the inclusion of children of disadvantaged households, of ethnic minorities as well as children with a disability. However, I believe the discursive framework does not properly address the work-family imbalance. To be truly inclusive, the argument in favour of an expansion of good quality and accessible ECEC services should be based on the universal right of children to resources of early non-family education and care, irrespective of the characteristics of their parents: not (only) because their mother is employed, or because they suffer from some kind of disadvantage.

Providing ECEC services to all children from an early age is crucial for granting equal developmental opportunities, as research shows, particularly for children under three. This research may however contrast with widespread ideas that the best care is provided by the mother only, and that ECEC services are surrogates for the mother's care. These ideas may be strengthened if the offer of ECEC is framed mainly as a work-family conciliation measure on the one hand, as targeting disadvantaged children on the other hand.

The more services are offered on a universal basis and as an opportunity for all children, the more they are accepted as beneficial in the process of growing up. Intensity in attendance may differ depending on individual needs and circumstances. Flexibility in time schedules is, therefore, advisable. The monitoring exercise should pay particular attention to the degree to which the gap in attendance by social class, citizenship status, ethnicity, presence or not of a disability, parents' education and occupational status is reduced at the national and intra-national level.

In this perspective, attendance to ECEC services, including those for children under three, should become a legal entitlement, as suggested by the Recommendation from the European Commission. The educational dimension of these services should also become explicit at the institutional level. Entitlement should include a (substantial) minimum of daily or weekly hours. While leaving parents freedom of choice in whether and with what intensity to use these services, the presence of a legal entitlement would incentivise national and local governments to provide, directly or through cooperation with the third sector, an adequate number of places.

The explicit definition and institutionalisation of the educational character of these services is also needed in order to avoid trading the professional quality of workers with quantity, a risk that has been documented in some countries.[54] Towards this end, countries should be required to set clear rules concerning the professional profiles and qualifications required as well as the standard wage level. These rules should be enforced across all institutional forms of ECEC services, be they public, third sector or market. They should also become the basis for a levelling of wages across public, third sector and private ECEC services and for the calculation of costs when the implementation of ECEC services is fully or partly allocated to the third sector or the market, with or without some public funding. These aspects should be part of the EU monitoring process. Only if wages are decent and acknowledge the professional profile of ECEC workers across all ECEC services irrespective of them being publicly or privately provided, there would be some guarantee concerning their quality, while unfair competition and social dumping as well personnel shortages may also be avoided.

Finally, the offer of ECEC services, in addition to being coherently integrated with the duration of parental leave in each country, should be accompanied by activities that support parents, both mothers and fathers in their relationships with children, in developing the attitudes and behaviour that the literature calls 'responsive parenthood'.

Finally, the offer of ECEC services, in addition to being coherently integrated with the duration of parental leave in each country, should be accompanied by activities that support parents, both mothers and fathers (starting before birth, taking advantage of the courses that prepare for delivery) in their relationships with children, in developing the attitudes and behaviour that the literature calls 'responsive parenthood'[55]. These activities should be staffed by an interdisciplinary team, that works in close collaboration with ECEC services and paediatricians. Given the importance of the first 1,000 days in the child's development, supporting parents in their care and education responsibilities in this crucial period should be considered a crucial dimension of any childcare strategy. It may also be an important means to help parents to understand the importance of ECEC services for their children's development and well-being.

The increase in coverage and quality of ECEC services certainly comes at a financial cost. This cost would, however, be compensated in the short term by the increase both in good quality jobs and in the labour market participation of mothers throughout the social stratification that their availability will incentivise, thus enlarging the tax base. In the long term, the early investment in the wellbeing and full development of children, including the most disadvantaged, supports children's health and harmonious development, thus their human capital, reducing the human, social and economic costs of bad illness, insufficient cognitive and relational skills, school dropout and early school living.

4.2 LONG-TERM CARE

Long-term care is much less widely acknowledged as a policy issue and as a collective responsibility across the EU countries than child education and care. There is a lack of cross-country tradition and shared consensus on the need for a public policy. This concerns both the distinction and balance (as well as the interdependencies) between health and other (relational, cognitive, emotional) care needs and the respective responsibilities of the family and the community.

While the healthcare needs of the frail population and their increasing costs for private and public budgets in ageing societies are widely acknowledged, less so are the other needs. This is particularly the case in countries where the family (spouses, children, parents in the case of children with severe disabilities) has long been the main responsible actor attending to the everyday needs of someone who is not self-sufficient. Given that women were and are de facto the most involved in family caregiving, and that many of them were out of the labour force (exited due to caring responsibilities,

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never entered, or were retired) has contributed to further hiding, or under-evaluating, the needs both of the severely impaired individuals and of their carers[56]. It has also meant an under-evaluation of the professional skills required to properly attend to the non-exclusively healthcare of severely impaired individuals**. The very fact that the European Commission feels that it should state that long-term care must grant the dignity of those who receive it is an indication of how often this does not happen.** There needs to be a clearer public discourse on the right to be adequately and holistically cared for - as well as the right of unpaid family carers to be supported and acknowledged; and of paid carers to be properly trained and paid a fair wage.

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While the Recommendation on LTC offers good elements for this discourse, it is too timid with regard to the long- and medium-term coverage goals of the different measures envisaged, the reduction of inequality in access to good quality care and non-family care. This timidity is somewhat analogous to that of the 2019 Directive on work-family balance, which introduces a right to time off work to care for a dependent family member (but at a minimal level and without including also the right to some kind of compensation). Concerning a policy field that, at least in some countries, has a low legitimisation, this absence of targets (and of an impact assessment) opens risks of no or marginal impact. It also complicates the construction of indicators for monitoring. In this perspective, it might be useful to ask countries preparing their national action plans in LTC to indicate their goals (and the relative timing) across all the relevant dimensions: home care and community-based care, closing territorial gaps, rolling out accessible innovative technology and digital solutions, ensuring accessibility for persons with disabilities, supporting family carers, ensuring fair wages and training for care workers in formal services, supporting the contractualisation of privately (family) paid workers.

> *While the Recommendation on LTC offers good elements for this discourse, it is too timid with regard to the long- and medium-term coverage goals of the different measures envisaged, the reduction of inequality in access to good quality care and non-family care.*

Also, the term 'informal care' is misleading, in that it covers care provided by a family member (which is the bulk of this kind of care), care provided by volunteers and care provided for pay by non-professionals, with or without a contract. These are very different situations that must be carefully distinguished. In particular, family carers, mostly women, are far from 'informal': they are expected to provide care, because of their legal family role and relationship. Defining them as 'informal' is another way of hiding them and their work, which is often, de facto, experienced as, morally or socially, compulsory, differently from that of a volunteer or a privately paid person.

Furthermore, they need training, support, respite, and unburdening of part of the care responsibilities. Paid private carers need clear contracts, fair wages and professional training, analogously to care workers in formal settings. Paid private carers and individuals and families that hire them also need some third party that offers reciprocal guarantees against exploitation and cheating. Finally, in countries where most LTC is left to families, including their ability to pay someone else, inequality in access to basic care may be enormous. Thus, there is a significant difference in whether there is some payment for care, how it is regulated, and who can receive it. For all these reasons, it is necessary to clarify the different figures, relationships and statuses included under the generic and imprecise term 'informal'.

In providing services, more attention should be given to the different needs of dependent individuals (and their families), given the different causes and forms of their dependency. As with disability (see chapter 10 by Florian Sanden on independent living for disabled people), although long-term care involves mainly old individuals, long-term dependency does not come only in one size and it is not only a matter of degree, even among the old (see Chapter 7 by Jean-François Lebrun on long-term care). In order to prevent or slow the road to long-term dependency, care must be tailored to the specific form of dependency. In this perspective, more attention should be given to the specific needs of severely disabled children and adolescents and people with dementia or Alzheimer's, and the offer of services should be as precocious as possible.

In order to improve the availability of meaningful relationships for dependent people, including at the intergenerational level, opportunities for young civil servants might be considered favourably: this would not be a substitution, but an integration of professional carers as a support for family carers. If adequately prepared and monitored, it would be a learning experience for the young involved - and it would enrich everyday life for the dependent persons, be they old, adolescents or adults.

Last but not least, coordination between health and long-term care providers should be promoted to avoid any shifting between the sectors based on financial or organisational motives (rather than the needs of the person involved). Coordination should also aim to develop a coherent approach that takes account of the dependent persons themselves and their family carers, given them the responsibility to make sense of different interventions, approaches, logics.

> *"The term 'informal care' is misleading, in that it covers care provided by a family member (which is the bulk of this kind of care), care provided by volunteers and care provided for pay by non-professionals, with or without a contract."*

4. ENSURING UNIVERSAL ACCESS TO CHILDCARE

4. ENSURING UNIVERSAL ACCESS TO CHILDCARE

Anna Gromada

Co-foundress of the Kalecki Foundation

1. INTRODUCTION

Even before the Covid-19 pandemic, some EU countries were failing to offer comprehensive early childhood education and care (ECEC) and education to all families, which reflected their policy priorities rather than available resources. This runs against the Sustainable Development Goals which commit all countries to provide all girls and boys with access to good-quality early childhood development, care and pre-primary education.

In the European Care Strategy presented, the European Commission proposed new targets: 50% of under three-year-olds and 96% of over three-year-olds should have access to childcare by 2030. These new, more ambitious goals, are a next step after the 2002 Barcelona Targets already discussed in the previous two chapters (see chapter 2 by Cecilia Navarro and Meenakshi Fernandes and chapter 3 by Chiara Saraceno).

Like the universal access to primary education that swept 19th century Europe – with school duties secured in the Duchy of Warsaw (1808), Prussia (1819), Austria (1869), Great Britain (1876) and France (1882) – European countries could lead the way in extending the right to education to younger children, with benefits for them, their caregivers and the society.

2. WHY DOING IT?

Investing in childcare is good for children, for parents and for society. This subsection follows the structure of a funnel: starting from the benefits for individual children, their immediate milieu and then society at large.

> *Provided its high quality, childcare fosters cognitive and social-emotional skills.*

2.1 CHILDREN'S WELLBEING AND EDUCATION

Provided its high quality, childcare fosters cognitive and social-emotional skills. The brain is most plastic between the ages of zero and five and stimulating it through play or play-based learning is more effective than later in life. Interactions with peers enhance social, emotional and behavioural development, giving children competence they can use in life and school. This is especially true now, when Europe is becoming a region of one-child societies. For many children, day-care provides the first platform where they have to negotiate something on an equal footing with their peers.

2.2 INEQUALITIES AMONG CHILDREN

In countries with low enrolment, childcare is typically used by the privileged. High-income households are almost twice as likely to use formal care for children under three – a gap that narrows down to a few percent for children aged three-to-five. This is problematic given an equalizing potential of high-quality childcare – especially propitious in preventing children from disadvantaged backgrounds, and children whose parents left education early from falling behind.[57]

The dimensions of disadvantage tend to overlap. For example in 2014, when Poland's enrolment stood at 7.2% for children under the age of three, the country was dotted by vast 'childcare deserts'. As many as 80% of all communes, including 91% of rural communes, did not have a single institution for children at this age,[58] meaning that parents outside of metropolitan areas could not use childcare regardless of its price and quality.

> *Providing universal childcare should relieve exhausted parents, provide a better work-life balance and enable the return to work for those who wish to do so.*

2.3 GENDER EQUALITY AND LIFE-WORK BALANCE

Despite considerable progress in gender equality, women still carry a disproportionate share of care (see chapter 2 by Cecilia Navarra and Meenakshi Fernandes and chapter 8 by Barbara Helfferich). In the EU, 90% of the formal care workforce is made up of women, including 97% of childcare teachers, while almost eight million women are out of employment because of care responsibilities.[59] Providing universal childcare should relieve exhausted parents, provide a better work-life balance and enable the return to work for those who wish to do so.

Such support would be especially welcome in countries torn by the two waves of 20th century urbanisation. For example, in eastern Europe many young people with children do not have access to family help. They tend to live in big cities, where they emigrated to get higher education, have their own grandparents in the countryside and parents in small and medium-sized towns, where the communist regimes deliberately located new workplaces. This comes on top of the scale of single parenthood. In 2020, 14% of households with children in the EU were run by a single parent – ranging from 5% in Croatia to 34% in Sweden.[60]

2.4 DEMOGRAPHIC CHALLENGES

The EU faces a demographic crisis: it has a sub-replacement fertility rate of 1.5 children per woman and many populous countries, such as Spain and Italy, have rates below 1.3. In most EU countries, people would like to have more children but they don't[61] due to the conflicts of the modern world: between personal and professional life, between actual and desired material conditions and between the evolving ideologies, including those about gender roles. A good social policy would mitigate these conflicts while respecting individual freedom. One of its elements would be high-quality childcare as the availability of places in nurseries indirectly influences fertility: easing the burden of the first childbearing makes people more willing to have a second child.

2.5 BENEFITS FOR THE SOCIETY

High-quality early education is a gift that keeps on giving: it is linked to better academic opportunities, higher income, better health, lower possibility of using welfare, committing a crime and ending up in prison. According US-based research, one dollar invested in a children's programme yields up to $10 in future returns.[62] In this way, it is an auspicious long-term investment in society.

3. CHILDCARE TRENDS

This second subsection presents childcare access, quality and affordability trends. The three are inextricably combined and should be analysed together. For example, in Hungary, where the average caregiver looks after 14 children, many parents might understandably have questions regarding the wellbeing and security of their offspring. In neighbouring Slovakia, geographical and legal access is of secondary importance for some groups, if the average single parent has to spend half her salary on childcare. Access to childcare should be understood as access to high-quality affordable services.

3.1 ACCESS

All European countries with available data provide some free access to childcare. However, in most countries the access does not start until the child is three years old, while in Austria, Finland, Greece and Portugal even later. Only Belgium, Denmark, Lithuania, Norway and Slovenia provide free access for children under three. In Denmark, the entitlement starts within the first year of the child's life, while in Norway after the child's first birthday.

However, the free access averages 25 hours weekly and is incompatible with full-time employment.[63] In the EU, 59% of mothers with at least one child under three are employed – ranging from 16% in Hungary to 82% in Sweden.[64] Childcare entitlement, funding and enrolment tend to go together with women employment rates. According to the FEPS-FES EU Care Atlas (based on OECD data), this reality explains why as many as 24% of women in the EU work part-time.[65] This average increases to 56.8% in the case of the Netherlands.

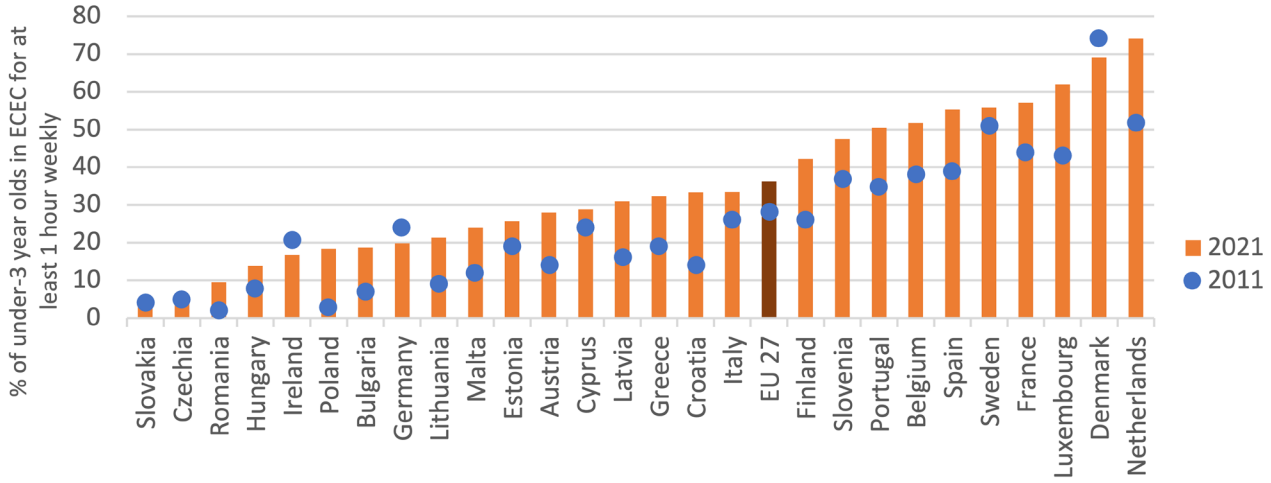
> *"In 2020, 14% of households with children in the EU were run by a single parent – ranging from 5% in Croatia to 34% in Sweden."*

3.2 ENROLMENT

Over the past decade, in the EU, enrolment increased by almost a third (from 28% to 36%) for children under three (Figure 4) and from 66% to 84% for children between three and school age. As shown in Figure 5, low enrolment typically means that the privileged use more childcare. In the EU, formal childcare for under three-year-olds was attended by 28% of children from low-income households, 38% of children from middle-income households and 45% from high-income households. In the 3-5 age group, these numbers stood at, correspondingly, 83%, 90% and 93%[66]. In practice, increasing access to childcare means creating more opportunities primarily for those from disadvantaged backgrounds. Closing this class-of-origin gap is doable – as evidenced by the case study of Denmark where there are no statistically significant differences in enrolment by income level.[67]

> *In practice, increasing access to childcare means creating more opportunities primarily for those from disadvantaged backgrounds.*

Figure 4 - Over the past decade, the use of childcare increased by almost a third
ECEC enrolment of under three-year-olds in 2011 and 2021



Notes: In 2021, the enrolment reflected various Covid-restrictions. For example, in Germany, enrolment rose from 24% (2011) to 31% (2019) and then fell to 16% (2020) and 20% (2021).

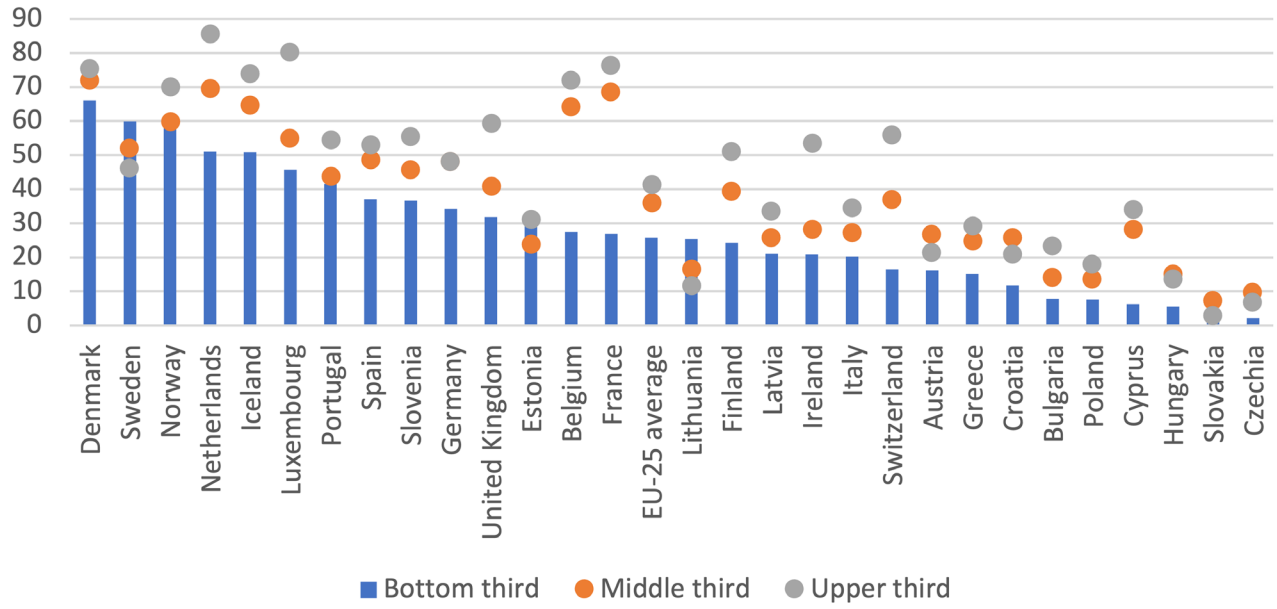
Source: Eurostat 2021 (apart from Slovakia – 2020)

Higher childcare enrolment has been typically reached by a mix of legal and financial support. The legal right for children over the age of one came into force in Norway in 2009, in Germany in 2013 and most recently in the UK in 2023.[68] Yet, legal access remains hollow if it is not backed by money. In Spain, the 'Educa3' programme was granted an initial budget of €100 million for the period 2008-12 to improve childcare access for children under three.[69] In Poland, the programme 'Maluch' was launched in 2011 to finance childcare institutions, at a time when enrolment of under three-year-olds was a meagre 3%. Initial budgets amounted to €21-32 million. By 2021, with

central funding, enrolment increased six-fold to 18%. As of 2022, the government will almost double the budget: from €500 million to almost €1.2 billion in 2022-2029. This will create an additional 100,000 places in day care – to reach 230,000 places – a sharp increase from today's 130,000 places and 80,000 places available in 2013.

Figure 5 - Families of means are twice as likely to use childcare for under 3-year olds

ECEC participation of children under three, by income level, in 2020



Note: Disposable income (post-tax and post-transfer) is equivalised to account for the family size in 2020 except in Germany (2019), Italy (2019), Iceland (2018) and United Kingdom (2018).

Source: OECD Family Database (2023).

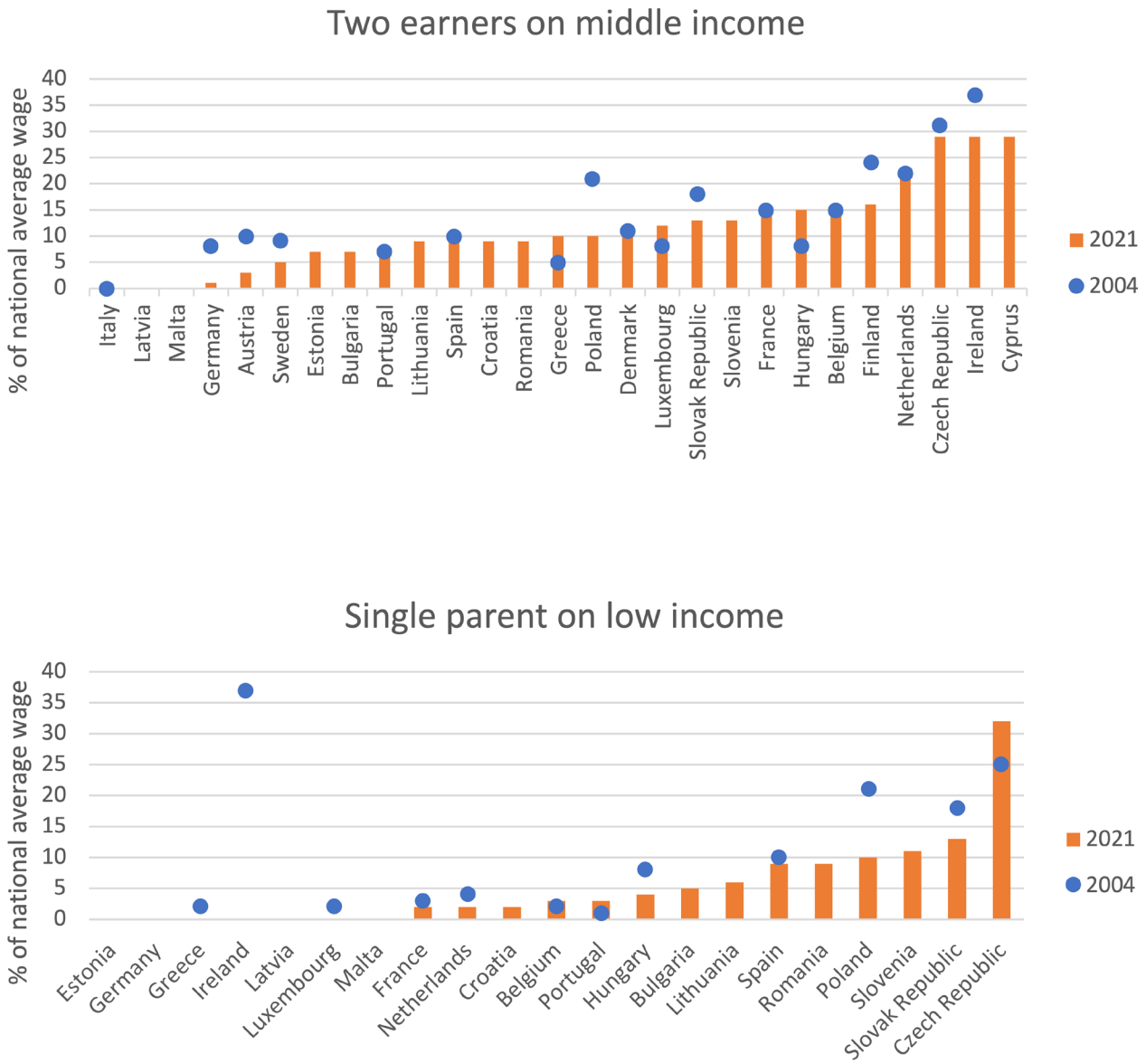
3.3 AFFORDABILITY

Over the past decade, EU childcare has become more affordable. For a couple on two average wages, the burden fell slightly from 13% of one salary (2004) to 11% (2021). Still, this masks huge disparities – ranging from free services in Italy, Latvia and Malta to 29% of one salary in Ireland, Cyprus and Czechia (Figure 6).

EU countries heavily subsidize childcare for disadvantaged groups. The financial burden for a single parent on low earnings fell from 11% of the average wage (2004) to 5% (2021) for childcare for two. In seven EU countries, such parents would be exempt from any payments (Estonia, Greece, Ireland, Latvia, Luxembourg, Malta and Germany[70]). Ireland has made impressive progress over the past years: the childcare cost for single parents kept falling from 37% (2004) to 20% (2018) and to zero in 2020. Still, in the Czech Republic, parents would need to spend a third of the average salary.

EU states spend 0.6% of GDP on care of children aged three to five. Compared to higher levels of education, childcare is more dependent on decentralised funding. In 2019, 43% of public funding came from local, 14% from regional and 43% from central government.[71] This comes on top of private funding – 41% of children before the start of the pre-primary are enrolled in private institutions – ranging from 7% in Slovenia to 100% in Ireland.

Figure 6 - In the 21st century, childcare has become more affordable, especially for single parents
% of the average wage that two types of households spend on childcare for two in 2004 and 2021



Note: The simulation is run for two types of households with two children in full-time childcare after social assistance benefits: 1) a household of two earners, each earning the national average wage, 2) a household run by a single parent on a national minimum wage.

Source: Calculated using the data extracted on 06 Dec 2022 from OECD.Stat

3.4 QUALITY

Care quality is best measured by outcomes, such as the child's social, emotional and cognitive skills. Yet, a lack of updated comparable data allows only to measure it by inputs, such as staff qualifications and children-to-staff ratio. Only 10 European countries report this ratio for childcare: it ranges from three children per caregiver in Norway, the UK, Iceland and Denmark, four in Germany, five in Sweden and Slovenia, six in Austria and Lithuania up to 14 in Hungary. Low ratios ensure that each child gets enough attention, which enhances their development and safety.

3.4.1 Material and symbolic recognition of childcare teachers

In 2019, the EU's Council of Ministers acknowledged that the caregiving profession suffers from a 'rather low profile and status' in many countries [72] Unfortunately, many caregivers feel the same. Only 36% of childcare teachers in Germany feel valued by society – a ratio which is higher in Denmark (56%) and Norway (58%). Interestingly, caregivers feel highly valued by people they directly interact with: children and their parents.[73]

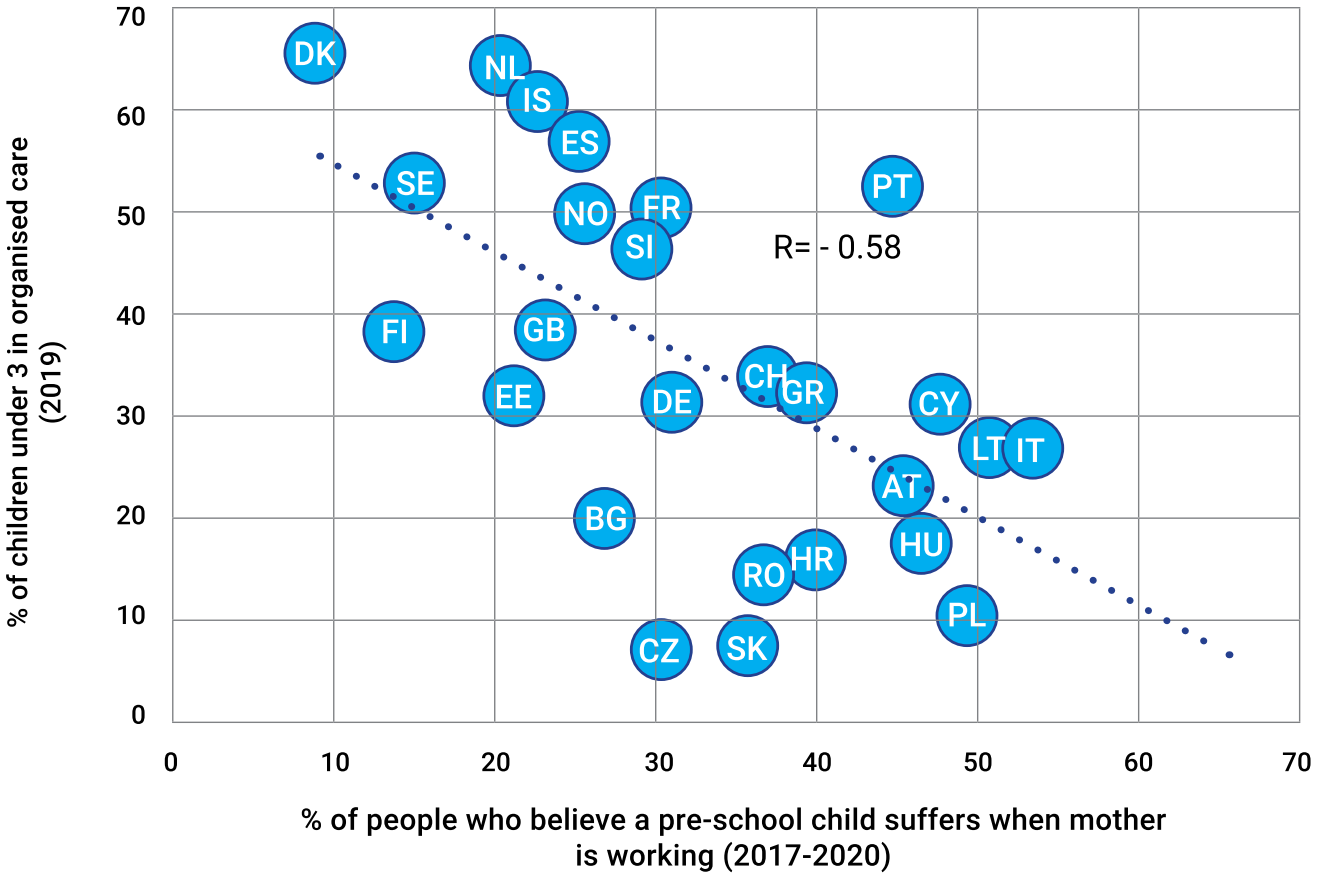
The common misperception of childcare as work that 'everybody can do' stands contrary to the basic requirements of high-quality care: emotional and cognitive skills embedded in a deep understanding of child development. Insufficient material and symbolic recognition translate into short supply and high staff turnover with consequences for the future of childcare. In the EU, only 13% of staff is under the age of 30.[74] In Lithuania, there are five times more teachers above 50 than teachers under 30, which raises questions about the country's capacity to replace retiring teachers in the future.[75]

3.4.2 Ideological views

The perception of childcare quality is inextricably linked to ideological convictions on what are the best sources of care. In three European countries – Italy, Poland and Lithuania – most people believe that a pre-school child suffers when a mother is working, a view shared by less than a fifth of the Danes, the Swedes or the Finns (Figure 7). At national level, ideological views about childcare are strongly (r=0.59) related to enrolment of children under three but weakly related (r=0,27) to enrolment of older children.[76]

In 2016, about half of parents of children under three reported no need for childcare – a share largely unrelated to the current enrolment rates. This declaration reflects parental preferences, the availability of informal care but also ideological differences in childcare styles.[77]

Figure 7 - Enrolment reflects cultural views about the needs of children and the role of women
% of people who believe a preschool child suffers when
the mother is working and enrolment of children under three



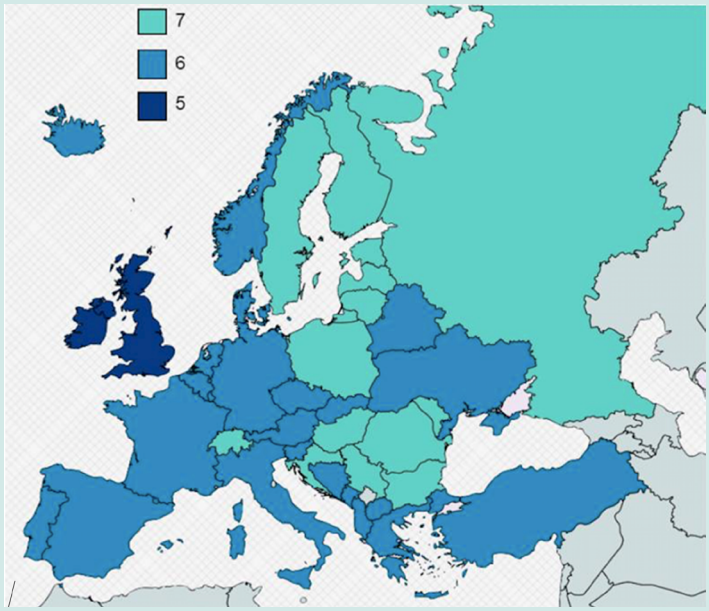
Note: % of people who believe a preschool child suffers when mother is working is a sum of responses 'strongly agree' and 'agree'.

Source: Gromada, Anna, and Richardson, Dominic, Where do rich countries stand on childcare?, UNICEF Office of Research – Innocenti, Florence, 2021, based on Eurostat (2019) and World Value Survey wave 7 (2017-2020).

CASE STUDY: POLAND'S CIVIC SOCIETY AGAINST EDUCATION REFORMS

Poland has Europe's highest school starting age, set at seven, which subsequent governments have tried to lower since the 1970s. In 2011, Civic Platform (PO) government lowered it to six – provoking an unparalleled social backlash led by the movement 'Ratujmy maluchy' ('Save the kids'). In just a few months, the movement collected 350 000 signatures to revoke the reform – more than tripling the number required to qualify for a legislative initiative to be voted in the Parliament. The Parliament rejected this proposal but the movement kept growing. By 2013, it gathered over one million signatures, called for a national referendum and became a bargaining chip in the 2015 elections – with Law and Justice (PiS) candidates promising to renege on the reform. Within the first few weeks in power, PiS revoked compulsory schooling for 6-year-olds and compulsory kindergarten for five-year-olds. Public opinion applauded this move: 67% of Poles (84% of PiS voters and 41% of PO voters) believe that the school age shouldn't be compulsory for 6-year-olds.78

Figure 8 - Age of compulsory schooling in Europe



Note: author's design using the OECD data

This case offers some lessons for reforming childcare and education – especially in more conservative countries. In my view, there were five main nails in the coffin of this otherwise desirable reform that could serve as a cautionary tale for European reformers:

1) Making the reform compulsory – rather than facultative with 'opt in' option for 6-year-olds set as a default
2) Ignoring the civil movement and assuming that the government knows what is good for the children better than their parents
3) Although the intention was good – the reformers hoped that six-year-olds in schools would free spaces for younger children in ECEC – they ignored the context. Parents had higher trust in local kindergartens than in schools. For them, the six-year-olds were not easily 'transferable' between these institutions.
4) Many primary schools were merged with secondary – meaning that six-year-olds would be in the same building as 15-year-olds – which raised concerns about the safety and well-being of the former. In my opinion, the reform would have had a better chance of success had it organised the first year of learning in kindergartens. They are typically much smaller in size and host children in a narrower age range of 3-6.
5) Some schools were not prepared to receive six-year-olds in legal, staffing and organisational terms: they didn't have play corners, equipment and cafeterias; they were overcrowded and practiced a shift system. The government did not allocate sufficient funds for this reform and did not set the standards. Parents wanted the revocation of this reform, rather than its postponement, because they did not trust that the state will provide adequate conditions in the future.

4. POLICY RECOMMENDATIONS

In light of the above considerations, it will be crucial that in implementing the European Care Strategy, the European Union and its members states make sure that the revision process of the Barcelona Targets goes beyond a numerical threshold setting exercise. Although the adopted Council Recommendation already acknowledges this, it will be essential that the following policy recommendations are taken into account for universal access to childcare to materialise.

Financial

1. Increase childcare funding through direct provision as well as through support of employers and local governments

High-quality childcare is an investment. Its magnitude currently ranges from 0.3% of GDP in Ireland and Greece to 0.9% in Sweden. Providing free-of-charge or symbolically paid services to all families is the preferred option, which in most EU countries would require a sharp increase in funding. Not all of it needs to be a direct service provision. In countries with very low enrolment, large employers could be encouraged to invest in childcare facilities through subsidies or tax breaks.[79]

2. Given the persistence of class-of-origin education gaps, prioritise affordability for low-income households

If the provision of free or symbolically paid services for all is untenable, consider fee systems, ranging from free to a nominal charge for richer parents. Inequitable access to childcare can widen development gaps between children of different backgrounds even before the start of primary school. These gaps tend to persist and deepen as children advance through school. The best time for addressing them is before the start of compulsory education.

3. Make sure that local governments – which disproportionately carry the burden of childcare – are well equipped to do so.

In the EU, most childcare funding comes from local and regional governments. National governments could subsidise childcare to avoid the scenario known from primary schools in the US – where local funding deepens the inequalities as schools in poor areas receive less funding from poorer communes. For poor counties, the required down payments and funding instability were deterrents against setting up new childcare places. In the case of such a long-term investment guaranteeing the stability of funding can be more important than its initial amount.

Quality-related

4. Lower the children-to-staff ratio

In some countries, people do have a negative view of ECEC, and sometimes it is for good reason. In post-communist states – Estonia, Lithuania, Latvia, Poland, Czech Republic, Slovakia, Hungary and Slovenia – daycare for very small children can conjure up the spectre of pre-1989 inadequate care or even of child collectivisation. Some quality concerns remain valid today. For example, in Hungary, where the average caregiver supervises 14 children, parents have every right to worry about the security and development of their children. Providing adequate attention by decreasing children-to-staff ratio should do the job. Sometimes one highly-qualified teacher accompanied by teacher aids is a good solution.

5. Build the prestige of the teaching profession both financially and symbolically.

High-quality childcare is not a job that 'everybody can do'. It requires qualified personnel with high social and emotional skills. European countries should set the standards and invest in the childcare workforce and their working conditions, to ensure high-quality childcare. Their professional development opportunities could draw inspiration from pan-European higher education programmes, for example, by providing Erasmus exchange programmes for pre-primary teachers.

Legal and practical

6. Align the end of parental leave with availability of childcare

In many EU countries, the statutory maternity and paternity leave ends before the childcare entitlement begins. This creates a time gap in which parents struggle as some of them look to return to work and others struggle in terms of time pressure and foregone income. The governments should ensure a smooth transition from leave to childcare.

7. Increase the hourly allowance

In the EU, free access to childcare averages 25 hours weekly – which makes it incompatible with full-time employment. Currently, only two EU countries – Greece and Czechia – offer at least 40 hours of free childcare – which could be set as a European standard. Even for parents who work part-time, the very awareness that they have back-up childcare in the case of emergencies can ease off their stress and improve their work-life balance.

8. Remove regulations that aren't conducive to child wellbeing

Sometimes low childcare access reflects bureaucratic hurdles. For example, in Poland, until 2011 daycare was supervised by the Ministry of Health and had to meet stringent regulations of health care facilities. After the supervision was passed to the Ministry of Labour, some regulations were relaxed and enrolment of under three-year-olds rose from 3% to 18% in a decade.

Other examples of unnecessary hurdles include legal difficulties in employing teachers by groups of parents in countries where employment contracts can be issued only by legal entities (such as companies or public institutions) or administrative units (such as communes or counties). In those countries, parents resort to informal arrangements or contracts of mandate. In both cases, caregivers miss out on social protection and the right to paid leave.

Some parents prefer alternative arrangements – such as Poland's small 'punkt opieki' with one professional teacher accompanied by a rotating parent (each parent volunteers twice a month). In such cases, the rotating parent should be exempt from administrative duties.

Psychological and Cultural

9. Understand the loss that parents are going through and strive for a bipartisan consensus

When I was a social policy advisor in an EU government, I participated in ministerial consultations on childcare expansion. The meeting was dominated by a conservative lobby opposing childcare institutions and suggesting that the funding should be redirected as cash payments to stay-at-home mothers. From today's perspective, I perceive this situation as a clash over social recognition of the work of housewives. The generations of women who sacrificed their lives to stay with their children might experience a psychological loss, if childcare 'outsourcing' is perceived as a new norm or, even worse, when the state suggests that children are better-off in institutions rather than with their parents.

To avoid the division into career-oriented parents and stay-at-home parents, ECEC could be available to all, possibly in different forms – including those that accord a large role to parents, such as Poland's 'punkty opieki' (where a professional teacher is accompanied by a rotating parent and care takes place in a private house).

10. Refrain from value judgments and respect people's choice

Flexible and affordable quality childcare should be available to all parents. Such access will allow families to execute their preference between earning, using informal childcare and using ECEC.

Yet, some parents have good reasons for avoiding big childcare institutions, e.g. high contagion rates. They should have a choice. One alternative is France's ***crèche familiale*** – an intermediate institution between home and daycare, where five children are cared for by a professional guardian, supported by a rotating parent with the right to use the infrastructure of formal childcare institutions. Even 2-3 hours of an education programme three times a week can bring substantial benefits while allowing stay-at-home parents to recoup some free time.

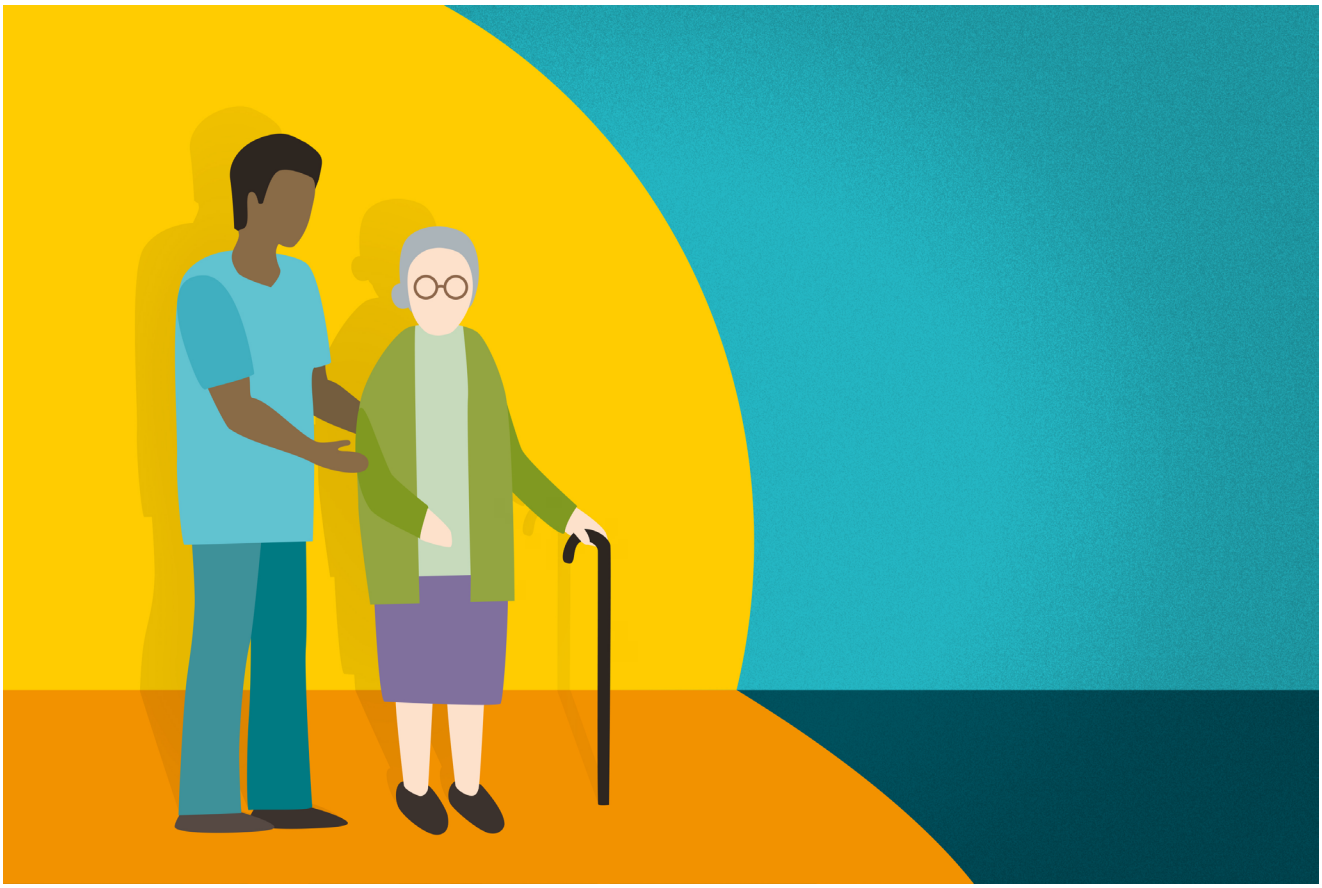
11. Consult widely and strive to make childcare universal without making it compulsory

Some reports by governments and international organisations present a purely technocratic view – as if childcare and education were culturally neutral subjects to be determined by the statistical models of returns on investment. They are not. As Figure 4 showed, in the EU there are 12 countries where over a third of the society believes that a pre-school child suffers when the mother is working – an ideological conviction that influences parental choices.

As explained in Box 1, parents can organise serious opposition even to the best-intentioned reforms. Instead of making the reforms compulsory, countries could make them facultative with the desired option set as a default, while keeping the 'opt out' available. Before proposing any reform, ensure that the implementing institutions are well-prepared in legal, staffing nor organisational terms to receive children. The reforms will have higher chances of success if implemented by those whom parents already trust.

5. BUILDING A RESILIENT CARE SECTOR: A HUMAN CENTRED APPROACH

5. BUILDING A RESILIENT CARE SECTOR: A HUMAN CENTRED APPROACH



Tuscany Bell, EPSU

Policy Coordinator for Social Services and Youth

> *The conditions of work are the conditions of care.*
> P. Armstrong, H. Armstrong, I.L Bourgeault (2020)

For many, a defining memory of Covid-19 will be standing at the window every evening to applaud health and care workers. Indeed, the pandemic shone a light on the fundamental role of these frontline workers in our societies. However, it also revealed the underfunding, understaffing and neglect that has long characterised the care sector. Tragically, for many others, memories of the pandemic will instead be marked by the preventable deaths of elderly relatives in long-term care facilities.

The recently adopted European Care Strategy acknowledges this contradiction: there cannot be a resilient care sector without a resilient workforce. The disproportionate death toll amongst care residents during the pandemic is directly linked to care workers' lack of personal protective equipment (PPE), limited entitlement to sick pay, low staff-to-user ratios, and the fact that many care workers had multiple jobs and travelled between residencies.[80] This chapter looks at the factors that have undermined the resilience of the workforce, including underfunding, privatisation and the undervaluation of professions overrepresented by women. It also provides policy recommendations as to how these issues can be addressed through the European Care Strategy (ECS).

1. TRENDS IN THE CARE SECTOR

Workforce issues in the care sector began long before the outbreak of Covid-19, and care services were already heavily overburdened when the pandemic hit. According to the OECD, staff shortages have been worsening since 2011, with population ageing and demand for long-term care outpacing the growth of the workforce in most countries.[81] A 2021 study published by the European Federation of Public Service Unions (EPSU) found that 'the ratio of long-term care workers per 100 people aged 65+ fell from 4.2 to 3.8 between 2011 and 2016 as an average across the EU'.[82] Almost all EU member states report significant numbers of unfilled vacancies, and

by 2050, over 1.6 million more long-term care workers will be needed just to keep coverage at the same level as today.[83]

Despite clear demographic projections and calls from civil society organisations and trade unions for sustainable public funding, the response to the increasing demand for long-term care has instead been decentralised, fragmented and in many countries market driven.[84] Austerity measures and the retrenchment of the welfare state following the 2008 financial crisis opened the way for outsourcing and commodification of the sector, with disastrous consequences.[85] Substantially financed by state subsidies, private providers extract millions from the sector not only in the form of profit, but also rent from nursing home real estate, management fees and complex debt schemes.[86] The allocation of public funds to private providers has also widened geographic and socioeconomic disparities in terms of accessibility to care provision.

Despite clear demographic projections and calls from civil society organisations and trade unions for sustainable public funding, the response to the increasing demand for long-term care has instead been decentralised, fragmented and in many countries market driven.

Private investors generally cater to the needs of high-income communities with the means to pay hefty fees, leaving many lower-income communities lacking accessible services.[87] Neoliberal policies that promote private investment allow profits to be maximised at the overall expense of public health and care systems. For example, many private providers cut costs on prevention and rehabilitation measures, even though this has better health outcomes for recipients and can avoid health problems that are more expensive to treat later when public health systems inherit the higher cost.[88] It should not come as a surprise that during the pandemic, for-profit residencies had substantially higher death rates than not-for profit homes.[89]

The market mentality behind the boom in private investment in long-term care was explained by Jean Claude Marian, founder of one of Europe's largest multi-national care providers, Orpea, in a 2015 interview: 'We are lucky to be riding the wave of the exploding needs of the very elderly. This will allow us to continue having for the coming five, 10, 15 years the possibility for considerable growth.'[90] Indeed, since 2015, Orpea has added on average one bed per hour to its operations. In 2020, the group acquired a new care home or hospital every 3.3 days and between 2015 and 2020, turnover increased by 64% (from €2.4 billion to €3.9 billion), with profits growing from €183 million to €210 million.[91]

Neoliberal policies that promote private investment allow profits to be maximised at the overall expense of public health and care systems.

Of course, what Marian did not explain was the sordid underside of the group's relentless pursuit of profit: cost reduction by whatever means possible, whether by shifting funds to hidden offshore structures,[92] low pay and illegal use of temporary contracts for carers,[93] or by restricting food and hygiene products for elderly residents.[94] Many of these details were revealed in a 2022 book by investigative journalist Victor Castanet, 'Les fossoyeurs' (The Gravediggers), which caused outrage in France and beyond. The book details a lack of basic hygiene, with some elderly residents 'being left in their own excrement because diapers are rationed.'[95] Union and worker representatives who have complained about the appalling working conditions and the inability to provide quality care have faced bullying and harassment, with the company going as far as threatening to hire private investigators to intimidate union members.[96]

Not long after the publication of Castanet's book, during a surprise inspection of an Austrian residence owned by an Orpea subsidiary, SeneCura, inspectors were shocked to find residents left in dire conditions as a result of staff shortages, including one resident with large bedsores which had not been monitored or treated

with professional cleaning. The inspectors recommended the resident's immediate transfer to a hospital, where they tragically died soon after.[97] After these revelations caused Orpea's shares to fall by 90% in value, the group struggled to manage the heavy debts it incurred through its aggressive expansion.[98] In February 2023, the financial arm of the French State, the Caisse des dépôts et consignations, had to make a restructuring deal with the group to save it from bankruptcy, injecting large amounts of public money.[99]

Not only do competitive tendering and profit-oriented strategies encourage cost-cutting, drive down wages and increase working hours, but market mentality has also fundamentally changed the nature of care work.[100] In her book, 'The Care Crisis* What Caused it and How Can We End It?', the author and researcher Emma Dowling demonstrates how caring – tending to the emotional and physical needs of someone – has come into conflict with 'logics of measure, profitability, time constraints, cost reduction, standardisation and economies of scale'.[101] In order to make care provision more 'efficient', the relationship-building aspects of care have largely been replaced with repetitive, standardised tasks which are to be completed as quickly as possible.[102] Breaking down the profession in this way has gone hand-in-hand with an increase in part-time, zero-hour and temporary contracts, limiting worker access to social protection as a result. This way of organising care work also carries higher psychosocial risks for workers,[103] and downplays the complex, emotional, physical, and psychological support aspect of the role.[104] This helps to frame the profession as low-skilled thereby justifying low wages.

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Low pay is one of the main reasons it is so difficult to recruit and retain care workers. Despite the strenuous nature of the work, and its fundamental value to society, many carers are found in the bottom third of the wage distribution.[105] In 2018, wages for social services workers – the vast majority of whom work in the long-term care sector – were 21% lower than the average national hourly earnings.[106] This wage data may even inflate the average earnings of care workers, as it is unlikely to take account of undeclared work. Care work is overwhelmingly dominated by women, and there is a strong gender dimension as to why it is so undervalued.[107] While low pay is common across the health and care sectors, an EPSU-commissioned report by the European Trade Union Institution (ETUI) finds that the higher the proportion of women workers, the lower the average relative income.[108] This kind of gender segregation between sectors is a significant driver of Europe's gender pay gap.

Rather than tackling staff shortages by improving pay and conditions, many EU countries have instead relied on low-paid migrant workers to fill the gap.

Rather than tackling staff shortages by improving pay and conditions, many EU countries have instead relied on low-paid migrant workers to fill the gap.[109] Whether documented or undocumented, migrant care workers are more likely to be subject to job insecurity and substandard working conditions, and less likely to be covered by collective bargaining agreements.[110] Live-in care roles are particularly likely to be undertaken by migrant workers (see Chapter 9 by Elisa Chieregato). A 2016 EESC report found that these arrangements 'increase the reliance of workers on their employers, and lead to isolation, working on-call, and the risk of exploitation, while placing live-in care workers in an especially vulnerable position in relation to immigration policies.'[111]

2. A ROLE FOR THE EU

The European Care Strategy largely takes stock of these trends which have characterised the care sector over the last decade. It recognises that care is a public good, and that structural changes to the care sector are needed to realise the rights enshrined in the European Pillar of Social Rights, specifically: Principle 18 on the right to affordable long-term care services, Principle 9 on work-life balance for people with care responsibilities, and Principle 17 on the rights of persons with disabilities.[112]

To achieve this, there is an increasing need for EU-level coordination in the care sector. The issue of staff shortages which is perhaps the most urgent problem facing care services is felt across Europe. Migration between member states expounds the workforce shortages in sending countries and disincentivises receiving countries to improve conditions to attract a local workforce.[113] A coherent, European-wide approach is therefore needed. Furthermore, with the expansion of multinational care companies across Europe, more rigorous European standards are needed to ensure decent working conditions and accessible, quality care for all.

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The **European Care Strategy is complemented by the recently adopted EU Minimum Wage Directive**.[114] Firstly, the Directive requires member states to set adequate minimum wages, based on indicative reference values such as 60% of the gross median wage or 50% of the gross average wage.[115] As many workers in the care sector are employed on minimum wage, their salaries will likely increase with national minimum wages. As women are heavily overrepresented in the lowest-paid care workforce, raising the wages of these workers will also help close Europe's gender pay gap and deliver on the fundamental EU right of equal pay for work of equal value. Secondly, the strategy recognises that the best way to ensure workers' rights are respected across the EU is to strengthen collective bargaining. In this way, it is complemented by the Minimum Wage Directive requirement for any member states where collective agreements cover less than 80% of employees to establish national plans to promote collective bargaining.[116] As it stands, the social services sector has a particularly low rate of collective agreement coverage in many EU countries.[117] Strengthening collective bargaining in the sector will therefore be necessary for the implementation of the Minimum Wage Directive.

> *The Care Strategy further recognises the importance of collective bargaining at EU level and supports the establishment of an EU sectoral social dialogue committee for social services*

The Care Strategy further recognises the importance of collective bargaining at EU level and supports the establishment of an EU sectoral social dialogue committee for social services,[118] as was formally requested in June 2021 by EPSU and the Federation of European Social Employers.[119] With financial support from the European Commission, EU level social partners can carry out transnational projects to improve conditions and can engage in capacity-building of national level social partner organisations. They can also negotiate legally binding agreements which are then adopted by the Council as EU Directives, as well as non-legislative agreements that must then be implemented by the national social partners.[120] In this way, EU level social partners can play a crucial role in implementing the recommendations in the strategy.

The European Care Strategy complements and builds upon several pieces of EU legislation aimed at protecting working conditions and workers' rights, including those on transparent and predictable working conditions and work-life balance.[121] For example, it aims to build on the EU Framework Directive on Occupational Safety and Health, according to which, if a risk assessment proves

that working conditions derived from work organisation are hazardous to health, those conditions must be changed at the source and with the participation of workers' representatives.[122] The strategy also recognises the significant role played by undocumented migrant care workers and the need for special measures to protect their labour rights. In doing so, it seems to build upon the EU Employers' Sanctions Directive which, despite serious shortcomings, makes the labour rights of undocumented migrants part of EU law,[123] and complements the recently announced Skills and Talent Package which will explore avenues for legal migration in the care sector.[124]

> *The European Care Strategy complements and builds upon several pieces of EU legislation aimed at protecting working conditions and workers' rights, including those on transparent and predictable working conditions and work-life balance.*

Finally, the strategy recognises that a lack of strictly applied, high-quality standards can lead to neglect and abuse of care recipients and poor working conditions for carers.[125] This supports a statement made during the pandemic by Council of Europe Human Rights Commissioner, Dunja Mijatović, who noted the seriousness and prevalence of human rights abuses against elderly care residents.[126] While EU Single Market and competition rules limit options to control private markets, the European Care Strategy does call for tighter quality assurance.[127] At EU level, it is possible to establish monitoring mechanisms, for example, that ensure transparency. Furthermore, the EU Semester, the annual cycle during which member states coordinate their social and economic policies, can be a useful tool. Since the Covid-19 pandemic, the Principles in the European Pillar of Social Rights (EPSR) have been formally integrated into the semester process, [128] which has historically prioritised macroeconomic considerations. The Country Specific Recommendations, which take account of member state Social Scoreboard performances based on the EPSR, can be used to ensure elderly care is included in social protection systems and that social services receive sufficient funding to achieve the right to care.

3. POLICIES FOR A RESILIENT CARE SECTOR

3.1 STRENGTHENING PUBLIC SERVICES

Ensuring the right to care for all Europeans requires high-quality, formal care services based on need. **To overcome geographic and socioeconomic disparities, care should be integrated into national social protection systems** which are best placed to deliver on an equitable basis. This was recognised by the European Social Protection Committee, the advisory policy committee to the ministers in the EU Employment and Social Affairs Council.[129] **Recognising long-term care as a public good, as the European Care Strategy does, is one thing, but ensuring that social protection systems are developed and public services available is another.** The strategy finds that where social protection is available, it is still often inadequate – that, even after receiving support, 'nearly half of older people with long-term care needs are estimated to be below the poverty threshold after meeting the out-of-pocket costs of home care'.[130] This increases old age poverty and results in over-reliance on informal carers – including family members, friends and neighbours – most of whom are women, which is neither a suitable nor a sustainable solution.

> *Recognising long-term care as a public good, as the European Care Strategy does, is one thing, but ensuring that social protection systems are developed and public services available is another.*

To ensure universal access to high-quality, affordable care, EU member states must invest more in integrated public health and social care services. This was made clear during the Covid-19 pandemic when better integrated and well-resourced public health and social care systems proved to be critical to the resilience of long-term care services.[131] Integration of health and social care as well as higher public investment was a key recommendation in a report of the Pan-European Commission on Health and Sustainable Development, convened by the World Health Organisation (WHO) Regional Office for Europe.[132] However, as the report

highlights, few governments have put in place systems to adequately fund social care.[133] In 2019, public expenditure on long-term care amounted to only 1.7% of EU gross domestic product.[134] By comparison, the value of the hours provided by informal carers (were they monetised) is estimated at 2.5% of EU GDP.[135]

In the past, through the European Semester, the European Commission has promoted austerity measures and prioritised balanced budgets over adequate funding for health and social care.[136] A 2021 report of the Corporate Europe Observatory found that since the first European Semester in 2011, the Commission had issued 107 recommendations to member states to cut the budgets for their health sectors, including long-term care.[137] Not only did this undermine the recovery from the 2008 financial crisis, but it also left care services woefully ill-prepared for the pandemic, proving to be more costly in the long term.[138] These mistakes cannot be repeated. **Going forward, the Country Specific Recommendations must instead encourage higher public investment in public health and care services.**

3.2 REVERSING PRIVATISATION

Higher public investment however should not be allocated to private care providers to take higher profits. The links between the unpreparedness of long-term care facilities for Covid-19 and private owners privileging profits over the quality of care were recognised by Human Rights Commissioner Mijatović.[139] Whilst the Care Strategy calls for tighter quality mechanisms,[140] given the gravity of recent human rights abuses in for-profit facilities, this does not go far enough. Serious questions need to be raised about the ethics of private investors making millions from the basic needs of the very elderly, while care workers are so underpaid[141] and many Europeans with long-term care needs fall below the poverty threshold.[142]

Far-reaching structural changes are needed to ensure that public funding intended for care is spent on those in need of care in a way that upholds the human rights and dignity of workers and recipients. Where EU or national public funding supports care provision, it is clear that stronger conditions should be attached. **Rigorous EU and national regulatory frameworks are needed that enforce transparency and accountability** - and limit the level of profit-making from care services. One example would be to place profit caps on all care providers regardless of legal form in order to ensure that any profits are reinvested into the service. **The Country Specific Recommendations can also be used as a tool to ensure that public funding for care services is put first and foremost towards public care and not-for-profit care.**

> *"In addition to tighter regulation, the care profession needs to be fundamentally revalued, both in terms of pay and conditions. This means reversing the market mentality which breaks care work down into a series of repetitive and standardised tasks."*

In addition to tighter regulation, the care profession needs to be fundamentally revalued, both in terms of pay and conditions. **This means reversing the market mentality which breaks care work down into a series of repetitive and standardised tasks.** This market-driven approach has been linked to care professionals leaving the sector thereby creating a vicious cycle in which staff shortages make conditions worse, which then pushes even more workers to leave the sector.[143] The sense of powerlessness that care professionals feel when they are unable to provide quality care as a result of understaffing leads to emotional burnout which further perpetuates the cycle.[144]

Organising care work in this way to maximise productivity and profitability whilst removing workers' autonomy to deliver care increases exposure to psychosocial risks.[145] Psychosocial risks, related to the way work is designed, organised and managed, as well as the economic and social contexts of work, are among the most challenging concerns in the area of occupational safety and health. They are associated with musculoskeletal disorders, fatigue, burnout, post-traumatic stress disorder, anxiety and depression, all of which are common among workers in the care sector.[146] However, there is no specific EU Directive on psychosocial risks, despite the fact that they are increasing and causing ever more complex health issues. Whilst the EU Framework Directive on Occupational Safety and Health does cover some of these risks, there is a clear need to develop more specific EU legislation.

3.3 INCREASING COLLECTIVE BARGAINING

As well as posing greater risks to workers, organising care in a repetitive and standardised way frames the profession as low-skilled, and is linked to the prevalence of precarious contracts and low pay.[147] The European Care Strategy recognises that these are all factors which make the sector less attractive, hinder recruitment

and retention, and that the best way to change this is through collective bargaining with unions and employers' organisations.[148] **Social partners can tackle this by negotiating pay increases and by designing and implementing opportunities for continuous professional development.** Stronger union presence is needed, whether in residential care settings or home and community-based care. This was made clear during the pandemic, when lower union presence was correlated with higher death rates in care homes.[149] Without union protection, workers are more at risk of being fired for failures to provide quality care, even when this stems from management practices, as well as for reporting the problems that lead to failures.[150] Protecting workers who raise issues on the ground will lead to significant improvements, both in terms of working conditions and quality of care. Worker participation, dialogue with employers and engagement with public health systems are necessary parts of the solution. **As a matter of urgency, workers should be involved in discussions about pay, skills and training needs, and carrying out risk assessments. At both national and European level, access to public funds for care providers should be made conditional upon having a collective agreement in place.** Without the input of workers, it will not be possible to tackle low recruitment and retention rates, maintain high working conditions and revalorise the sector.

3.4 PROTECTING THE RIGHTS OF LIVE-IN AND MIGRANT CARE WORKERS

Live-in care workers face especially low unionisation rates and are particularly vulnerable to exploitation.[151] The strategy is right to recognise that specific measures should be taken to increase the protection of live-in carers and to support the ratification and implementation of the International Labour Organisation Convention No.189 on the Rights of Domestic Workers across EU member states.[152] **In order to enforce this convention, stricter regulation in the care sector is needed, including by enabling labour inspectorates and other relevant state and non-governmental organisations to access workplaces that are in private households.**

One of the biggest barriers to protecting the rights of live-in carers is the fact that they work alone, in a private space, and often have little contact with other people.[153] Therefore, not only are the carers unable to communicate their conditions to others, but it is difficult for others to communicate the rights of carers to them.[154] Trade unions can help to ensure legislation is strengthened and more rigorously applied to protect live-in care workers from exploitation. An example of this is the recent victory by the German union ver.di, which won a court case against the exploitation of a 24-hour care worker. The Federal Labour Court ruled that the statutory minimum wage also applied to round-the-clock care.[155]

> *"To improve the conditions of undocumented live-in care workers, member states must fully implement complaints mechanisms and procedures for workers who have been exploited, as required by the Directive."*

Legislation at EU level must also be strengthened. The EU Directive providing for minimum standards on sanctions and measures against employers of illegally staying third-country nationals, known as the 'Employers Sanctions Directive', recognises the labour rights of undocumented migrants in EU law.[156] The directive has been heavily criticised as serving less as a means to limit exploitation than as a means to control migration.[157] Nonetheless, it does include some important protections, such as the provision that undocumented migrant workers are entitled to the same salary that nationals would receive for doing the same work.[158] The Commission announced in 2020 that it would be assessing how to strengthen the effectiveness of the Directive and evaluating the need for further actions, and in 2021 it released its report on the implementation of the Directive.[159] It is worth noting that the EU Agency for Fundamental Rights also released a report in 2021 on the Directive's implementation, which found major gaps in the full and meaningful transposition and implementation of the Directive into national law and practice.[160] To improve the conditions of undocumented live-in care workers, member states must fully implement complaints mechanisms and procedures for workers who have been exploited, as required by the Directive. **Labour inspectorates should also be more rigorous in carrying out inspections and imposing sanctions, and member states should collect data on the number of inspections carried out, the number of complaints lodged by workers and the number and types of sanctions imposed on employers.**

Recognising the significant role played by undocumented migrant care workers and non-EU nationals, the European Care Strategy calls for pathways to regularise their

employment status so that they can officially work in the care sector, while helping to address gaps in the labour market.[161] This proposal is also made in the Skills and Talent Package, which includes a legislative pillar, to revise the Long-term Residents Directive and Single Permit Directive, an operational pillar, to develop EU talent partnerships and an EU talent pool, and a 'forward-looking pillar', to explore avenues for legal migration in three areas: care, youth and innovation.[162]

The focus should not simply be a question of 'matching' skills, but rather about helping migrant workers to access decent and good quality jobs based on the principle of equal treatment.

While protecting the rights of undocumented migrant care workers is of utmost importance, the Skills and Talent Package poses a number of risks. Firstly, it does not incentivise member states and employers to improve pay and conditions to attract a local workforce. Migrant care workers are instead subject to these often-substandard conditions and low pay. Furthermore, the talent matching pool seems to resemble outdated models of labour migration designed for, and driven by, employers.[163] The focus should not simply be a question of 'matching' skills, but rather about helping migrant workers to access decent and good quality jobs based on the principle of equal treatment.[164] However, the talent pool has no legal basis for governance and accountability and does not specify the need for the involvement of trade unions in both origin and EU countries. **Rather than prioritising the development of talent pools and talent partnerships, the Commission and member states should promote fair recruitment standards, including bans on abusive practices and recruitment fees**, as recommended by the European Trade Union Confederation.[165]

Rather than prioritising the development of talent pools and talent partnerships, the Commission and member states should promote fair recruitment standards, including bans on abusive practices and recruitment fees

4. CONCLUSION

The European Care Strategy recognises many issues and trends that have undermined the resilience of the care sector, including underfunding, understaffing, low pay and poor working conditions. While this recognition at EU level is a positive step, across Europe, there is a critical need for more structural change to the way care is organised.

The sector has long relied on the moral commitment of its staff, and many care workers will cite the feeling of doing something meaningful as one of the main reasons for choosing the care profession. [166] However, the consistent demand to do more with less often leaves care workers unable to provide the level of care the recipients need, while low pay, strenuous conditions and lack of professional development can make the sector an unsustainable career choice in the long term.

To address staff shortages and improve recruitment and retention rates, there needs to be a fundamental revaluing of the care profession and pay and conditions which match the crucial role of carers in our societies. This includes improving opportunities for continuous professional development and changing how care work is organised so that is not broken down into standardised repetitive tasks. A stronger role for trade unions and collective bargaining is necessary to make the sector more attractive and to protect all care workers, rather than relying on unsustainable, employer-driven migration schemes to fill staff shortages.

Finally, adequately funded and well-integrated public health and social services are needed to deliver the right to care. Ensuring long-term care is a public good and a human right necessitates a limit on, or better yet a reversal of, the commodification of care. Profits should be directly reinvested into the sector to improve the accessibility and quality of care and to ensure good working conditions. **A human-centred approach, not a market-driven approach, is needed to address the dependencies of Europe's ageing population.**

6. THE NEW CHALLENGES OF CARE WORK IN LIGHT OF DIGITALISATION AND PLATFORMISATION

6. THE NEW CHALLENGES OF CARE WORK IN LIGHT OF DIGITALISATION AND PLATFORMISATION

Claire Marzo

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1. INTRODUCTION: DEFINITIONS AND CONTEXT

Digitalisation and platformisation are two of the most radical changes in today's society transforming all sectors. Care and care work are no exception. It is worth defining these terms in order to understand what changes are taking place.

Care and care services have been defined numerous times in this policy study. For our purposes, it will suffice to say that care is viewed as 'an activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web'.[168] Care work refers to services that contribute directly to social reproduction, or indirectly substitute for the absence of external provision of basic infrastructure that is essential for human survival[169].

The very nature of care work is that it can encompass a wide variety of different activities, require multitasking and move across a paid/unpaid, home/institution-based continuum, and incorporate many different levels of skill and training requirements[170]. It overlaps with domestic work but it can also be outside the home. Mostly, the focus is on children, old people and disabled people's care.

Digitalisation means the 'adaptation of a system, process, etc. to be operated with the use of computers and the internet'[171]. This very broad definition allows for the incorporation of digital technologies into business/social processes. In the field of healthcare, digitalisation corresponds, for instance, to telemedicine, artificial intelligence (AI)-enabled medical devices, and blockchain electronic health records. It transforms our interactions with health professionals, how our data is shared among providers and how decisions are made about our treatment plans and health outcomes. The healthcare industry is entering the era of digital innovation, as

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> *One usually thinks of Deliveroo drivers and Uber taxis, but in the field of care, platform work has also developed to encompass babysitting, cleaning, old-age care, special needs care, etc.*

patients seek on-demand healthcare. In the field of care, digitalisation encompasses the former but also includes digital education, digital monitoring, etc.

Platformisation is linked to digitalisation but is a bit more precise. It focuses on work enabled by new technologies. Platform work has been defined by the European Council as 'a form of employment in which organisations or individuals use an online platform to access other organisations or individuals to solve specific problems, or to provide specific services in exchange for payment.'[172] It is 'an umbrella concept covering a heterogeneous group of economic activities completed through a digital platform.'[173] One usually thinks of Deliveroo drivers and Uber taxis, but in the field of care, platform work has also developed to encompass babysitting, cleaning, old-age care, special needs care, etc.

In the European Union, comparative studies have shown that there are 28 million platform workers and there will be 43 million in 2025, and the majority of them are not employees.[174] It is still difficult to find statistics relating to care platform work, but it is generally accepted that domestic help is an occupational group where platforms are booming internationally - and that it still consists mainly of women. A few examples of online platforms where you can find help in and around the house are Care.com, Helpling, wecasa (France), etc. These are often country-specific platforms.[175]

> *It is still difficult to find statistics relating to care platform work, but it is generally accepted that domestic help is an occupational group where platforms are booming internationally - and that it still consists mainly of women.*

TABLE 2 - Selection of platforms operating in the EU member states in the area of personal and household services (e.g. gardening, cleaning), care services, teaching and handiwork

COUNTRY	PLATFORMS FACILITATING ON-LOCATION PLATFORM WORK
AT	Extrasauber.at, Haushaltshilfe24.at (part of Lemonfrog AG Switzerland), Betreut.at (part of care.com Europe Berlin)
BE	Helpper, Bringer Nanny Nina, Martha, Kidssitting, B-homecare.be, Handyfriend, Harry Butler, Itzu, Trixxo, Youpijob, Dienstenbrigade, Jellow, ListMinut, Teacheronline, Bijleshoek
BG	Housecare.bg, phcare.bg, bavachki.bg, maistorplus.com, domestina.bg
CY	Douleftaras.com.cy
CZ	robeeto.com, grason.cz, nejremeslnici.cz, supersoused.cz, hlidacky.cz
DE	betreut.de, haushelden.de, Gewerbeschein, Helpling, Expat.com
DK	Happy Helper, Chabber
EE	UpSteam, Care Mate
EL	Douleftaras.gr, Paramana.eu

ES	Specialised platforms: Cuideo, Aiudo, Wayalia, Cuorecare, Joyners, Cuidum, Familiados, Depencare, Nannyfy, Sitly, Topnanny. Multi-service platforms: Yocuido, Cronoshare, Clintu, Care.com, Topayuda, Yoopies
FI	Seure.fi
FR	AlloVoisins
HR	Clintu, Cuvalica.hr, Trebam.hr
HU	Expat.com, Rendi.hu
IE	Home Care Direct, Mindme, Laundr, Pristine, Helpling.ie, babysits.ie
IT	Sitly.it
LT	GETFIX, PortalPRO, Domio, myHelper, Discontract
LU	n/a
LV	Expat.com, Greataupair.com, baltichousehold.lv
MT	Genie
NL	Charly Cares, Careibu, Croqqer, Handige helden, Hlprs, Hulp.nl Helpling, Tisser, YouBahn, My Flexwork, Flexbook, Inhuren.com, Wurcly, care.com, petbnb L1NDA.com, Temper, Jobner, Kolibri next, Now jobs, Ploy, Duobus, Elanza, Kraamzorg1op1, Roamler Care, Bsit, Holiday sitters, Oppasland, Nanny Nina, Sitly, Top sitters, Rapid Workers, Roamler retail, Jellow (Care), Fiverr, PeopleperHour, Planet Interim, Staffyou, Any Jobby, Werkspot, Young Ones, Temper, Randstad Go, Roamler Tech, Casius, Klusup, Zoofy
PL	hojoclean.pl, oferia.pl, niania.pl, favore.pl
PT	Dona Rosa, Simplicasa
RO	n/a
SE	Yepstr, Tidy App, Taskrunner, Techhbuddy, nanny.nu
SI	beeping
SK	Jaspravim, Domelia

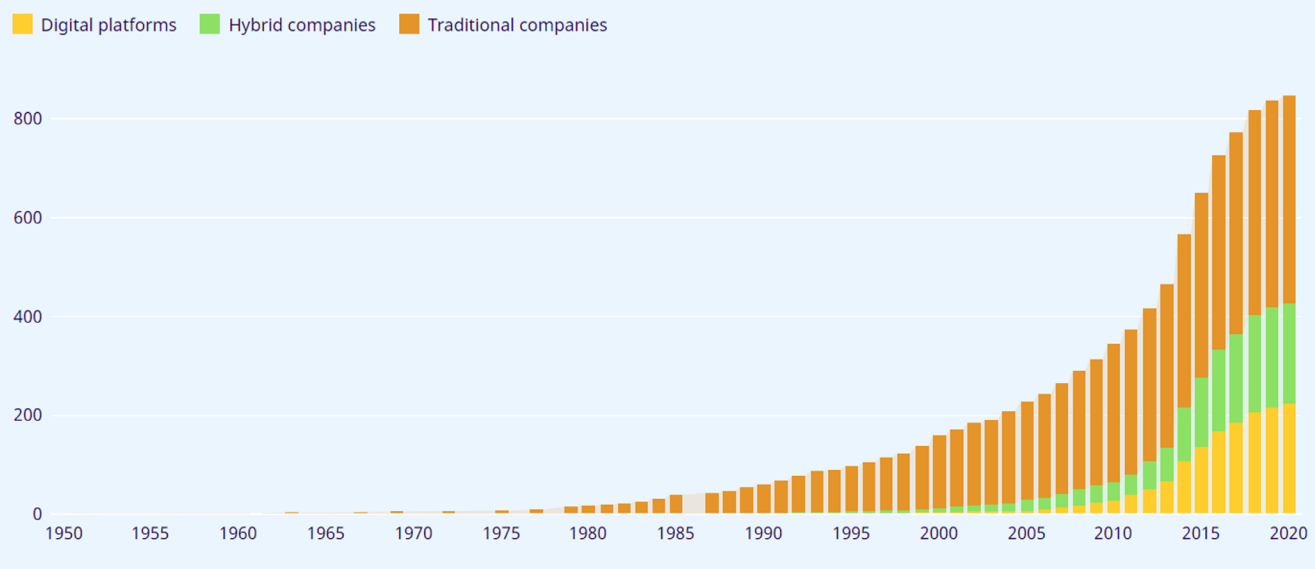
Source: Hauben et al, p.13-15.

Domestic workers have often combined multiple jobs for different households. Some of this work is now organised through platforms that provide an overview and convenience in such a fragmented market. The majority of work is still informally arranged.[176] Although, 'domestic workers are increasingly hired through service providers, including digital platforms. The number of such platforms in the sector rose eightfold in a decade, from 28 in 2010 to 224 in 2020'.[177] As highlighted in the European Care Strategy (hereafter ECS), '[t]he size of EU platform economy in the domestic and care sector has grown to €1.5 billion in 2020 from €0.8 billion in 2016'[178] and is expected to continue to grow in size post-COVID.[179]

"The size of EU platform economy in the domestic and care sector has grown to €1.5 billion in 2020 from €0.8 billion in 2016 and is expected to continue to grow in size post-COVID."

6. THE NEW CHALLENGES OF CARE WORK IN LIGHT OF DIGITALISATION AND PLATFORMISATION

Figure 9 - Number of active domestic work platforms globally 1950-2020 (ILO 2021)



Source: ILO (2021). "World Employment and Social Outlook - the role of digital labour platforms in transforming the world of work".

Having emphasised the changes, it must also be said that the digital transition does not change the existing classical tensions: the main issues of job recognition, care accessibility, and inclusion of non-professional carers are unaffected by digitalisation. But this phenomenon can bend the trends: for instance, paradoxically, digitalisation can exacerbate existing tendencies to discriminate as well as remedy some issues of accessibility.[180]

In light of the changes taking place, two main issues emerge:

- The challenges and opportunities brought by digitalisation and platformisation in the provision of care services, whether they are provided by a public or a private entity.
- The challenges and opportunities brought by the platformisation of care services in terms of job transformation, workers' statuses and rights.

This chapter aims to assess the answers proposed by the European Care Strategy to these questions. It particularly seeks to answer two questions. Firstly, what are the opportunities and threats posed by the use of digital platforms to meet care needs? And secondly, is the Care Strategy up to speed with the emerging digitalisation of care services?

In order to formulate concrete, EU-oriented policy recommendations and solutions and identify possible blind spots in the strategy, we will focus on the digitalisation of care services (I) and the platformisation of care work (II).

2. THE EUROPEAN CARE STRATEGY: TOWARDS DIGITAL CARE SERVICES?

The European Care Strategy refers to the 'digital transition'. It mentions innovative digital solutions such as information and communication technology, assistive technology, telecare, telehealth, artificial intelligence and robotics.[181] But it does not go beyond this factual assessment to measure its impact. We feel it should be tackled as such in order to ask the questions of whether digital care services should be seen as an opportunity (2.1), and/or as a threat calling for regulation (2.2). It should be seen as a whole subject per se in order to be aware of the extent of possible further reforms (2.3).

The European Care Strategy refers to the 'digital transition'. It mentions innovative digital solutions such as information and communication technology, assistive technology, telecare, telehealth, artificial intelligence and robotics. But it does not go beyond this factual assessment to measure its impact.

2.1 OPPORTUNITIES

The Commission is aware of the advantages that digitalisation can bring. Overall, the goal is to use digitalisation to make health, social and long-term care services easily accessible and user-friendly.[182] The strategy mentions advantages in terms of care and long-term care improvement.[183] They consist of 'access to high-quality affordable care services and aid[ing] independent living' (p.10).

Digital tools can 'take over certain laborious or hazardous tasks of care workers, improving case management and occupational safety and health at work, helping the remote monitoring of care recipients and facilitating the training and recruitment of care workers' (European Care Strategy, p.10).

A clever use of digital innovations can help 'simplify administrative procedures and speed up communication between service providers and service recipients'[184], match more easily offer and need, make it easier for citizens to have better, maybe even equal access to high-quality care and increase the feasibility of home care as a long-term care option. In the field of healthcare, with telemedicine developing, it helps 'promote health, prevent and control disease, help address patients' unmet needs'[185]. In the long term, it can also reduce demand for healthcare and improve public health.

The strategy's section about early childhood education and care completely overlooks considerations related to the digital transition. However, digitalisation has a lot to offer in terms of education, as emphasised in the Digital Education Action Plan (2021-2027). Beyond offering new tools for the improvement of the educational system as such, it can also help better overcome mobility challenges (e.g. for children with long-term diseases or physical disabilities). This being said, the ECS recognises some limitations to the extent that 'technology cannot and should not replace human interaction' (p. 10). In particular, online teaching alone cannot substitute quality, in-person childcare.

2.2 THREATS AND THE CONSEQUENTIAL NEED FOR REGULATION

The omission of any mention of the dangers associated with digitalisation contrasts with earlier caution expressed by the European Commission. Whereas the 2018 Communication on 'enabling the digital transformation of health and care in the Digital Single Market; empowering citizens and building a healthier society'[186] underlines that digital solutions will create opportunities, 'if designed purposefully and implemented in a cost-effective way' (p. 1), the Care Strategy remains silent.

It is important to warn about these dangers and to identify effective safeguards to be created to react to these threats. For instance, care and health data in research and innovation calls for more comprehensive protection mechanisms than what is currently foreseen in the EU General Data Protection Regulation (hereafter GDPR). Another example worth citing is the use of remote monitoring of care receivers, which requires the implementation of clear rules to ensure the protection of private life.

The strategy's section about early childhood education and care completely overlooks considerations related to the digital transition.

2.3 REFORM SCOPE

The strategy states three goals: "investing [...] in digital skills, removing accessibility barriers for persons with disabilities, and improving connectivity in rural and remote areas' (p.10). We welcome the will of the European Commission to finance research (Horizon Europe or Digital Europe programme[187]) on the meaning of digital care, on digital tools, 'on addressing territorial inequalities in care and research into the development of integrated care solutions, including digital tools and telecare'.[188] Similarly, the European Commission 'calls [...] on the Member states, social partners and civil society to tap the potential of and mainstream digital solutions when designing, implementing and monitoring policies and related funding for care'.[189] But it fails to elaborate on a more precise and concrete action plan outlining the scope of the envisaged reforms and incentives. It

does not tackle the questions of the accessibility of digital public services and the creation of a European Health Data Space[190]. The strategy too timidly affirms new fundamental digital rights and the need to develop safety nets for citizens in Europe.

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The strategy could have gone even further by including three other objectives[191]: the continuity of care across borders; the reform of health systems and their transition to new care models, centred on people's needs; and a shift from hospital-centred systems to more community-based and integrated care structures. Beyond the effect on the European internal market, the political and visionary characteristics of these aims are obvious. The strategy could take a stand regarding these reforms as it calls for a transformative vision of society through a drastic reappraisal of care services.

This reasoning could be pushed further to reflect the reality of digital care services. Creating a digital public service that is inclusive and accessible is a major challenge for the future. Digitalisation and platformisation should not hide or hinder the need for quality care service – whether provided by public or private actors – whether serving the private or public interest (like the majority of schools). It could develop at the national as well as at EU level. Looking at the 1996 declaration on Services of general interest in Europe, one can recall its founding principles of full territorial coverage or universal access. Or even recall the French administrative law principles of continuity, equality and adaptability. The tendency appears discreetly in the annex entitled 'Long-term care quality principles', which also defines principles including continuity and person-centredness.[192]

In concrete terms, while keeping in mind the EU competence limitations and the political appropriateness, one idea would be to complete this growing field with an obligation – and not just an incentive – for member states to create internet access in rural areas just as is now taken for granted with water, electricity, roads or postal services. Would it amount to distributing smartphones or ensuring that strong internet is provided across territories? The European Care Strategy not only matters for care receivers and the nature of services but also for caregivers, more specifically professional carers. Care workers and their working conditions must be analysed in light of the digital transition.

Digitalisation and platformisation should not hide or hinder the need for quality care service – whether provided by public or private actors – whether serving the private or public interest.

3. THE EUROPEAN CARE STRATEGY: TOWARDS PLATFORM CARE WORK?

The ECS does mention platform work but because of the structure of the text, its objective is not to improve the working conditions of caregivers but more to focus on 'making the care sector more resilient and gender-balanced' (Title 3). This focus can hide or relegate to second place the aim of protecting caregivers in light of the digital transition and the appearance of digital platforms. It would have been interesting to add another title specifically dedicated to protecting care workers and more specifically care platform workers. It would allow a focus on platform carers' opportunities (3.1), their needs in terms of legal recognition (3.2) and the protection of their rights (3.3).

3.1 PLATFORM WORK AS A CHALLENGE AND AN OPPORTUNITY

Because of this perspective, the European Commission analyses the digital transition as 'a structural challenge'[193] which has caused workforce shortages in an already undervalued and underpaid care sector.

It would have been interesting to add that the digital transition can also be understood as an opportunity to modernise the job of professional carers. Giving it a platform can contribute to a definition and a formalisation of the services to be fulfilled. In turn, this increases work visibility.

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But this also requires safeguards for the workers. The drafters of the strategy suggest raising wages[194] and improving working conditions[195] as a way of enhancing the attractiveness of care work. Amongst the different pathways for improvements put forth in the strategy, it reads:

'Better working conditions and wages, supported by strong social dialogue, education and training, will make care jobs more attractive. Long-term care and early childhood education and care workers should be able to effectively exercise their social and labour rights, regardless of the type of employment or whether they are employees or self-employed, including those who work through digital labour platforms. Providing care workers with career development opportunities via reskilling and upskilling helps increase the resilience of the sector to unexpected shocks, such as the COVID-19 pandemic and helps workers progress in their careers. Better working conditions will also help attract more people to the profession, including men, thus improving gender balance in the sector.'[196]

We argue that the above statement falls short of references to fundamental rights and to dignity in working conditions as core objectives. Taking a firmer stance on these aspects would allow a move away from rhetoric of recommendations to the use of the language of rights and obligations.

3.2 PROTECTIVE LEGAL STATUSES

Before we turn to professional workers' rights, it is interesting to examine their legal statuses. The strategy states:

'Atypical contracts and the steady expansion of platform work play an increasingly significant role in the care sector. This brings challenges, such as workers having limited access to social protection, labour rights and adequate occupational health and safety.' [197]

This is particularly true in the context of platform work. We noted in the introduction that this type of work is increasing and that most platform workers are independent workers, even in apparent situations of subordination.[198] As noted in previous research, '[o]ften considered as self-employed, even in cases where their work is supervised and under a dependency relationship, workers engaged in digital labour platforms tend to lack labour and social protection'.[199]

In this light; it would have been interesting to draw conclusions from this dichotomy and note that most EU labour law texts apply to employees and not to independent workers[200]. This means that most professional carers (whether or not they work via a digital platform) are excluded from their scope of application[201]. This being said, the strategy builds on two legal texts which are starting to tackle this discrepancy: (a) Directive proposal 2021/762 on platform workers working conditions[202] which might create a presumption of employment, and (b) Council Recommendation of 8 November 2019 on access to social protection for workers and the self-employed. There is a need to look further for concrete measures to address this inequality comprehensively. For instance, if the proposed directive 2021/762 is adopted, could it then extend to all carers (whether or not they work via a platform)? Also, how to ensure social protection for all workers?

The Charter of Fundamental Rights is merely alluded to in connexion with the right of elderly people to lead a life in dignity and independence whereas the situation of workers remains unaddressed.

3.3 RECOGNITION OF PROFESSIONAL CARER RIGHTS

If statuses are not improved, then each right must be upgraded and extended in light of ILO convention 189 concerning Decent Work for Domestic Workers and convention 190 as well as recommendation 206 both about Violence and Harassment in the World of Work. The added value of these texts is to explicit the concrete content of each right. The strategy could have proposed this upgrade coupled with more explicit references to the Charter of Fundamental Rights. The latter is merely alluded to in connexion with the right of 'older people to lead a life in dignity and independence'[203] whereas the situation of workers remains unaddressed.

Even if the EU does not have the competence to ratify the ILO conventions and even if social policy is a shared competence, the strategy could have set out the rights. It did focus on training but not as a right (3.3.3), and it could have insisted more on labour rights (3.3.1) and social dialogue rights (3.3.2).

> *Even if the EU does not have the competence to ratify the ILO conventions and even if social policy is a shared competence, the strategy could have set out the rights.*

3.3.1 Labour rights explained and renewed in light of the digital transition

If the expression 'improvement of working conditions' is used, no objective is set. It would have been interesting to include one on the strategy. This strategy could have focused on several fundamental rights in two ways: 1) labour rights of professional carers in general and more specifically when those can be jeopardised by digital platforms trying to avoid national protective labour laws; 3) non-discrimination rights.

The strategy refers[204] to the corpus of existing and emerging EU labour laws (for instance in relation to the new directive on minimum wage[205] or the directive on transparent working conditions[206], but it would be interesting to specify the relevant fundamental labour rights (workers' dignity, working and rest time, adequate wage, training, access to social protection, health and safety at work, professional disease and work accidents, etc…). They are particularly relevant for carers and platform carers in light of the threat of platformisation to avoid the protections afforded by a contract of employment.

Moreover, one should add digital labour rights which are ignored in the strategy. We are thus confronted with a missed opportunity to include the specific rights that have come to existence[207]: caregiver data protection, protection of their private life, protection of their online conversations, protection in case of disconnection or end of contract, right to access data, right to appeal, protection in case of harassment online or via the internet, etc.

Finally, beyond these general provisions which are part of a new EU labour law, this strategy could specifically rely on the principle of non-discrimination enshrined in article 19 TFEU to protect carers, especially when they face 'challenging social behaviour, including verbal and physical violence, bullying and sexual harassment which are said to be frequent problems, in particular for long-term care worker'[208]. This principle has been implemented by hard law – directives and directly effective treaty articles – and is sanctioned by civil and criminal convictions.

3.3.2 A reinforced and modernised right to social dialogue

The strategy notes that social dialogue is a useful tool.[209] However, it could go further (see Chapter 5 by Tuscany Bell). In light of guidelines 2021/8838 on the application of EU competition law to collective agreements regarding the working conditions of self-employed persons[210], the European Commission could consider removing barriers to collective bargaining via the removal of competition law prohibitions. It could even go further and recognise a right to social dialogue building on the Charter of Fundamental Rights or even impose social dialogue (like the French platform sectoral elections in summer 2022).

A digital right to social dialogue could be imagined: if the core idea of collective bargaining remains the same, it is transformed by digitalisation. For instance, social networks and associations now often replace trade unions and online bargaining has started to occur (see an example of Facebook bargaining).[211]

3.3.3 A right to training

The strategy dedicates an entire section to training. Yet, it does not sufficiently differentiate between the training of care receivers and caregivers (professionals and non-professionals) who need to develop their digital competences. On the one hand, care receivers and non-professional caregivers need help to master technology. It is particularly true for old age persons who can be deprived of internet access. The European Commission considers 'large scale partnerships with healthcare, proximity and social services'.[212] They could be developed in tandem with a digital public service (see supra). On the other hand, when the strategy proposes that 'all kinds of care staff are able to participate both in high-quality initial education and training as well as continuing professional development programmes over the course of their careers', it addresses paid professional carers. It insists more specifically on digital competences.[213] Here again, incentive measures are preferred as well as financing of masters.[214] As welcome as these policy actions are, they could be completed by the recognition of a justiciable right to training drawing on Article 14-1 of the Charter of Fundamental Rights and the Digital Education Action Plan.

4. CONCLUSION

In conclusion, the European Care Strategy acknowledges the digital transition. It takes note of the numerous changes it brings. It states the intention to finance research programmes in order to study their depth and impact on care. It underlines strong and commendable values and principles of access to affordable, accessible and high-quality care, dignity, human rights, inclusion and opportunities for better life and career prospects, 'the backbone of our European way of life' [215] which apply both to care and digital care.

Nevertheless, it could go further by specifying digital care rights for care receivers – e.g. in the framework of a new digital care public service – and digital labour rights for caregivers – e.g. through the building of an emerging EU digital labour law.

This strategy could become a cornerstone of the EU's approach regarding digital and social policies and find its place in an EU digital labour and social law which is nowadays undoubtedly emerging.[216]

7. TOWARDS A HOME CARE STRATEGY FOR LONG-TERM CARE

7. TOWARDS A HOME CARE STRATEGY FOR LONG-TERM CARE

Jean-François Lebrun

Personal And Household Services Specialist

All EU member states have developed policies to support direct care activities for elderly people (notably through social services of general interest). However, their budgets do not always reflect the current and future importance of long-term care in a demographic context of an ageing population. In household support or indirect care activities, few member states have developed a support system able to offer decent working conditions, to professionalise these service jobs, to effectively tackle undeclared work and to meet the growing needs of working households and elderly people who are self-sufficient or have low levels of dependency. Yet there is a strong case for developing indirect care activities, given the extent of informal care needs and the importance of increasing labour market participation, particularly among women, while maintaining a good work-life balance.

This chapter is therefore an exercise of quantifying care (both direct and indirect) for people aged 65 and over across the EU. It is an exercise because, faced with data that are often partial or unavailable, certain assumptions are made to try to complete the picture for care provision. This will involve a description of the scale of the problem, which highlights the urgent need to address the issue of population ageing. This chapter will also attempt to quantify the development of an indirect care support policy for elderly people and their informal carers.

This attempt at quantification is all the more important today as on 8 December 2022, the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) adopted a recommendation on access to affordable high-quality long-term care[217]. In this recommendation, point 9(c) states that member states should support informal carers by providing them with access to social protection and/or adequate financial support, while making sure that such support measures do not deter labour market participation. This last element is particularly interesting

because there are few support measures for informal carers that do not negatively affect their participation in the labour market, with the exception of support for indirect care which frees up time and including time to be more present in the labour market.

Care work consists of two overlapping activities: direct, personal and relational care activities, such as feeding a baby or nursing an ill partner; and indirect care activities, such as cooking and cleaning.

1. DIRECT AND INDIRECT CARE: THE TWO COMPONENTS OF CARE

Care work consists of two overlapping activities: direct, personal and relational care activities, such as feeding a baby or nursing an ill partner; and indirect care activities, such as cooking and cleaning.[218]

This duality is apparent in home-based care, where – in the event of an increase in dependency or a loss of independence – all needs must be met, whether in relation to personal care or maintaining quality of life. A job in the care sector involves a mixture of direct and indirect care activities. It is rare to find a long-term care (LTC) job that solely consists of providing direct care: only childcare could be described as being confined to direct care activities. Jobs that are based exclusively on indirect care activities seek to maintain quality of life (for example, by doing laundry and preparing meals).

Lastly, indirect care activities for informal carers can help reduce the burden of maintaining quality of life and thus give them more time, whether for themselves, to care for their loved ones or to earn a living. This is even more important to the extent that care concerns the entire population – whether dependent or independent – on a lifelong basis.

2. LONG-TERM CARE

Today, people aged 65 and over account for 21% of the EU's total population (93 million), while those aged 85 and over account for 3% of the total population (nearly 13 million). By 2050, the over-65s will represent more than 30% of the total population (130 million) and the over-85s more than 6% (27 million).

Currently, the percentage of people aged 65 and over in need of LTC[219] is estimated at 26.1%, or 24 million people[220]. By 2050, this percentage will remain unchanged, but will equate to 33 million people. The additional 9 to 10 million people aged 65 and over in need of LTC will require LTC provision to adapt. Public spending on LTC will grow from 1.7% of GDP to 2.5% by 2050[221], an increase of more than €110 billion based on current policies.

Being over the age of 85 creates a dependency risk factor. Despite the increase in healthy life years, the risk of illness or disability increases with age. Many elderly people gradually become frailer and more dependent in long-term care (see Figure 10).

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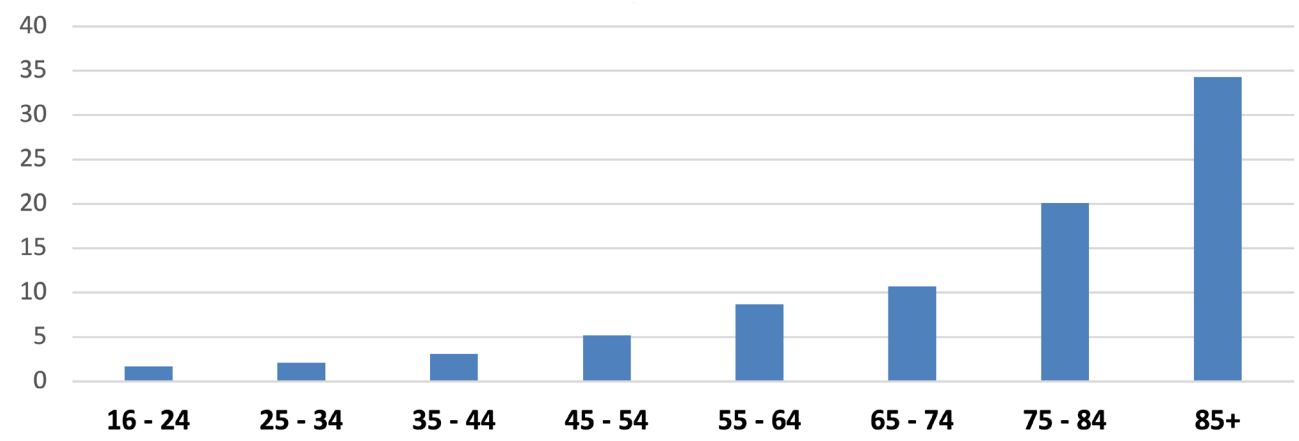
Figure 10 - Trends in the severe level of dependency with age - EU-2020

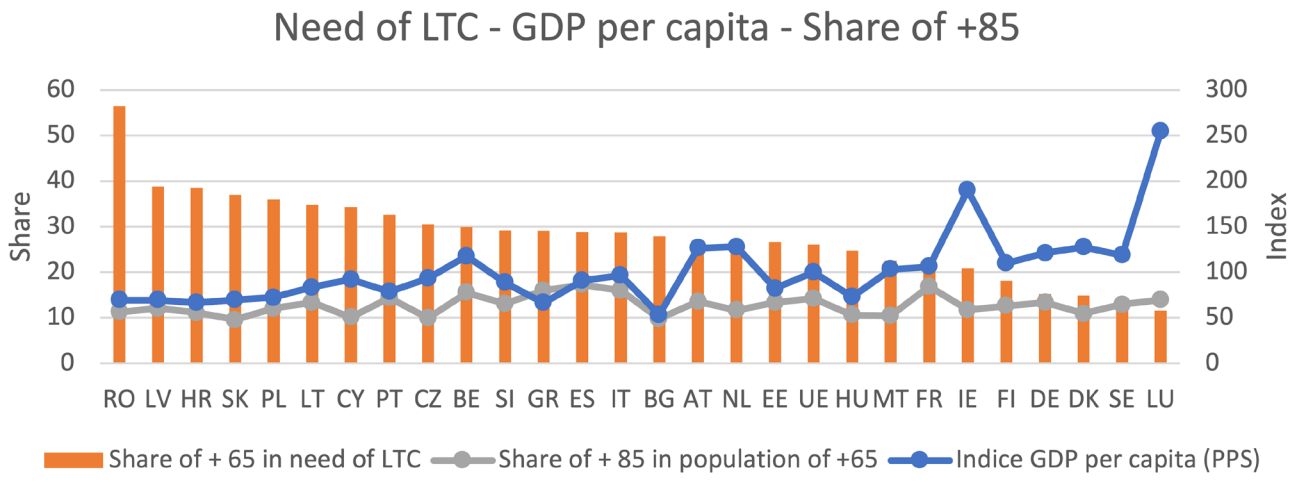


Source: Eurostat [hlth_silc_06], 2020

Yet old age alone does not explain the differences in dependency ratios within the EU. Elderly people on low income are more likely to need long-term care and support than those with higher incomes. In the first income quintile, 35.9% need long-term care, compared with 17.2% in the fifth income quintile[222]. The increased need for long-term care for people on low income is explained by the fact that this group generally has poorer health. People with low socio-economic status are exposed to more health-related risk factors, such as poor living and working conditions. In addition, certain lifestyle behaviours (such as diet, exercise, obesity and smoking) can be significant risk factors for many diseases, resulting in a need for LTC later on.

This finding by income quintile can also be found in GDP per capita. The higher the GDP per capita, the lower the dependency level (see Figure 11). Socio-economic factors seem to be more decisive than old age in explaining national differences in the level of dependency.

Figure 11 - Share of the population aged 65 and over in need of LTC
(the GDP per capita index is on the right-hand axis)



Source: Eurostat and Long-term care report 2021

7. TOWARDS A HOME CARE STRATEGY FOR LONG-TERM CARE

IMPORTANCE OF PREVENTION

Reducing dependency and the associated costs, as well as increasing the well-being of elderly people, requires an investment in preventive measures. The adage 'prevention is better than cure' is particularly true when it comes to ageing. Adapting homes for an ageing population is crucial in this respect, alongside preventive medicine, exercise and the dissemination of best practices, particularly when it comes to diet.

2.1 THE NEED FOR HOME CARE

Fewer than four million elderly people live in a care facility in the EU[223]. In general, only people with a very low level of independence are admitted to a care facility. Of the four million elderly people living in care facilities, 3.25 million receive financial assistance from the state[224].

The other over-65s in need of LTC (some 19-20 million people) live at home or with their children, and to a lesser extent in shared housing. The 67 million elderly people without a high level of dependency (moderate or no dependency) also live at home. In any event, both dependent and non-dependent older people would prefer to live at home. This is reflected in the political will in many member states to prioritise community-based care over institutional care.

According to Eurostat[225], 28.6% of people aged 65 and over living at home with a severe level of dependency say that they use professional services for personal care or household activities. This 28.6% represents less than six million people in need of LTC. Of these six million, 5.1 million people aged 65 and over receive home care which is either provided or subsidised by the state[226]. The remaining one million people may be among the 8.1 million people aged 65 and over who receive a cash allowance from the government. This allowance can cover the costs of staying in a care facility or pay for professional LTC services, informal care or even undeclared care work. Only some of the people who receive a cash allowance use it to pay for professional home care services.

In addition, 6.9% of people aged 65 and over with a moderate level of dependency use professional services for personal care or household activities (i.e. 1.5 million), while 2.8% of people aged 65 and over with no dependency use such services (also 1.5 million)[227]. In both cases, these are likely to be mainly indirect care activities.

On the basis of these initial observations, we can estimate the number of people aged 65 and over who could use professional care services (see Textbox 1). This shows that 14 million elderly people in need of LTC do not receive professional care, and neither do 19 million people with a moderate level of dependency.

TEXTBOX 1 - ESTIMATED NUMBER OF PEOPLE AGED 65 AND OVER WHO COULD USE PROFESSIONAL CARE SERVICES

92 million people aged 65 and over (130 million by 2050228)

- **24 million people** in need of LTC (33 million by 2050)
  - 4 million in care facilities, 3.1 million receiving state support (6 million by 2050)
  - 6 million people receive home care (assuming that the quantity and quality of that care is sufficient to cover their needs). Of these, 5.1 million receive state assistance and 1 million receive a cash allowance to pay for professional care (8 million by 2050)
  - 14 million people have no LTC service despite being need of it (20 million by 2050)
- **20.5 million people** have a moderate level of dependency229 (29 million by 2050)
  - 1.5 million people receive home care (2 million by 2050)
  - 19 million people do not use services but have moderate needs (27 million by 2050)
- **47.5 million people** without dependency (67 million by 2050)
  - 1.5 million people receive home care (2 million by 2050)
  - 46 million people do not have home care (65 million by 2050)

A total of **33 million people** aged 65 and over with a high or moderate level of dependency do not use or make insufficient use of LTC services (**47** million by 2050).

2.2 FULFILMENT OF HOME CARE NEEDS

In addition to the 33 million elderly people with a high or moderate level of dependency but without access to professional services, there are 46 million elderly people who have no dependency and do not use any registered support services. This makes the total number of people aged 65 and over who do not use professional services 79 million (112 million by 2050). There are several reasons why people aged 65 and over do not use professional services or do not make more use of professional services, as shown in Table 3.

TABLE 3 - Reasons for not using or not making more use of professional services for households with at least one person aged 65 or over in the EU.

REASONS	%	IN MILLIONS BY 2020	IN MILLIONS BY 2050
Financial reasons	33%	26	37
Lack of availability or quality of service	9.4%	7.5	10.5
No need	36.2%	28.5	40.5
Refusal by the person	7.6%	6	8.5
Other reasons	13.8%	11	15.5

Source: Eurostat [ILC_ATS15]

Eligibility for LTC services is means-tested in member states that have social welfare. In addition, care services are based on a personalised care plan drawn up according to the level of dependency, aimed at adapting care provision to government subsidies. In view of the budgetary constraints, quotas for care provision often exist.

Potentially therefore, almost 33.5 million older people do not have access to professional home care services for financial, availability or quality reasons. This figure of 33.5 million is consistent with the figure of 33 million given in Textbox 1. Some of these unmet needs correspond to indirect care (mainly for people with a moderate level of dependency, i.e. around 60%).

DEVELOPMENT OF LTC SERVICES

In view of the future growth in needs, even where an effective prevention policy exists, member states need to adapt their LTC policies: in the short term, to cover people in need of LTC who do not receive care services (14 million people), and in the longer term (by 2050), to cope with the increase in the number of people in need of LTC (nine million people). This increase in budgetary resources must go hand in hand with actions to make these care activities attractive, to retain workers in the sector and to professionalise them. If not, LTC provision will be inadequate. Now is the time to prepare for the future, which in demographic terms is an inevitable process that has already begun.

3. FULFILMENT OF NEEDS EXCLUDING SUBSIDISED SERVICES

Given the current underdevelopment of LTC, and excluding subsidised services, what solutions are available to people aged 65 and over with LTC needs (significant or moderate)?

- Use non-professional, informal care (mainly spouse, family and friends)
- Use non-subsidised care service

3.1 USE OF INFORMAL CARE

The entourage of the person who needs LTC, primarily the family (spouse and children), can provide a significant amount of support.

Data from various surveys shows that between 12% and 18% of the EU population aged 18-74 provide informal care on a weekly basis[230]. This corresponds to 52 million informal carers aged 18-74[231]. An average of 16 hours a week is spent on care. For more than 31 million carers, care provision amounts to fewer than 10 hours a week. For 10 million carers, between 10 and 20 hours a week are spent providing this care (in terms of paid work, this would equate to working for a quarter or half of the time). Lastly, fewer than 12 million carers provide informal care for more than 20 hours (equivalent to working between half of the time and full time).

TEXTBOX 2 -MORE WOMEN THAN MEN CARERS

The majority of informal carers (59%) are women. Across the EU, women (18% of adult women) are more likely to provide informal care than men (12%).

%	Percentage of carers in the population	Fewer than 10 hours per week	From 10 to 20 hours per week	More than 20 hours per week
MEN	***12***	***65.2***	***16.3***	***18.5***
WOMEN	***18***	***57.3***	***18***	***24.6***

The more time is spent on care each week, the higher the proportion of women carers.

“By 2050, all other things being equal, there will be the same number of informal carers but for a much higher number of highly or moderately dependent older people (47 million instead of 33 million). Consequently, there will be a shortfall of more than 10 million informal carers.”

It can be assumed that some of these carers supplement the work of professional services for severely dependent people living at home[232] (six million) and provide essential care to those who do not have access to professional services (14 million). Others provide support to elderly people with moderate dependency (20.5 million). The care provided by the 52 million informal carers also includes severely disabled people under the age of 65.

By 2050, all other things being equal, there will be the same number of informal carers but for a much higher number of highly or moderately dependent older people (47 million instead of 33 million). Consequently, there will be a shortfall of more than 10 million informal carers. A solution could be to increase the informal care provided by elderly people who are independent, a population that is expected to grow by 20 million.

As mentioned earlier, women are involved in informal care activities to a much greater extent than men. Working part time is often the only option available to active women.

TABLE 4 - Use of part-time work due to informal care in the EU.

	MEN	WOMEN	RELATIVE GENDER DIFFERENCE
Main reason for part-time work: Caring for others (% of part-time employees)	5.2	26.2	+404%
Total number of people working part time (in millions)	8.7	26	+199%
Number of people working part time due to caring for others (in millions)	0.45	6.8	+1411%

Source: Eurostat, ELFS, 2020

According to the figures in Table 3, 6.8 million women opt for part-time employment so that they can provide care, compared with 0.45 million men. This means that there are 14 times more women working part time due to caring for others than men. Women are therefore much more likely than men to face difficulties in balancing work and family life (see also Chapter 4 by Anna Gromada on childcare).

Lastly, as Table 3 illustrates, the division of unpaid housework within the family is an additional burden for women.

TABLE 5 - Unpaid work

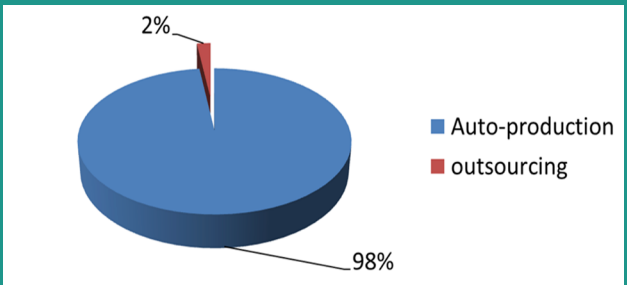
UNPAID WORK (IN MINUTES PER DAY)	MEN	WOMEN	RELATIVE DIFFERENCE BETWEEN WOMEN AND MEN
EU	143	263	+84%

Source: OECD, Time Use, 2021

“6.8 million women opt for part-time employment so that they can provide care, compared with 0.45 million men. This means that there are 14 times more women working part time due to caring for others than men.”

TEXTBOX 3 - SELF-PRODUCTION OF CARE ACTIVITIES OR UNPAID CARE WORK

In the case of non-dependent persons, the vast majority of care tasks, particularly indirect care tasks, are performed by members of the household. Time-use surveys[233] indicate that on average, this unpaid care work represents three hours per adult per day in EU member states. By subtracting the hours outsourced (declared or not), we find that self-care accounts for 98%.



Source: Personal calculations based on time use and NACE and Eurobarometer employment data

This average number masks significant differences between men and women. For women, the time spent on family and household tasks is more than four hours, compared with just over two hours for men. This difference is not unconnected with the difficulties they encounter in balancing work and family life. It is a major factor in women's mental workload and exacerbates the gender pay gap. To the question 'How easy or difficult is it to combine paid work with care responsibilities?', 44% of women answered 'Rather difficult to difficult', compared with 30% of men.[234]

Based on these various aspects linked to informal care, it is possible to identify two impacts on the labour market and on public finances:

- firstly, on the labour market, women are expected to contribute more than men; women are driven more towards forced inactivity or part-time work, despite having a higher level of education than men (57% of graduates from higher education are women)[235].
- Secondly, on public finances, the lower participation of informal carers in the labour market leads to a loss of revenue for the government. This loss has been estimated at 1.05% of GDP, or around €150 billion[236].

DEVELOPMENT POLICY FOR INDIRECT CARE

For informal carers, the possibility of reducing their domestic workload or indirect care responsibilities would be invaluable in improving their well-being and enabling them to work more or return to the labour market. Similarly, support with those responsibilities for severely and moderately dependent elderly people would provide respite for informal carers, who could thus be relieved from having to carry out these activities for their parents.

3.2. NON-SUBSIDISED HOME CARE SERVICES

There are two options to consider:

- undeclared work (or the shadow economy);
- declared (or formal) care service work (direct or indirect).

3.2.1 Undeclared work

It is essential to take account of undeclared work in this sector. Undeclared work in the EU accounts for around 3.5 million workers[237], with notable national differences (from 20% to 75% of all care workers)[238]. Consequently, undeclared work in this sector is not anecdotal. For the European platform tackling undeclared work, this sector is ranked third for undeclared work behind the construction and hotel and catering sectors[239].

The importance of undeclared work in this sector is due to economic rationality. To explain this, we can refer to Gary Becker's work on family economics (Textbox 4)[240].

> *Undeclared work in the EU accounts for around 3.5 million workers , with notable national differences (from 20% to 75% of all care workers).*

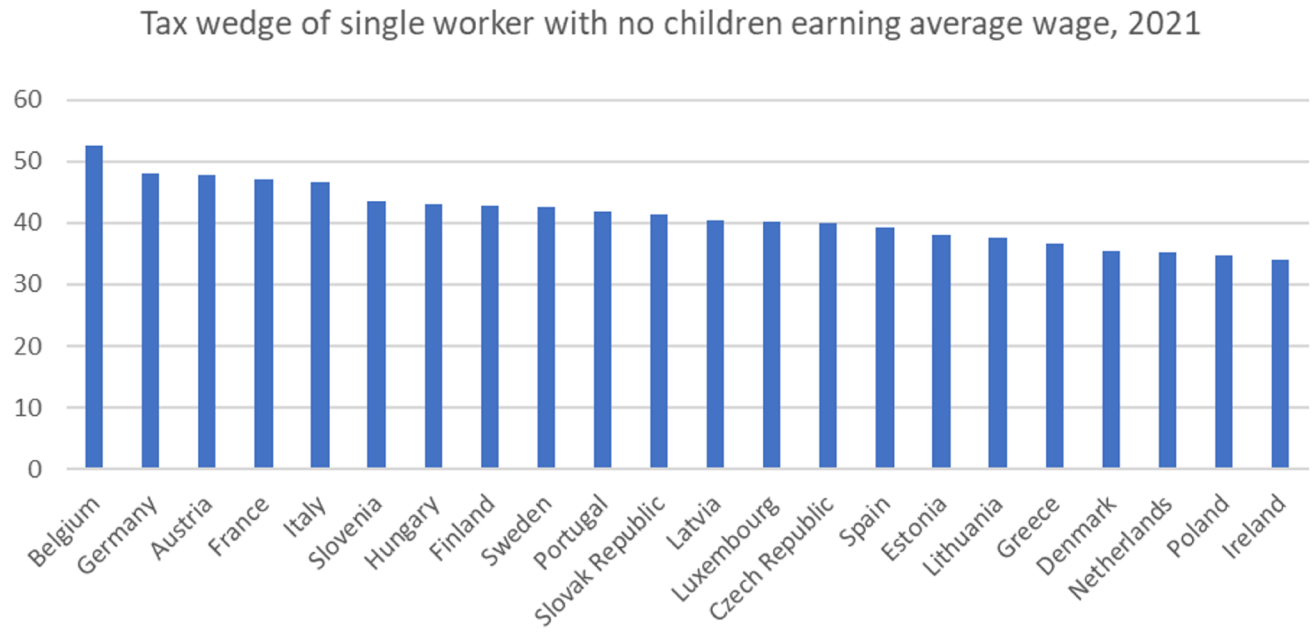
TEXTBOX 4 - COST OF SUBCONTRACTING, POLITICAL SUPPORT AND UNDECLARED WORK

According to Gary Becker (1992 Nobel Prize in Economics), the family can be considered as a place of production. It produces services, in this case personal or household services. The household wants to provide satisfying results such as a clean house and ironed linen. This production can be based on its monetary budget, its time budget and the relative prices of the different inputs. The provision of household services is a time-based resource allocation problem, where time is typically a scarce resource. It is the net salary of each member of the household that determines the opportunity cost of the time they are willing to spend on providing care. An increase in net salary will lead to the substitution of less time-intensive 'household' production. Therefore, the actual price of one hour of housework is not the same for everyone, because the value of time (net salary) varies from person to person depending on his or her net salary.

The household has several options: self-production of care activities, especially indirect care activities, by one or all of its members (higher proportion of women in self-production of care activities due to differences between men's and women's salaries), outsourcing to an undeclared worker whose frame of reference is also expressed in terms of net salary, or hiring a formal worker, the cost of which will depend on his or her net salary and the deductions made from the labour input (social security contributions and taxes). The latter option is rarely used, because the average cost will be higher than the user's opportunity cost.

In 2001, the EU tax wedge241 represented just over 40% (see graph below). In order to subcontract one hour of declared housework, a household has to work for nearly two hours.

This reasoning is relevant for indirect care services. For care provided to dependent people (direct care), the impossibility of self-production of care activities is another factor to consider.



Source: OECD – Taxing Wages 2022 (%)

The differences between prices and production costs in the EU show how undeclared work seems to be an economically rational choice for a large part of the population.

TABLE 6 - Average hourly prices and costs in the EU (€/h)

PRICE OF UNDECLARED CARE WORK	7.7
COST OF DECLARED DIRECT CARE WORK (SERVICE PROVIDER)	21.4
COST OF DECLARED INDIRECT CARE WORK (SERVICE PROVIDER)	17.8
COST OF DECLARED INDIRECT CARE WORK (DIRECT EMPLOYMENT)	13.5
COST OF DECLARED WORK (REST OF THE ECONOMY)	25.35

Source: Eurostat, LCS, 2016 and personal calculations for undeclared work
(annual net earnings for a single person without children at 50% of average salary)

The price of undeclared work can thus be considered a benchmark for such activities.

State-subsidised care provision makes LTC services affordable, especially for people on low incomes. Indeed, the co-payment made by the recipient of those services is generally a function of the level of income (except in member states with a long-term care insurance scheme or a universal care system).

In the French-speaking part of Belgium, this co-payment can range from less than €1 to almost €8. Above €8, the use of the Belgian system of service vouchers (indirect care) becomes advantageous. Note that almost 30% of users of these service vouchers are people aged 65 and over. Belgium is one of the few member states to have a policy aimed at making formal indirect care work competitive compared with undeclared work (see Textbox 7 below on the Belgian case study).

“Only eight member states have ratified the ILO Convention No. 189 on Domestic Workers.”

In addition to the non-payment of taxes and social security contributions, it is the absence of rights for undeclared workers that is the main issue. It is noteworthy that only eight member states[242] have ratified ILO Convention No. 189 on Domestic Workers[243]. However, simply ratifying that convention does not mean that the situation for domestic workers will change in practice. There is what can be called the ‘paradox of improving domestic working conditions’. By improving working conditions, the employee can be offered comprehensive social protection (sickness, accident, family, unemployment, pension, etc.). However, those rights are linked to the payment of social security contributions and taxes, which increase the cost of labour. Without support measures, including the increased solvency of demand, there is a risk that, faced with this increase in the cost of formal employment, the latter will be replaced by undeclared work. A de jure improvement does not mean a de facto improvement.

“Without state support and in the theoretical absence of undeclared work, only a limited number of households – namely high-income households – can afford unsubsidised formal care services.”

3.2.2 Declared care work

As mentioned previously, recourse to formal employment without government support is too expensive for the vast majority of households. Without state support and in the theoretical absence of undeclared work, only a limited number of households – namely high-income households – can afford unsubsidised formal care services. It is interesting to know what this percentage of households is, because it is relevant for the deadweight or substitution effect (see below).

The French and Belgian examples of indirect care support policies show that providing an adequate level of solvency (co-payment almost equal to the price of undeclared work) does not affect the public finances after factoring in the direct and indirect feedback effects (see below).

Other member states such as Germany (Mini-jobs) and Spain (Sistema Especial para Empleados de Hoga)[244] have opted for a social protection exemption system for these types of jobs. In this system, social security contributions are lower but so are acquired rights. In the Netherlands (Regeling Dienstverlening aan huis), anyone who employs a person to provide indirect care for fewer than four days a week is exempt from social security and tax obligations. This can be regarded as a form of legalisation of undeclared work.

TEXTBOX 5 - FORMAL HOME CARE JOBS

For direct care activities (all user groups), the number of jobs is estimated at 3.6 million, while indirect care is estimated at 2.8 million (all user groups), giving a total of 6.5 million declared care jobs[245]. These 6.5 million jobs are divided between 3.8 million service providers and 2.6 million direct jobs[246]. In general, these are not full-time jobs. In France, for example, the average working time is close to 950 hours per year for service provider jobs and 550 hours for direct jobs[247]. The number of formal full-time equivalent (FTE) jobs[248] is therefore close to three million.

Informal care, with 52 million people working 16 hours on average, accounts for around 22 million FTEs. Informal care exceeds formal care by a factor of nine. The Ecorys study[249] reports that in FTEs, informal carers account for almost 80% of all care providers at EU level.

Informal care for elderly people is clearly vital. Unless an extra €93 billion to €137 billion per year is invested today in home-based LTC services for the 14 million people aged 65 and over in need of LTC and without access to such services[250]. By 2050, those figures would rise to €134 billion and €196 billion at constant prices.

4. COST OF DEVELOPING INDIRECT CARE

There are several areas where developing an indirect care support policy would be of significant interest within the framework of a broader care policy:

- for people aged 65 and over who are moderately dependent (around 20 million people);
- for people aged 65 and over with high dependency who do not have limited access or who have limited access to subsidised care services (around 14 million people);
- to provide respite for informal carers aged 18-74 (around 52 million people).

> *“Almost one in 5 European adults could thus benefit from an indirect care support policy.”*

Almost one in 5 European adults could thus benefit from an indirect care support policy.

Pigouvian subsidies, which justify state intervention by the need to increase consumption in view of the positive externalities that result, can be applied to the care sector. In these cases, there is the well-being of elderly people to consider, as well as the positive effects that stem from care jobs (see below). The subsidy mechanism might be either supply-side or demand-side, in the form of a flat-rate or proportional subsidy.

The expected feedback effects are twofold:

- **Direct effect** linked to social security contributions and taxes levied on jobs generated by the support measures. This extra revenue may be accompanied by a reduction in unemployment benefits for people who have returned to work in indirect care and who are eligible for such benefits.

- **Indirect effect** of returning to work or increasing the number of working hours for people receiving these indirect care services. In Belgium, under the service voucher scheme, 3.6 FTE indirect care jobs will generate one job in another economic sector[251]. This effect is obtained in a system where 70% of users

are working age. Less time spent on unpaid care work means more time that can be spent doing paid work. This increase in working time generates social security and tax revenues.

In addition, the difference in wage costs between this indirect care sector (around €16 per hour[252]) and other sectors of the economy (around €25 per hour) must be taken into account, since social security and tax revenues depend on the level of wage costs. We will focus on the main indirect effects[253].

It is also important to take account of the negative impact on the public finances of the deadweight effect. For people using care activities in the absence of state support, the introduction of this support allows them to reduce their consumer spending. For the government, however, the subsidy will have no positive effect; instead, it is a loss that the state incurs. There is also a substitution effect if unsubsidised jobs are replaced by subsidised jobs. For government policies linked to employment, the deadweight effects can be very significant at around 36% and 81%[254]. In the case of care activities, the demand for unsubsidised formal jobs is thought to be relatively low. The substitution effect is estimated at 9.3% of direct returns in the case of the service voucher scheme in Belgium[255].

There are three possible hypotheses concerning the level of subsidies to be granted:

- Subsidised price < Undeclared price: High demand, focus on low incomes, reduction in undeclared work but significant risk of a government budget deficit. This option may be chosen as part of a social policy that reflects our choices as a society.

- Subsidised price = Undeclared price: Moderate demand, focus on average households, reduction in undeclared work and a balanced government budget.

- Subsidised price > Undeclared price: Low demand, high-income households (the advantage for these households is often linked to tax optimisation mechanisms when the subsidy takes the form of tax relief or a tax credit (e.g. Kotitalousvähennys in Finland and RUT-Avdrag in Sweden)), negligible impact on undeclared work, the budget may be in deficit because the deadweight or substitution effect plays a significant role.

The following two examples of a policy relating to the second hypothesis (Text boxes 6 and 7) illustrate the effects of a support policy on the public finances.

TEXTBOX 6 - FRENCH CASE STUDY

Since the early 1990s, and particularly 2005, the French government developed various instruments to support personal services that correspond to (direct and indirect) care activities carried out in the recipient's home.

These instruments have helped to create formal jobs in this sector. An estimate of the cost to the government of all the support schemes for personal services shows that for 2014[256], the burden on the public finances can be calculated by taking into account the tax and social security revenues generated by those activities. It is balanced for indirect care, or help with daily living activities (slight gain of €70 million), and in deficit by €2.8 billion for direct care, or services for vulnerable groups. These findings are consistent with the policy objectives linked to those two categories of activities – namely, ensuring access to direct care which is as universal as possible for vulnerable groups, which can result in a co-payment which is much lower than the price of undeclared work, and creating jobs and tackling undeclared work for daily living activities (indirect care), aimed at a co-payment which is close to the price of undeclared work.

This estimate relies on two assumptions: first, the deadweight effect (the fact that even without government support, users would still have used those services, which may be the case for high-income households) is considered equivalent to the positive externalities caused by the use of those services (better work-life balance and home care for dependent persons, for example); second, the jobs created as a result of government support will not entail other significant public expenditure (for example, an increase in the level of pension provision)[257].

IN €BN	ALL PERSONAL CARE ACTIVITIES	SUPPORT FOR VULNERABLE GROUPS	DAILY LIVING ACTIVITIES
Gross cost	11.5	7.2	4.3
Exemptions, allowances and reduced rates	2.8	1.8	1
Direct subsidies (and other subsidies)	5.1	4.6	0.5
Tax reduction/credit	3.6	0.8	2.8
Gross receipts	8.7	4.3	4.4
Burden on public finances	-2.7	-2.8	0.1

Source: Trésor Eco 175

In France, both direct jobs and service provider jobs can benefit from government support. Direct jobs have been criticised in the past as being tantamount to employing domestic workers. Today, however, France and Italy have shown that it is possible to implement extensive collective agreements erga omnes together with an appropriate legislative framework, ensuring that these jobs are comparable with other jobs. In addition, cohabitation between direct jobs and service provider jobs exerts competitive pressure on service provider jobs, limiting the profit margins of those service providers.

TEXTBOX 7 - BELGIAN CASE STUDY

In 2004, the government introduced the service voucher scheme, a demand-driven subsidy mechanism aimed exclusively at indirect care activities. A service voucher purchased for €9 or €10 in the Brussels-Capital region (minus a tax deduction, which varies depending on the region[258]) involves a subsidy of around €13.5. That means th voucher is actually worth €22.5, the cost of an hour's work by a service provider, including social security and tax contributions.

A study by IDEA Consult[259], which for several years was in charge of evaluating this system at federal level and is currently doing so for the Brussels and Walloon regions, presents the gross and net cost for a service voucher worker on a full-time equivalent (FTE) basis.

It is interesting to note that while a net cost still exists for the state (€1,203 per worker), it is much lower than the gross cost of €25,354. This is due to the direct and indirect feedback effects. The net cost is explained by the high subsidisation rate, at around 65%. After the tax deduction, the co-payment in Belgium is lower than the price of undeclared work.

Two points need to be made. Firstly, unlike the evaluation for France, the Belgian evaluation incorporates indirect feedback effects linked to positive externalities (increase in the activity rate of the working population via a better work-life balance). According to this study, 3.6 FTE service voucher workers create one additional FTE in the rest of the economy. Secondly, it also includes a deadweight effect around 9.3% of the direct feedback effects.

2016 COST PER SERVICE VOUCHER WORKER PER FTP (GROSS COST)	IN € 25,354
Feedback effects of wich	24,151
Increase in activity and productivity rate of the active population	8,684
Création of service voucher companiers	247
Creation of new management positions in the service voucher system	1,293
Creation of new iobs for service voucher workers	13,927
Net costs	1,203

It is essential to evaluate the budget for the government and the social security system, taking into account all direct and indirect costs and revenues.

Based on the evaluation of these national experiences, an initial costing exercise can be attempted for the development of an indirect care support policy.

The figures presented in Text box 8 below are intended to show that such a support policy is close to budget neutrality for the government (including for social security). This budget neutrality is due to a co-payment for users that is close to the price of undeclared work, taking into account both the direct and indirect feedback effects, as well as the deadweight effects.

TEXTBOX 8 - COSTING OF A POLICY FOR THE DEVELOPMENT OF INDIRECT CARE AS PART OF A CARE STRATEGY

Target market: more than 70 million people made up of

all informal carers, i.e. 52 million people;

everyone aged 65 and over living at home with a moderate level of dependency and without access to formal services, i.e. 19 million people.

Indirect care hours per person: 120 hours per year

This figure is close to the average number of service vouchers per person (one service voucher = one hour) in Belgium.

Average hourly cost: €16

This is based on the current ratio between direct jobs (44%) and service provider jobs (56%) and on the costs shown in Table 4 above. In this costing, these indirect care activities are exempt from VAT.

Average subsidy rate: 50%

This is higher than the tax wedge of 40% because it is necessary to take into account the additional costs related to service provider employment (overheads and margins), which also explain the difference between the hourly costs of these two models.

Gross cost to the government

Number of beneficiaries * Number of hours * Hourly cost * Subsidy rate =

70,000,000 * 120 * 16 * 0.5 = €134.4 billion * 0.5 = €67.2 billion

Direct feedback effect and social security and tax rates: 40%

The deductions will be equal to €134.4 billion * 0.4 = €53.8 billion.

We do not consider there to be any reduction in unemployment benefits.

Creation of indirect care jobs

On average, indirect carers work 900 hours per year (more for service provider jobs and less for direct jobs260)

Number of users * number of hours / 900 hours =

70,000,000 * 120 / 900 = 9.3 million jobs

Or 4.8 million FTE jobs (1750 hours per year).

Indirect feedback effect

In this example, we will limit the indirect feedback effect to 1 FTE job in the rest of the economy for 5 indirect care FTE jobs, rather than the 3.6 FTE jobs presented in the Belgian case study, given that some family carers are over 65 years of age.

This is equivalent to creating 0.96 million FTEs in the rest of the economy.

This additional job creation in the rest of the economy will generate social security and tax revenues: 0.96 million * 1750 hours * €25.35/h * 0.4 = €17 billion

Deadweight or substitution effect

We will maintain a deadweight effect equal to 10% of the direct feedback effects.

This is equivalent to 10% of €53.8 billion = €5.38 billion

Net cost to the government

Gross cost – direct feedback effect + deadweight effect – indirect feedback effect =

€67.2 billion - €53.8 billion + €5.38 billion - €17 billion = €1.8 billion

Or a net subsidy of €2 per recipient per month.

The unemployment benefits saved could also be deducted from this net expenditure.

This net public expenditure for developing indirect care of €2 billion compares to the gross public expenditure of €93 billion, at best, to offer professional direct care services to the 14 million people in need of LTC who do not currently receive it, and to the shortfall in social security and tax revenues of around €150 billion, due to there being fewer informal carers in the labour market. Evidently these figures are up for discussion, but the orders of magnitude mean that the development of indirect care should be integral to the implementation of a European Care Strategy for elderly people.

> *The development of indirect care should be integral to the implementation of a European Care Strategy for elderly people.*

Nevertheless, this costing raises a question: is the subsidy rate of 50% sufficient for all elderly people and for all informal carers? If the rate had to be increased for some elderly people, the net cost to the government would be higher. This is a question concerning our choices as a society that could translate as 'how do we want to help the most disadvantaged people?'

The willingness of people to engage in indirect care activities is also crucial. The attractiveness of those activities is a sensitive issue not only because of the working conditions, but because of the social value added and the quality of the care provision for our elderly.

Furthermore, efforts should be made to establish a clear and straightforward system for all players. Such support measures should also be accompanied by more streamlined administrative procedures[261]. In that respect, digitalisation offers significant potential in that everyone could have access to a personal account into which the subsidy could be paid on request, depending on various criteria (earnings, level of dependency, activity, etc.). Digitalisation thus allows precise targeting while remaining simple for recipients (see Chapter 6 by Claire Marzo on the digitalisation of care work).

Consideration should also be given to other aspects of the support policy, such as capping the subsidies per person, deciding whether prices should be regulated and settling the question of service provider accreditation (individuals and companies), alongside aspects such as professionalisation, working conditions and quality.

In the longer term, it is essential that we improve the professionalisation of these jobs. Care providers must be recognised as professionals who offer more quality or are more productive than unpaid work care. People are only willing to pay more than the opportunity cost between doing and getting done if the work performed is different from their own. **Training in the care professions and the introduction of new technologies must be integral to any care strategy, together with the aim of reducing undeclared work.**

The real aim of any such support policy is not that all informal carers of working age should use declared indirect care services, but that they should be offered a choice: freedom to choose between having more time to care for their loved ones, more time for themselves or more time to earn a living. Bear in mind that women are more educated than men: we are currently squandering a vast amount of talent, not to mention losing billions in social security and tax revenues.

5. CONCLUSION

A three-pronged action plan focusing on prevention, the development of LTC services and an indirect care support policy should be a central tenet of a European Care Strategy which all member states would have to implement. It is worth recalling that in the adopted EU Council Recommendation on access to affordable high-quality long-term care[262], member states are recommended to submit to the Commission a national action plan within 18 months of the adoption of the Recommendation.

In the medium term, preventive actions must reduce the proportion of dependent elderly people. Those actions must focus on lifestyles (such as diet and exercise), preventive medicine and home adaptations for the elderly. A major prevention effort aimed at people on low incomes could have a decisive impact on the level of dependency, given that the number of dependants in the least affluent section of the population is twice as high as in the most affluent section.

The development of publicly funded LTC services is essential, given that more than 63% of people aged 65 and over living at home and in need of LTC do not have access to publicly funded services, and the inevitable prospect of ageing, which will lead to a 33% increase in the number of older people with a high level of dependency.

7. TOWARDS A HOME CARE STRATEGY FOR LONG-TERM CARE

In view of the minimum financial investment (assuming the same level of home care assistance as currently) of more than €110 billion (from 1.7% to 2.5% of GDP), setting up an additional branch of the social protection system in the form of home care insurance, funded by social security contributions or taxes, could soon be an avenue worth exploring, given that 2050 is not far off in political terms. Governments must also be aware that the care professions require a significant effort in terms of training, retention (professional development) and attractiveness if the necessary care provision is to be available in the near future, including for migrant workers, who are already largely bring called upon in the sector[263].

> *In the medium term, preventive actions must reduce the proportion of dependent elderly people. Those actions must focus on lifestyles (such as diet and exercise), preventive medicine and home adaptations for the elderly.*

The development of indirect care is essential to help elderly people, whether dependent or otherwise, as well as informal or family carers. It is particularly a question of helping women cope with the difficulties of reconciling personal and professional life, so that they are free to choose between paid and unpaid work. The cost of this development is much lower than it appears at first glance if the various feedback effects are taken into account. Any such development must factor in the level of solvency of demand, the simplification of the system put in place and the professionalisation of indirect care jobs. The Recommendation on access to affordable high-quality long-term care indicates that member states should support (informal) family carers in their caregiving activities by providing them with adequate financial support, while ensuring that such support measures do not discourage their participation in the labour market[264]. The proposed development of indirect care satisfies this requirement.

The advantage of demographic change is its inevitability. The question is not whether or when to deal with ageing, but how to deal with it. Options are available, systems are already in place and studies have been carried out. The foundations are there. All it needs is the political will to prepare for what lies ahead.

> *The development of publicly funded LTC services is essential, given that more than 63% of people aged 65 and over living at home and in need of LTC do not have access to publicly funded services, and the inevitable prospect of ageing, which will lead to a 33% increase in the number of older people with a high level of dependency.*

The development of indirect care is essential to help elderly people, whether dependent or otherwise, as well as informal or family carers. It is particularly a question of helping women cope with the difficulties of reconciling personal and professional life, so that they are free to choose between paid and unpaid work. The cost of this development is much lower than it appears at first glance if the various feedback effects are taken into account.

8. THE CARE STRATEGY AS A REMEDY FOR GENDER INEQUALITY?

8. THE CARE STRATEGY AS A REMEDY FOR GENDER INEQUALITY?

Barbara Helfferich
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1. INTRODUCTION

After years of prioritising competition policy over care, the European Union finally responded to the challenge in September 2022 when it published its European Care Strategy.[265] The COVID-19 pandemic, which had arrived in early 2020, had put the spotlight on care workers in particular: the EU had to live up both the crisis and expectations.

The recent European Care Strategy (ECS)[266] has been welcomed as a game changer.[267] It shifts attention in the care sector towards a sustainable and human rights-based care model that includes inter alia a focus on formal and informal care, which is for the most part provided by women. In addition to ensuring quality, affordable and accessible care services across the EU, the strategy 'sets an agenda to improve the situation for both carers and care receivers [....] with better working conditions, gender equality and work-life balance of carers.' [268]

Civil society actors, trade unions and those institutions that provide care have for the most part embraced the strategy, but also point out that proper financing and implementation are crucial for its success.[269] Moreover, success can have many faces. In this chapter, we will examine to what extent the strategy presents a paradigmatic shift not only for women working in the care sectors, but also for women in general. Does the strategy take sufficient account of the gender dimension in caring and are the policies proposed up to the task of ensuring a dual carer model? Is it enough to address some specific gender inequalities, or do we need a whole new approach to care in Europe in the form of a European care economy as has been suggested by the European Women's Lobby?[270]

2. CURRENT TRENDS AND CHALLENGES

Does Europe do enough to address the persistent discrimination of women and undervaluation of their care work, both at home and at work? And to what extent does the Care Strategy foster gender equality? First, we need to look at how gender and care work interact to understand the enormous challenges that lie ahead for tackling gender equality and the care crisis.

2.1 WHO CARES AND AT WHAT COST?

Women continue to be the main caregivers. Whether they are employed or not, women take on most of the unpaid care work at home.[271] Eurofound reports that 'when considering the entire EU population, data reveals that 92% of EU women are regular carers – meaning that they provide unpaid care at least several days a week.'[272] Without doubt, care can be a rewarding activity, but for women it often carries an enormous penalty. The inequalities are painfully evident in the unequal division of care work in the private and public domain. The European Institute for Gender Equality (EIGE) reports that 'on a daily basis, 81% of women and 48% of men provide care. This rises to 88% for mothers and 64% for fathers of children under 18.' [273]

This unbalanced distribution of care work sets the frame for discrimination and inequalities that women suffer throughout their lifecycle. This includes employment opportunities (with the EU employment gender gap of 11.5%), pay differences (with the EU gender pay gap of 13%) and pension benefits (with the EU gender pension gap of 29%).[274]

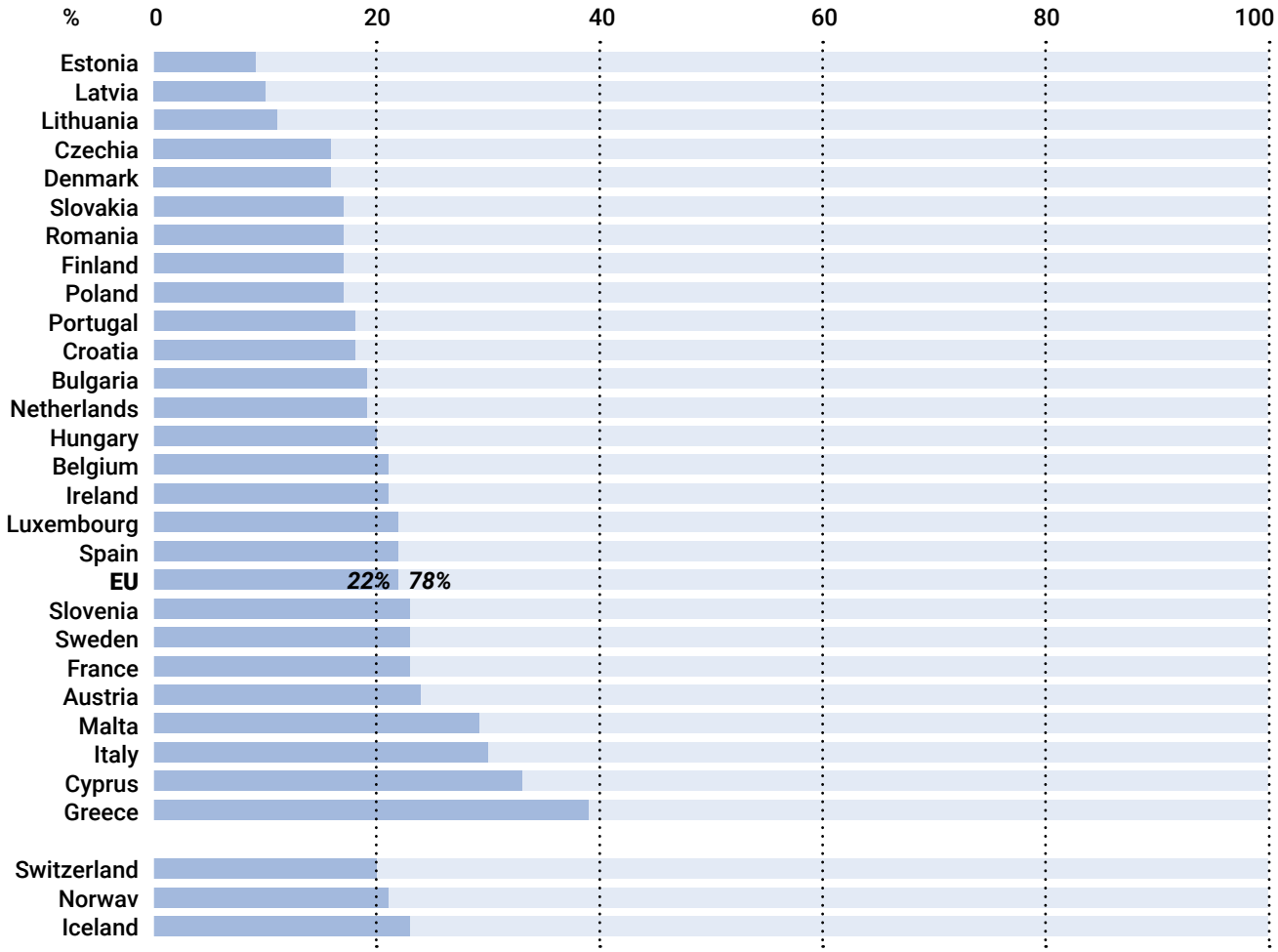
In addition, as care is still largely considered a 'feminine' activity and rarely as work when performed at home, its economic value remains very low. When women stay home to care for family members, they are referred to as 'inactive', an unfortunate term that does not reflect the complexity and hard work that care entails. EURCARERS reports that in some countries, more than 25% of inactive women are 'inactive' because of caring responsibilities[275] meaning that they had to forgo employment opportunities. As a result of unpaid care responsibilities, a staggering 7.7 million women are unable to work.[276] The European Institute for Gender Equality shows that 'women are also more likely to take up non-standard and low-paid jobs (with little or no security and social protection), as the flexibility of these arrangements allows them to reconcile their paid employment and caring duties.'[277]

In the care professions, including health, childcare and long-term care, the proportion of women is estimated to be 76% of the 49 million care workers in the EU.[278] Women account for 93% of childcare workers and teachers' aides, 86% of personal care workers in health services and 95% of domestic cleaners and helpers. [279] Moreover, the European Institute for Gender Equality cautions that these figures are 'probably underestimated due to the large share of undeclared employment, especially in the domestic care sector.'

The gendered segregation of the labour market perpetuates and reinforces the undervaluation of care and care work and remains a formidable barrier to reaching real gender equality. These professions are some of the most undervalued and underpaid jobs in the EU. 'More than half of personal care workers in health services are among the 30% lowest paid workers. Domestic cleaners and helpers mainly work part-time (69%) and more than half have a migrant background (55%).[280] They are often irregularly employed with low wages (82% of domestic cleaners and helpers are among the 20% lowest paid) and poor working conditions.'[281]

All too often paid care work means low income, a precarious job, and in general fewer career opportunities. The result of lower earnings and insecure job contracts can work as a driver for women to opt out of paid employment and rather care for their families.

Figure 12 – Health workers per gender, Q3 2020 (data not available for Germany).



Source: Eurostat (2020).

When it comes to providing formal long-term care in people's homes, an estimated 4.5 million out of the 5.5 million workers in the EU are women.[282] Moreover, it is worth noting that 38% of these women are aged 50 years and older, according to Eurofound.[283]

These numbers not only indicate that we are facing a care crisis, but that we will be soon reaching a tipping point where care may challenge the very foundations of European cohesion.

8. THE CARE STRATEGY AS A REMEDY FOR GENDER INEQUALITY?

3. EUROPEAN CARE INFRASTRUCTURE IN CRISIS

The availability of high-quality, accessible and affordable care services has featured significantly on the policy agendas of most EU member states. While it is recognised that these services are essential to ensure that more women enter the labour market, women still bear a disproportionate amount of unpaid care work, including housework, care for children as well care for older people and people with disabilities, investments in care infrastructure have been low and slow.

The FEPS-FES interactive Care Atlas shows, the effects of insufficient care coverage are significant and profoundly gendered showing that millions of women are kept out of the labour market due to caring responsibilities. [284] At the same time, caring needs are increasing disproportionally.

It is estimated that by 2023, 37 million individuals in Europe will be over the age of 80, the number of one-parent families is set to increase and 76% of unpaid care activities will still be carried out by women.[285] What is more, one in four people in the EU is currently affected by a long-term disability with women affected in larger numbers than men (27% vs 22% respectively).

This reality underscores the observation that 'gender is a key issue in analysis of LTC services, including barriers to access, as women make up the majority of both care recipients.' [286] Previous research namely evidences that 'gender intersects with other axes of marginalisation, affecting which groups access formal LTC services [meaning that people] with low income, people with low education (among whom women are over-represented), migrants and ethnic minority women have greater difficulty in accessing formal LTC services.'[287]

This means that EU institutions and member states are under increasing pressure to find sustainable and affordable models to meet the ever-increasing demand for LTC services.[288] The European Commission notes that the care sector has a high potential to create jobs, driven by the population ageing that presents so many challenges. More than 1.6 million long-term care workers would have to be added by 2050 to keep long-term care coverage at the same level. To respond to the demand for care, the sector needs not only to retain staff but also to attract more workers with the right skills.[289] The skills gaps at this point are closed to some extent by migrant workers (see chapter 9 by Elisa Chieregato on 'Care at the intersection of multiple discriminations' for a more detailed discussion on this specific aspect). But while policy responses reference gender, they fail to put it at the centre of the response. The new European Care Strategy is no exception.

4. THE RELEVANCE OF A STRONG EU INVOLVEMENT IN CARE

EU member states have been promoting very diverse care policies, but collectively they have failed to address the gendered nature of caregiving. Hence, a European approach was called for to tackle these issues from a gender perspective with the view to coaxing member states to consider reforms in this direction.

5. GENDER MATTERS

While the EU's express competence is limited to addressing care systems, it has specific and far-reaching competences for promoting gender equality. As such, the European Care Strategy was built around already existing instruments and legislation in place or under consideration such as the Work-Life Balance Directive[290] designed to promote inter alia greater involvement of men in childcare. Moreover, the new European Care Strategy is embedded in the European Gender Equality Strategy. In particular, actions to address the gender care gap in the formal and informal economy contribute to debunking the myth of women being predestined to care as a way of justifying their main responsibility for caring.

In its proposal for a Care Strategy, the European Commission addressed the increased challenges to occupational health and well-being of women in caring professions whilst also focusing on the role of unpaid care work.

6. HOW AMBITIOUS IS THE STRATEGY FOR ADDRESSING GENDER EQUALITY?

As 'the strategy calls for boosting access to quality, affordable and accessible care services and improving working conditions and work-life balance for carers', it has set itself very ambitious goals.[291] But can it really address the underlying structural barriers that women experience as carers and care receivers? Is the care strategy built around a life-cycle approach and the imbalance with which women need to address care over time? Can it seriously address the vertical and horizontal gendered segregation of the care sectors? Does it in any way propose to address the much-needed structural re-valuation of unpaid care?

The European Women's Lobby lauded the publication of the European Care Strategy calling it 'a stepping stone towards a European Care Deal.'[292] The EWL response

to the strategy is both welcoming and cautious. It is welcoming because the strategy has the potential to trigger a paradigmatic shift in the EU's approach to care, both in economic and social terms. It certainly signals a change in the narrative. As such, it could pave the way towards the understanding that care is a continuum that intersects with both the economic and social realities. For the first time care, both paid and unpaid, is acknowledged as primordial for a functioning society. And unlike other strategies, where gender issues are mentioned but remain marginal, the strategy acknowledges the gendered nature of the sectors and their gendered interaction with the economy and society.

> *"There is no doubt about its relevance for revaluing the work of care; for putting the spotlight on the persistent discrimination of the feminised care sectors; for the penalties that women suffer on account of being primary carers ; for foregoing pay and careers to deliver care to those in need of it."*

But we also need to be cautious and acknowledge the limitations of the strategy in terms of its possible overall impact on gender equality. There is no doubt about its relevance for revaluing the work of care; for putting the spotlight on the persistent discrimination of the feminised care sectors; for the penalties that women suffer on account of being primary carers; for foregoing pay and careers to deliver care to those in need of it. However ambitious, the strategy misses important elements that would make it a truly feminist approach to care and would seriously challenge the patriarchal structure of the care systems in Europe.

Nancy Folbre and other feminist economists have called to move beyond the male breadwinner model.[293] The equal earner/carer model requires external care services including high quality, affordable and accessible child and long-term care services which in turn requires a revaluation of the care sector and implies employment that is well renumerated. Yet, we have not even come close to such a scenario. The new European Care Strategy does not offer structural solutions to the vertical and horizontal segregation which is so dominant in the care sector. Failing the structural test, what does the strategy do for gender equality and could it be improved?

7. SOMETHING GAINED – SOMETHING LOST

There are important elements in the strategy that have the potential to elicit positive policy changes at member state level. The focus on fair working conditions and training for care staff, the insistence on the highest standards of occupational health and safety and the explicit mention of tackling gender stereotypes as well as the call for the ratification and implementation of the ILO Convention No. 189 on domestic workers will not doubt mean improvements for women working in the care sectors. Likewise, investments in the LTC infrastructure will bear fruit for women carers and receivers, while the revision of the Barcelona targets will hopefully ease the burden of mostly mothers who are searching for good, affordable and accessible day care. That such targets do not exist for the LTC sector is a serious shortcoming of the European Care Strategy.

We also need to bear in mind that many more women than men will require long-term care. Women in need of long-term care will by far outnumber men with 33% compared to 19% respectively.[294] It is high time to investigate the gender dimension of long-term care from the receivers' side.

The gender pay and pension gaps are also attributable to what is termed the motherhood or care penalty for women. A 2019 report by The Economist reveals that women in Germany face a 60% drop in income a year after having given birth.[295] Unfortunately, the European Care Strategy does not provide guidance to the member states on how to address this. Child-care credit systems can, for example, work to boost mothers' pension entitlements, as for example in Poland, 'but not enough to fill the gaps caused by career breaks, and the effect of child-care credits depends on the design of the pension schemes.'[296] In fact, '[s]ome of the goals of child-care credit systems, such as rewarding vital social activities, achieving gender equality, and relieving old-age poverty of women, are attained only to a limited degree.'[297] Despite the obvious shortcomings of such credit systems, exploring such policy tools would have added a new and creative policy dimension.

The most important policy issues missing from the strategy may not be available, but they should have been at least mentioned in some contextual detail. **The**

first one is the lack of a coherent and inclusive gender mainstreaming approach. When I first read the strategy, I was impressed by the wealth of data and the reference to 'it's a woman's job and it is a huge penalty'. But when it came to concrete policy proposals, the neutered approach to care once again made women invisible, both as carers and receivers of care. As a matter of fact and as a curious detail, most of the rest of the text of the strategy avoided the word women altogether.

> *Policy coherence and linkages are key to promoting positive outcomes, which in the case of the European Care Strategy can be considered a success as the strategy is bringing together various instruments related to care.*

The second missing link is gender budgeting, which in the case of the strategy would have been a powerful way of addressing the gendered and discriminatory nature of the way care is organised. The tools for such an approach have long been developed thanks again to the work of the European Institute for Gender Equality. Both gender mainstreaming and gender budgeting could have been a real gamechanger.

Finally, the European Care Strategy clearly outlined the gender trap of unpaid care work and its contribution to the continued inequalities that women suffer. While the solution given seems so common sensical – revalue care – the tools proposed in the form of a campaign addressing inter alia unpaid work, are a far cry from providing relief. **Addressing unpaid work should have been a central element of such a care strategy.** This is a lost opportunity.

'Unpaid care activities have long been left out of policy agendas. Yet, it is now evident that neglecting unpaid care work limits policy effectiveness across a range of socio-economic areas. Care has to be considered a central activity for the well-being of our societies and it should be redistributed between men and women, as well as between the family and the State.'

(EUROCARERS, 2022)

In this context, the European Care Strategy fails to point to the importance of non-discriminatory tax systems. In countries that allow a joint filing in personal income tax systems with a progressive rate structure, the low-income earner is effectively taxed at a higher marginal tax rate. As the OECD points out, 'the higher taxation of women's income may influence their labour market participation, childbearing behaviour […]. The design of the tax system in a country may impact both the distribution of income between women and men (distributional effect) as well as the distribution of paid and unpaid work (allocative effect)'.[298]

> *We would like member states to consider gender sensitive care credits earned throughout a lifetime and ensuring that the pension keeps women above the poverty-line.*

Policy coherence and linkages are key to promoting positive outcomes, which in the case of the European Care Strategy can be considered a success as the strategy is bringing together various instruments related to care. But it can present challenges for the implementation of policies if the instruments relied on are diverse and require multiple and oftentimes overlapping guidance and monitoring. Monitoring and guidance is indeed foreseen for the various initiatives under the strategy including through technical support instruments, EU funds and the European Semester. How and with what criteria and indicators such monitoring will be done, remains for the moment unknown. It is here where the important work of EIGE needs to be acknowledged and brought into policymaking. In recent years, EIGE has

given us a wealth of information and analysis that also contributed to the European Care Strategy. Likewise, its implementation will need to rely on the continued efforts that EIGE is undertaking to make the realities of women visible and understandable.

8. IS THIS A LOST OPPORTUNITY?

No. The European Care Strategy breaks new ground and presents a gentle shift from care as a problem to care as a solution. And while it lacks important elements for gender equality, it has changed the narrative and put women at the centre of a policy document. What is more significant is the fact that the ECS indirectly challenges the narrow focus of what constitutes an economy by putting care at the centre of policy and not competition. The strategy also takes the form of a dialogue with trade unions, employers, civil society and governmental agencies. Such involvement is crucial and would need to also respect gender parity in the consultation processes that will accompany the implementation of the strategy.

9. POLICY RECOMMENDATIONS

There are so many things one could wish for when it comes to gender equality, caring and the EU.

Women would wish for an inclusive strategy with the EU taking a lead to elaborate common targets and indicators which allow for effective monitoring, a detailed gender mainstreaming and budgeting approach aware of and including intersectional issues and themes, broadening our understanding of what constitutes an economy and giving it a distinctly gendered dimension. We would hope that there is finally a gender lens used to prepare for emergencies such as the recent pandemic. We would hope that account is taken of the fact that men and women care differently and that women are more affected by care in old age. We would like member states to consider gender sensitive care credits earned throughout a lifetime and ensuring that the pension keeps women above the poverty-line. We would like the tax system to be reformed to eliminate explicit and implicit gender biases and that family policies treat women as individuals with their own rights. We would like recognition of how families share work overtime. And that, finally, we would like a structural re-valuation of care and unpaid care work. But just launching a campaign won't do the trick.

9. CARE AT THE INTERSECTION OF MULTIPLE DISCRIMINATIONS: THE EUROPEAN CARE STRATEGY AND MIGRANT DOMESTIC WORKERS

9. CARE AT THE INTERSECTION OF MULTIPLE DISCRIMINATIONS:

THE EUROPEAN CARE STRATEGY AND MIGRANT DOMESTIC WORKERS

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1. INTRODUCTION

At the EU level, gender inequality is widely recognised as being shaped by the persisting unequal allocation of care responsibilities among men and women. The European Care Strategy, the integrated and comprehensive initiative aiming to ensure high-quality, affordable and accessible care services across Europe, is thus explicitly concerned with the promotion of gender equality. It recognises the importance of investing in care services not only for care receivers, but also to promote women's participation in the labour market and to improve the achievement of work-life balance for workers with care responsibilities. Moreover, with almost 90% of the formal care workforce composed of women, it acknowledges that improving the working conditions in the care sector would contribute to filling the gender pay gap, which is currently at 13% in the EU.

The extent to which the European Care Strategy tackles gender inequalities has been investigated in a previous chapter (see Chapter 8 by Barbara Helfferich on Gender Equality). Instead, the present contribution aims to assess the extent to which the strategy tackles intersectional inequalities.

Intersectionality refers to the combination of gender with other personal characteristics or identities, and how these intersections contribute to unique experiences of

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discrimination, in which several grounds of discrimination operate and interact with each other, for example, gender with other grounds of discrimination, such as race, ethnic origin, migration status, age, and disability, in a way that is inseparable and produces specific types of discrimination.[299]

Although the European Commission had long seen the promotion of equality between women and men as a gender-only issue, it specifically committed to intersectionality in the last EU Gender Equality Strategy (2020-2025), acknowledging that 'women are a heterogeneous group and may face intersectional discrimination based on several personal characteristics'.[300] For example, women with additional conditions of marginalisation, such as belonging to an ethnic or religious minority or having a migrant background, face a greater disadvantage in the labour market and greater difficulties in combining paid work and unpaid care.

Domestic work is an especially relevant site of intersectional discrimination, where the situation of structural disadvantage is determined by the interaction of gender with ethnic origin and/or migration status. This work is mostly performed by women, many of whom are from a disadvantaged ethnic minority or with a migrant background. It thus reveals the complexity of the unequal distribution of care work among women, depending upon other personal characteristics or identities, such as their ethnic origin, migration status, age, educational level and socio-economic status.[301]

Even if the performance of care work, whether paid or unpaid, remains a gendered activity, care is distributed differently between women who can afford to outsource part of their unpaid care work, and women to whom this unpaid care work is transferred. Therefore, domestic work not only reflects inequalities along gender lines, with women making up most of the sector. It also replicates and relies upon, specific socio-economic inequalities across households who operate as the demanders and suppliers of such work. This is the inequality between women who can outsource part of their unpaid care work to other workers with less economic means, and those workers performing paid work – themselves mostly women – who experience low wages and poor working conditions.[302]

Without an intersectional approach, care policies risk addressing the interests of only one group of women, at the expense of other women. Against this background, the present chapter examines whether the European Care Strategy acknowledges the diversity of carers, and whether it addresses the specific needs of, and challenges faced by, women who are in the most vulnerable category of care workers, domestic workers.

2. DOMESTIC WORKERS IN EUROPE: DEFINITION, NUMBERS AND CARE CHAINS

Domestic workers are workers who perform services for private households, such as direct care services for the members of the family, or other indirect care services such as cleaning and other forms of housework.[303]

Domestic workers experience some of the worst working conditions across the care workforce, being exposed to multiple forms of disadvantage ranging from low wages, long and unpredictable working hours, vulnerability to abuse and harassment, and precarious working conditions. This situation is due to various factors, such as the legacy of domestic servitude in contemporary domestic work, the location of domestic work in the invisibility of the private household, and especially its association with the performance of care activities.[304]

> *"There are 9.5 million domestic workers in Europe, 90% of which are women, according to recent data. It is estimated that 54.6% of the total domestic care workforce in Western Europe are migrants."*

In many legal frameworks, domestic workers are exempted from basic regulations on normal working hours and daily rest periods and are thus frequently obliged to work long or highly unpredictable hours. Moreover, domestic workers are often not protected against unfair dismissals, making them extremely vulnerable to the sudden termination of their employment. It is also extremely common that domestic workers are not covered by occupational health and safety legislation and minimum wage policies, and they may not be able to join trade unions and access collective bargaining.

Yet, even where domestic workers are covered by labour protections, the fact that their work is carried out invisibly in private households makes monitoring and law enforcement difficult, thus leading to a diffuse situation of non-compliance. In some countries, such as Germany and Austria, the enforcement of labour rights

is complicated by the fact that domestic workers are usually not employed directly by care recipients but are posted and assigned to families by service provider agencies.[305]

In other words, the sector is characterised by questionable work issues. This situation, which has sometimes been associated with modern slavery,[306] feeds into intersectional inequalities, since it affects a great number of women, and in particular women from the most marginalised groups, who already face discrimination on other grounds, such as migrant women, ethnic minority women, or low-income and less-educated women.

There are 9.5 million domestic workers in Europe, 90% of which are women, according to recent data. It is estimated that 54.6% of the total domestic care workforce in Western Europe are migrants.[307] The higher segregation of migrant workers in domestic work relies upon economic inequalities between countries in the globalised economy, which enabled the emergence of a transnational care market – famously labelled as 'global care chain'[308] – in which care work, in the absence of a more egalitarian redistribution between men and women, is transferred from women to 'socially and ethnically other' women.[309] The high proportion of migrants in the sector has also been supported by official policies. For example, in the 1990s and 2000s, Italy, Greece and Spain adopted specific quotas for the recruitment of domestic workers or promoted periodic sector-based regularisation, thus making domestic work an entry point to destination country labour markets for migrant women.[310]

Alongside a global care chain, recent decades have seen the development of a significant intra-European care chain, with many central and eastern European women migrating to western European countries to be employed as domestic workers.[311]

Although comparable data on the size of the sector is lacking due to the large proportion of undeclared work and lack of an univocal classification of domestic care workers, the sparse data available nonetheless indicates the relevance of the phenomenon. In Italy, there are an estimated 451,371 registered live-in domestic workers, 73% of which are migrant workers. Of this group, almost two-thirds come from Eastern Europe (esp. Romania, Ukraine, and Moldavia).[312] In Austria, data from 2016 show that around 60,000 registered live-in domestic workers worked in the country, of which the vast majority was composed of workers from Slovakia (47%) and Romania (37%).[313] An estimated 300,000 live-in care workers are employed in Germany, almost all live-in domestic workers from eastern European countries, with 46.2% from Poland.[314]

"Alongside a global care chain, recent decades have seen the development of a significant intra-European care chain, with many central and eastern European women migrating to western European countries to be employed as domestic workers."

The situation in Central and Eastern European countries is different, however, since the number of migrant workers in the domestic care sector remains negligible and limited to the provision of domestic work to high-income families. Yet, even in these countries, it is possible to see another pattern of care migration emerging also in eastern European countries, with live-in carers being mainly from neighbouring non-EU countries (from Ukraine and Belarus in the case of Poland, from Bosnia and Herzegovina in the case of Croatia) [315]

INTRA-EU CARE MIGRATION DURING THE COVID-19 PANDEMIC

Western European dependence on migrant domestic workers, in particular intra-EU migrants from Central and Eastern European countries, became apparent during the first months of the Covid-19 crisis, when the closure of national borders and travel restrictions severely affected labour migration. This was particularly detrimental to the circular care migration patterns that form the so-called rotational '24-hour care work' scheme used in Austria and Germany, in which one care worker works around the clock, alternating every two to four weeks with one or more care workers.

Austria and Germany responded to this disruption by setting up 'care corridors' to enable entry into the country of migrant care workers. Indeed, in the very first months of the pandemic, three chartered planes from Bulgaria, Croatia, and Romania, as well as six special trains from Romania were organised to bring migrant care workers to Austria.[316] Similarly, in Italy, a new scheme was set up to regularise the migration status of domestic workers, to enable them to either enter the country or bypass the lockdown measures to perform their work.[317]

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However, the increased attention on domestic workers as essential care providers did not result in greater interest in the material improvement of their working conditions. On the contrary – in the case of Italy – live-in domestic workers were excluded from the temporary income support provided in response to the Covid-19 crisis, thus making clear that safeguarding the provision of live-in care was given priority over decent working conditions for those who provide it.

3. DOMESTIC WORKERS AS ESSENTIAL CARE PROVIDERS

In recent decades, with the rise in the demand for paid care services – and the public spending cuts in care services in favour of direct economic support of families to buy care services in the market through cash-for-care transfers – domestic workers have become increasingly relevant as care providers, notably in the long-term care (LTC) sector.[318]

In 2020, Eurofound innovatively included domestic workers in its study on the LTC workforce, owing to their significance in the provision of LTC in seven member states (Austria, Cyprus, Germany, Greece, Italy, Malta and Spain), whose welfare states have traditionally been characterised by a strong reliance on the family as the main care providers. Yet, more recently, the number of domestic workers providing LTC appears to be on the rise in other countries, including the Netherlands, Poland and Slovenia.[319]

In these countries, it has become increasingly popular to employ domestic workers throughout the live-in care arrangement, where the worker provides care services while living in the household of the care recipients. This 'migrant in the family' model emerged and has been established as a low-cost alternative to insufficient, or not affordable, LTC services,[320] where the cost of labour is reduced through the provision of board and lodging, and through the employment of migrant or ethnic minorities women.

The live-in care arrangement has also been preferred for cultural reasons, since it ensures the continued presence of a carer in the household and the flexibility to respond to the multiple care needs that can emerge in the home of the care recipient, in proximity to the ideal model of family care. Moreover, it meets care recipient preferences for staying in the home environment, in line with deinstitutionalisation processes. However, the employment of live-in domestic workers is made affordable for families at the expense of the working conditions and wages of workers, whose working conditions can even be exploitative. In fact, to ensure constant LTC, a live-in domestic worker is usually required to work or be present at the house of the care recipients basically around the clock, with no rest time, and being remunerated for only a limited number of working hours.

> *"The new European Care Strategy addresses this invisibility by innovatively considering domestic workers and the specific challenges they face in the broader strategy to promote better working conditions and pay in the LTC workforce."*

Notwithstanding the relevance of domestic workers in the provision of LTC and the specific challenges faced by them, domestic workers have long been invisible in EU policymaking, in particular in the EU agenda on Work-Life Balance.[321] Yet, as will be examined in the next section, the new European Care Strategy addresses this invisibility by innovatively considering domestic workers and the specific challenges they face in the broader strategy to promote better working conditions and pay in the LTC workforce.

4. THE CONSIDERATION OF DOMESTIC WORKERS IN THE EUROPEAN CARE STRATEGY

The European Care Strategy pays much attention to promoting the affordability of care services, in order to extend the range of households that can use care services: it is estimated that 13% of households do not make use of childcare because they cannot afford it, and one in three households with long-term care needs do not make use of it because of its cost. In particular, in the Communication on the strategy, the European Commission emphasises the importance of improving the accessibility, availability and affordability of care services, to ensure 'fairer access to care'.[322]

Along with such concern to reduce the barriers to access to care services, the European Care Strategy innovatively goes beyond the perspective of care recipients (and their

> *Attention to promoting the affordability of care services, in order to extend the range of households that can use care services: it is estimated that 13% of households do not make use of childcare because they cannot afford it, and one in three households with long-term care needs do not make use of it because of its cost.*

informal caregivers) to consider the tension between promoting access and social rights for those in need of care and ensuring decent and attractive working conditions for care workers. Significantly, the European Commission acknowledges that 'challenges relating to the affordability of care can exert downward pressure on wages' in the care sector.[323] To this aim, the strategy affirms the necessity to invest in the care sector not only to promote accessible and affordable care services but also to improve the working conditions and wages of care workers. This is especially motivated by the need to make the sector more attractive to tackle the serious staff shortage in the sector.

As such, the need to promote fair working conditions in the sector emerges an integral aspect of its strategy to promote quality care, ensure the sustainability of the social care system, and respect the dignity and fundamental rights of all those involved in the care relationship, both recipients and workers.

> *The strategy affirms the necessity to invest in the care sector not only to promote accessible and affordable care services but also to improve the working conditions and wages of care workers. This is especially motivated by the need to make the sector more attractive to tackle the serious staff shortage in the sector.*

Care workers usually face poor wages and difficult working conditions, with limited access to social protection, labour rights and adequate occupational health and safety. This is particularly the case in the LTC sector. The Proposal for a Council Recommendation on access to high-quality affordable LTC specifically acknowledges that LTC workers face poor working conditions, including precarious working arrangements, long and irregular working hours, physical or mental strains and low wages (Recital 18).

> *The Proposal for a Council Recommendation on access to high-quality affordable LTC specifically acknowledges that LTC workers face poor working conditions, including precarious working arrangements, long and irregular working hours, physical or mental strains and low wages.*

Significantly, the European Commission specifically mentions domestic workers as part of the LTC workforce. It is recognised that they are composed mostly of women with a migrant background and are subject to some of the worst working conditions in the long-term care workforce, 'including low wages, unfavourable working-time arrangements, undeclared work, and non-compliance with essential labour protection rules and irregular forms of employment' (Recital 19).

Against this background, the European Commission announced a series of measures to provide care workers with fair working conditions and adequate wages. Firstly, it announced the setting up of a new sectoral social dialogue for social services at EU level, and called on member states to foster effective social dialogue and to conclude collective agreements for the care sector. Secondly, it announced a review of the application of EU standards governing working conditions, including specifically for live-in domestic workers, to support better enforcement at national level. Likewise, member states are called to address gaps in the implementation and enforcement of EU labour law and working conditions acquis in the care sector, and to address workplace risks related to violence and harassment in the care sector.

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Specific attention is given to domestic workers. Member states are encouraged to ratify and implement the ILO Domestic Workers Convention No. 189. This landmark convention, adopted in 2011, recognised the specific decent work challenges faced by domestic workers and establishes that domestic workers have the same rights and freedom as other workers. Therefore, member states are also called to take steps to formalise and regulate the specific situation of domestic workers, including live-in domestic workers.

> *Despite the increasing relevance they have assumed as care providers, this is the first time that domestic workers are specifically included in an EU initiative aiming at promoting gender equality and better care services.*

In this regard, the proposed Recommendation on access to high-quality affordable LTC calls on member states to address 'the challenges of vulnerable groups of workers, such as domestic long-term care workers, live-in carers and migrant care workers, including by providing for effective regulation and professionalisation of such care work.' (Article 7). Moreover, it calls for pathways to regular employment status for undeclared workers to be set up (Article 8l). Moreover, member states are encouraged to explore legal migration pathways for LTC workers (Article 8(d)).

The European Care Strategy is also highly innovative, calling for consideration of care workers, including domestic workers, and their working conditions in the policy discussion on care and in the EU's broader gender equality strategy. Despite the increasing relevance they have assumed as care providers, this is the first time that domestic workers are specifically included in an EU initiative aiming at promoting gender equality and better care services.

With the Covid-19 pandemic showing the importance of care services, including those provided by domestic workers, the European Care Strategy takes a significant step forward, promoting a paradigm shift in the narrative on domestic work. In this regard, it is significant that the strategy stresses the importance of investing in care services, which could enable care receivers – and their informal carers – to afford care services without putting pressure on working conditions and salaries for care workers. The strategy assumes a broader and more comprehensive approach to care that involves both informal and formal carers. It takes into consideration the diverse needs and challenges of specific groups of women, including the most vulnerable ones, such as migrant domestic workers. In other words, the European Care Strategy innovatively affirms that the well-being of some may not be secured at the expense of the rights of a minority of the vulnerable, and often invisible, workforce.

Moreover, by explicitly recognising the role of domestic workers as a significant part of the LTC workforce, and by underlining the need to improve the working conditions of those at the bottom of the care workforce, such as migrant domestic workers who sit at the intersection of various axis of inequalities, the strategy seems to address the intersectional inequalities faced by migrant domestic workers.

Yet, in order to promote the rights of the most vulnerable care workers and tackle intersectional inequalities, there are some crucial issues which could have been included in the European Care Strategy.

> *The European Care Strategy does not acknowledge that care work migration has become a specifically intra-European phenomenon, which exacerbates the care shortage in Eastern European countries and contributes to regional inequalities along the East-West axis.*

First, whereas the European Commission acknowledges the role that migrant workers play in the provision of care services, the strategy does not fully recognise the interplay between restrictive migration policies and the poor working conditions in the domestic work sector. Indeed, does not mention that migrant domestic workers face a higher risk of exploitative working conditions due to fear of being reported to immigration

services, as well as to abusive and fraudulent practices of temporary work agencies. The European Commission suggests that (legal) labour migration could be a 'key driver' to remedy labour shortages, to attract care workers 'to the mutual benefits of all member states and countries of origin',[324] but offers no measure aims to improve migrant care worker labour rights. As noted by Ezzeddine, a more far-reaching initiative should have raised attention to structural inequalities based on nationality at the basis of care migration.[325] This would include, for example, the removal of the practice of reporting undocumented domestic workers to immigration services through labour inspection and promoting regularisation procedures, in order to enable migrants to file complaints to labour inspectorates and to access judicial remedies.[326]

> *"While the strategy calls on member states to ensure the effective enforcement of EU employment law in the LTC sector, it is not specifically stressed that the organisation of live-in domestic work in some member states may clash with EU employment law."*

Moreover, the European Care Strategy does not acknowledge that care work migration has become a specifically intra-European phenomenon, which exacerbates the care shortage in Eastern European countries and contributes to regional inequalities along the East-West axis.[327] In this regard, notwithstanding the specific issues faced by cross-border domestic workers working as posted workers, the European Care Strategy does not indicate specific measures at the EU level for intra-EU migrant (so-called mobile) domestic workers. On the contrary, to improve the working condition of intra-EU migrant domestic workers and avoid social dumping, it should promote the development of a common legal framework for regulating the cross-border provision of live-in care work, as already advocated by the European Economic and Social Committee (EESC) in 2016.[328]

Furthermore, while the strategy calls on member states to ensure the effective enforcement of EU employment law in the LTC sector, it is not specifically stressed that the organisation of live-in domestic work in some member states may clash with EU employment law. For example, it is not recognised that the '24-hour care work' model, in which the domestic worker is expected to be constantly available to work for a long period of time, is not compliant with the EU Working Time Directive, and therefore specific arrangements should be found to ensure that domestic workers enjoy adequate rest time and their right to privacy.

Ultimately, the main shortcoming of the European Care Strategy appears to be its lack of concrete, binding measures for member states, as it is so far accompanied by two proposals for Council Recommendations. It is therefore difficult to preview the concrete impact that these measures – if adopted - would have on member states.

5. POLICY RECOMMENDATIONS

At the EU level:

- To develop a European framework regulating the cross-border provision of live-in care.
- To ensure that EU domestic workers are treated equally with other workers, making sure that they are not excluded from relevant member states' employment-related regulations.

To EU member states:

- To ensure the full application of EU employment law to domestic workers, including in the areas of working time, occupational health and safety and minimum wage. This should be accompanied by measures enabling labour inspections within private households in order to supervise the effective enforcement of labour law legislation, while ensuring the privacy of the domestic employer.
- To regulate the live-in care arrangements in line with EU employment law, in particular with the EU Working Time Directive, amending the '24-hour care work' scheme to ensure limits to domestic workers' working time (including stand-by) and appropriate rest time.
- To favour migrant workers' ability to enforce their rights by promoting regularisation procedures, establishing effective firewalls between labour inspections and immigration services, and establishing formal redressal mechanisms specifically designed for domestic workers.

10. INDEPENDENT LIVING FOR DISABLED PEOPLE AND PERSONAL ASSISTANCE

10. INDEPENDENT LIVING FOR DISABLED PEOPLE AND PERSONAL ASSISTANCE

Florian Sanden

Policy Coordinator at the European Network on Independent Living (ENIL)

In promoting institutions as a legitimate service, the European Care Strategy cements the exclusion and discrimination of disabled people. We need an EU policy agenda that unambiguously supports deinstitutionalisation and an expansion of disability support services such as personal assistance.

The European Care Strategy includes three target groups: children; older people; and people with disabilities. To address the target groups specifically, the European Commission published two legislative proposals along with the strategy. The proposal for a Council Recommendation on the revision of the Barcelona targets on early childhood education and care (ECEC) aims to support member states in the provision and design of services for the target group, which includes children with disabilities. The proposal for a Council Recommendation of long-term care covers older people and people with disabilities.

“We need an EU policy agenda that unambiguously supports deinstitutionalisation and an expansion of disability support services such as personal assistance.”

10. INDEPENDENT LIVING FOR DISABLED PEOPLE AND PERSONAL ASSISTANCE

1. WHERE THE EUROPEAN CARE STRATEGY SUPPORTS DISABILITY

The ECEC Recommendation firmly emphasises the right of disabled children to participate in mainstream services on an equal basis with non-disabled children. It recommends that member states provide accessible infrastructure, make adaptations to the special needs of disabled children and parents and improve the professional skills of staff and specialists to adequately support children with disabilities. The proposed Recommendation on early childhood education and care is an example of good practice in policies to improve the inclusion of disabled people.

2. WHERE THE EUROPEAN CARE STRATEGY FAILS DISABILITY

Disabled people find barriers excluding them from equal participation in all areas of life. To achieve full inclusion of disabled people in society, to dissolve all barriers, disability needs to be mainstreamed across policy areas. What succeeded in the ECEC Recommendation fails drastically when it comes to long-term care. The first major failure is that disability is defined as a subtopic of long-term care. The second failure when it comes to disability is the strategy endorsing residential facilities as a choice equal to community-based services. The third is the embracing of 'innovative care settings, such as shared housing where people with long-term care needs share domestic support and care services'. All three issues sound relatively harmless at first. However, they signify choices in policy design with far-reaching impacts. This chapter addresses the three issues in greater detail.

3. THE MEDICAL MODEL OF DISABILITY

Disabled people have traditionally been seen as (incurably) sick people.[329] Under the still-dominant medical model of disability, the focus is on the individual and the impairment, which is seen as an issue to be fixed. Being disabled is viewed as a great personal tragedy and an insurmountable barrier to leading a normal life. Since incurably sick people fall under the competency of doctors, disabled people are commonly placed under the authority of medical professionals tasked to keep them in their care. Disabled people are still frequently confined to hospital-like residential facilities, nursing homes or psychiatric hospitals. Since sick people apparently don´t know what is good for them – but doctors did – disabled people were never asked what they wanted: their voice did not matter. Being 'taken care of' meant disabled people were robbed of all agency, objectified and stored away for safekeeping.

> *Being 'taken care of' meant disabled people were robbed of all agency, objectified and stored away for safekeeping.*

4. THE TRADITIONAL APPROACH TO INSTITUTIONALISING DISABLED PEOPLE

The justification for having to institutionalise disabled people to take care of them properly was never true. In reality, it was a cover-up for a far more abusive practice. The true intent behind institutions becomes clear in some examples from the Czech Republic and Sweden. The city of Prague has traditionally maintained a significant number of residential settings for disabled people. All were located in remote forest areas far away from the city, often in derelict castles.[330] Survivors of these institutional settings tell us that their only activity consisted of sitting around in empty rooms all day, with no disability support offered in any way. At night, they would be locked inside the building.[331] In the institutions of the service provider CSS Stod from the region of Pilsen, until 2006, disabled people lived behind bars and had to wear uniforms.[332] Karl Grunewald, assistant director and medical councillor at the Swedish National Board of Health and Welfare and influential figure driving the process of deinstitutionalisation, described in his volumes the intent that shaped institutional policies: 'It was generally thought that these individuals ought to be protected against the evil society. Later this changed to the opinion that the society should be protected against them.'[333]

Medical experts advised families to dispose of their disabled children in orphanages, forget about them and get new children. The psychiatrist Hakon Sjögren wrote:

'It goes without saying that the idiots need to be taken care of in special institutions. It is not uncommon that their mothers do not want to part from them, and in

misguided motherly love, wish to keep them at home which means considerable stress not only for the mother but for the rest of the family.'[334]

In the Eugeniahemmet orphanage in Stockholm, children with mobility impairments spent their childhood in a closed world, with locked gates and high fences.[335] These examples show how the motivation driving institutionalisation was to segregate disabled people from society, to lock them away so that they could not interact with 'normal' people or so that normal people did not have to see unusually shaped bodies or unusual behaviours.

The segregationist ideology driving institutional policies directed at disabled people, however, is still very much alive, as evidence from Bulgaria, Ukraine and Serbia demonstrates, where the practices described are still systematically applied.[336] Confining disabled people to institutions for the sole purpose of segregating them is still occurring in western and central Europe too. France send, thousands of disabled children to institutions in rural areas of Belgium, far away from their families. French authorities can take autistic children away against the will of the parents.[337] In France, the UK and Germany, autistic adults can be institutionalised against their will with only minimal justifications.[338] Autistic survivors of institutionalisation tell us their parents were pushed by psychiatrists towards placing them in orphanages, and that no meaningful support was provided when institutionalised, underlining the real purpose of orphanages. Survivors of institutions sometimes leave their country to evade the grasp of authorities. In such cases they live independently on their own.[339] Disability rights organisations in Greece or Romania tell us they receive regular calls from disabled people in institutions, wishing to leave but unable to do so.[340] Large-scale institutions still exist in almost every country in Europe, and new ones are being built in countries such as Austria and Poland with the support of EU funding.[341]

Disabled people living in institutions are not allowed to pursue intimate relationships, have children, or form a family. Being banned from forming close social relationships condemns them to a life of loneliness.

5. THE HARMFUL EFFECTS OF INSTITUTIONS

The most common harm that being confined to a traditional large-scale institution brings to children and adults is to be excluded from areas of life that non-disabled people take for granted. Disabled people living in institutions cannot pursue normal forms of employment or an education that provides qualifications. Pursuing the career of your dreams or learning about topics you might be passionate about thus becomes impossible. Disabled people living in institutions are not allowed to pursue intimate relationships, have children, or form a family. Being banned from forming close social relationships condemns them to a life of loneliness. The joys of engaging in leisure activities, going to a football game or a museum, taking walks in the forest or meeting people at the pub for a pint of beer are usually not permitted or supported.[342]

People affected often retain life-long feelings of shame, and this can be instigated by the medical professionals supposed to provide support.

A second harmful effect is trauma. Autistic people who were taken away from their families as children and confined to institutions are often unable to remember details about their time there. If memories come up, they are often accompanied by tears. Survivors of long-term psychiatric facilities also tell tales of controlling psychiatrists, the application of intimidation tactics, and constructing reasons to prevent a release into freedom. People affected often retain life-long feelings of shame, and this can be instigated by the medical professionals supposed to provide support.[343] Survivors of institutions can find it enormously challenging to live in a normal environment because they were never prepared for it.[344]

Thirdly, there is direct physical harm. Disabled people confined to institutions are frequently subjected to long-term restraints or the administration of medication without consent. In Finland, an autistic boy was found to have been taped to a chair for five years.[345] In the Czech Republic, an autistic woman was discovered

who had been tied to a bed for 12 years.[346] The author is aware of the case of an autistic person who had been kept in a state of sedation for years in the Netherlands.[347] There is the sad case of the French autistic boy Timothée. After he had to leave school at the age of 14, called 'descolarisation', he was brought to a psychiatric hospital by his father against the will of his mother. In the hospital the boy was over-medicated with neuroleptica. At the age of 16, he was brought into a psychiatric hospital again, where he remains until this date. According to his mother, he is being kept against her will, under the influence of unhealthy levels of sedation, and subjected to forceful handling and isolated confinement.[348]

During the COVID-19 pandemic, many public authorities and institutions decided that disabled people were not a priority when it comes to treatment and prevented residents of social care homes from being transferred to hospitals to receive life-saving treatment.

During the COVID-19 pandemic, many public authorities and institutions decided that disabled people were not a priority when it comes to treatment and prevented residents of social care homes from being transferred to hospitals to receive life-saving treatment.[349] People with disabilities accounted for up to 72% of deaths related to COVID-19 in some countries, 68% in Spain and 51% in the Netherlands.[350] Even outside the pandemic, residents of institutions face danger. From 2018 to 2022 the European Network on Independent Living recorded six instances in which disabled people lost their lives due to fires or flooding. The events occurred in Spain, Croatia, Bulgaria, the Czech Republic, Greece and Germany. In total, 44 disabled people lost their lives in these disasters.[351] Living in institutions increases the likelihood of losing one's life in natural disasters, or due to hazards or infectious diseases.[352] Residents of institutions are at a higher risk of rape, especially women.[353]

6. THE UNCRPD AND THE CALL TO DEINSTITUTIONALISATION

In 2006 the General Assembly of the United Nations adopted the UN Convention on the Rights of Persons with Disabilities (UNCRPD),[354] codified the right to equal participation in every conceivable area of life. Article 19 on independent living and inclusion in the community was included with the aim of ending the inherently abusive system of institutions. It confirmed that disabled people have the freedom to live independently in the community, outside institutional settings such as nursing homes, psychiatric hospitals or orphanages. The EU and its member states signed and ratified the Convention, thereby obliging themselves to implement it. In 2017 the official UN body tasked with implementing the UNCRPD, the Committee on the Rights of Persons with Disabilities (CRPD), published general comment No. 5 to provide additional clarification on Article 19 of the UNCPRD.[355] According to the CRPD, Article 19 implies that state parties have to release all disabled people from institutional settings within short time frames and provide for disability support services in the community. This interpretation clarified that the UNCRPD was calling on state parties to start a process of deinstitutionalisation, to permanently close institutions for disabled people.

7. THE TREND TO EVADE: SMALLER INSTITUTIONS

State parties do not make it easy to verify whether deinstitutionalisation is being implemented. To this date, no official data concerning the number of disabled people living in institutions are publicly available. To monitor state parties, one has to rely on studies, calculating estimates and conducting surveys among disabled people. A network of European researchers attempted large-scale estimates of the number of disabled people confined to institutions. To be able to compare, two major studies were conducted, one in 2007 and one in 2019. It was estimated that in 2007, 1.2 million disabled people lived in institutions across Europe.[356] In 2019 this number was found to stand at 1.4 million, slightly higher than before.[357] The ENIL (European Network on Independent Living) Independent Living Survey confirms that disabled people do not observe state parties conducting any efforts towards deinstitutionalisation. All survey respondents stated that their countries are not implementing Article 19 of the UNCRPD at an adequate level.[358]

Many state parties are not dismantling traditional large-scale institutions decisively. Among them are Belgium, France, Germany and Austria.[359] Some state parties

did indeed close these kinds of settings, for example, Sweden and Norway. [360] In these countries but also in Germany, Austria, Belgium or the Czech Republic, smaller types of institutions, often called 'homes' or 'innovative shared housing projects' are being built.[361] The problems remain the same in these settings, referred to as group homes, where considerably lower numbers of disabled people are clustered together. Disabled people remain segregated, unable to pursue a normal life like going to work, educating themselves, having a family or enjoying leisure activities. Swedish authorities are registering increasing numbers of complaints about abuse within group homes inside the country.[362] There is evidence of systematic abuse in sheltered-housing arrangements for autistic people in Germany.[363] At the same time, people who grew up in such places often express great fear at the prospect of living in the outside world, displaying emotional dependency and learned helplessness.[364]

> *Ableist views represent a value system that considers certain typical characteristics of body and mind as essential for living a life of value. Consequently, disability is considered a misfortune, leading to suffering, disadvantage and a low quality of life. This thinking devalues human life.*

8. WHAT IS CAUSING THIS?

The causes for the lack of progress on deinstitutionalisation are many. First and foremost is certainly the prevailing view that disabled people should be kept away from normal society, effectively segregated. In fact, disabled people encounter these and other ableist views almost everywhere. We find ableism deeply ingrained within societies, no matter the nationality.[365] The term 'ableism' was first defined in 1981 to describe discrimination and prejudices against disabled people.[366] Ableist views represent a value system that considers certain typical characteristics of body and mind as essential for living a life of value. Consequently, disability is considered a misfortune, leading to suffering, disadvantage and a low quality of life. This thinking devalues human life.[367]

A second cause for the lack of implementation of Article 19 of the UNCRPD is the dominance of service providers in policymaking. In France and Germany, institutions are to a large degree run by non-profit organisations, employing millions of people.[368] Despite the non-profit nature of these organisations, high wages are paid to top-level employees and many people depend on them for employment.[369] The service providers are political heavyweights who are too big to fail. Maintaining this business model and avoiding possible risks is usually more important to policymakers than improving the situation of disabled people.[370] In addition, these organisations manage to successfully claim superior expertise on what disabled people need and want, disregarding the principle that the choice of how to live is first and foremost an issue of democratic self-determination.

> *If a disabled person cannot support themselves due to poverty or because they are unable to function, going to live in an institution is often the only choice as no other support offers are provided.*

To block deinstitutionalisation, service providers managed to successfully claim that Article 19 of the UNCRPD provides the freedom for disabled people to choose to live in institutions. Most countries allow institutionalisation against a person's will. If a disabled person cannot support themselves due to poverty or because they are unable to function, going to live in an institution is often the only choice as no other support offers are provided.[371] Even the European Commission uses this argument to defend the endorsement of institutions in the European Care Strategy.[372] Further obfuscation came with the endless debates on how to define institutions, with many actors claiming that it is about the number of disabled people living together.[373] To put an end to these debates, the CRPD in September 2022 published new guidelines on deinstitutionalisation, stating that one cannot choose to institutionalise oneself and that an institution is defined by its approach, establishing a list of criteria allowing the identification of an institution. The new guidelines state that all institutions and group homes are to close. State parties are called upon to stop obeying service providers and to start working with disabled people and their representative organisations.

10. INDEPENDENT LIVING FOR DISABLED PEOPLE AND PERSONAL ASSISTANCE

9. NEW PROBLEMS: THE EUROPEAN CARE STRATEGY

Amid this battle over the future of disabled people, the European Commission introduced the European Care Strategy. By endorsing classic institutions and group homes as legitimate disability services, the strategy[374] is picking the side of those wishing to maintain the segregation and exclusion of disabled people. Furthermore, it violates its own obligations as a state party of the UNCRPD. The scheduled review by the CRPD on the EU´s progress in implementing the Convention started in 2022. The questions on the list of issues were very critical.[375] The next step in the review process will take place in 2023. The European Care Strategy will certainly not count in the EU´s favour.

10. THE TRANSFORMATION: TO INDEPENDENT LIVING THROUGH PERSONAL ASSISTANCE

To overcome the predominant, dependency-driven model of disability care, assistance has to function according to the concept of disability support as defined by the UN Special Rapporteur on the Rights of Persons with Disabilities.[376] Disability support aims to enable disabled individuals to live their life with the same self-determination and the same choices as non-disabled people. Disability support needs to be organised in such a way that access to all areas of life, for example, work, education, leisure or family, is possible. If a disabled person has these opportunities, this is called 'independent living'. Independent living is the opposite of living and doing everything alone. Independent living equals full integration into the community and receiving all the support needed.

> *Sweden, with its social democratic welfare state, expanded personal assistance like no other country in the world. Due to its personal assistance scheme, Sweden was able to close all large institutional settings within a short time frame.*

The most important disability support service to allow disabled people to live independently is personal assistance. It was established by Article 19(b) of the UNCRPD and further defined by general comment No. 5 and the Guidelines on Deinstitutionalisation. Personal assistance describes a one-on-one service based on the needs, wishes and authority of the disabled person. When personal assistance is provided, one or several personal assistants accompany the disabled person for as many hours during the day as needed and desired and perform almost any task the disabled person asks for.[377] This can involve support with activities such as getting dressed, cooking, reading, childcare, taking a walk or going to the pub. In some European countries, personal assistance has been available to disabled people since the 1980s. The first European personal assistance laws were introduced in Sweden in 1994 and in the United Kingdom in 1996.[378] Sweden, with its social democratic welfare state, expanded personal assistance like no other country in the world. Due to its personal assistance scheme, Sweden was able to close all large institutional settings within a short time frame.[379]

Disabled people who have access to personal assistance unequivocally report that it lets them pursue educational activities, such as vocational training or computer courses.[380] To illustrate this, there is almost no better example than the life of Adolf Ratzka, one of the founders of the European Independent Living Movement. In 1961, at the age of 17, Ratzka, then living in Germany, contracted polio, leading to a rapid paralysis of a large part of his body, including the breathing muscles in his lungs. Through a unique administrative solution, the German state agreed to finance personal assistance and education. Ratzka moved to Los Angeles in 1966 to pursue an education at the University of California.[381] Ratzka completed a bachelor's degree in sociology, a master's degree in business administration and a PhD in urban land economics.[382]

Personal assistance likewise lets disabled people purse a professional career.[383] Having moved to Sweden in 1973 for his doctoral research, personal assistance enabled Adolf Ratzka to found the Stockholm Cooperative for Independent Living (STIL). STIL became the first cooperative in Europe to help disabled people receive personal assistance. The work of the cooperative served as a model for the Swedish law on personal assistance that was introduced in 1994. In 1983, Ratzka founded the Independent Living Institute as an NGO to shape social policy in Sweden and Europe.[384]

The example of a colleague at ENIL who has the condition spinal muscular atrophy and can not move on his own accord serves to illustrate the effects of only partial access to personal assistance. In my colleague´s home country, Greece, there is at the moment no publicly

funded personal assistance scheme. Because access to personal assistance for EU citizens from other countries does not work well in Belgium, moving to Brussels to work at the ENIL secretariat is not possible. Working remotely is the only option. If an employer does not allow remote work, employment is not possible. Many other disabled people from Greece are unemployed due to the lack of personal assistance. Although the possibility of remote work allows my colleague to follow a career he is passionate about, he would prefer to interact with his colleagues face-to-face, rather than only online.[385] For business trips, he pays out of pocket for a personal assistant to accompany him. This arrangement allows him to travel to events such as the ENIL regional members' meeting in Budapest in July, or the Freedom Drive in September.[386]

> *"It can be very difficult for disabled people with support needs to pursue relationships and start a family. Personal assistance takes the duty of care away from family members so that a healthy relationship can flourish."*

It can be very difficult for disabled people with support needs to pursue relationships and start a family. Personal assistance takes the duty of care away from family members so that a healthy relationship can flourish.[387] Adolf Ratzka is married and has a daughter, who at the time of writing is 28 years old. According to Ratzka, without access to personal assistance his marriage would in all likelihood not have worked out.[388] He would probably not have a daughter. He would have had to lead a life of loneliness. When a life partner must perform the tasks of a disability support worker, this inevitably puts a strain on any relationship and might lead to its premature end.

Under the Swedish personal assistance act, 20 hours per week are granted for basic activities such as personal hygiene, getting dressed, communicating, structuring one's day, and cognitive and emotional support. Additional hours can be granted for other activities such as assistance at work, household chores, leisure and raising children.[389]

According to a key study from 2019, users of personal assistance regard the ability to choose the person acting as personal assistant as the most important factor. Being free from any interference in selecting the person to provide the personal assistance involves the ability to hire the personal assistant from the open labour market.[390] Thus, the disabled person becomes an employer who can also choose to end the working relationship at any time. If the responsibilities of the employer are delegated to a service provider, the disabled person must have complete control over which individual is acting as their personal assistant.

To be able to act as employers and retain control, disabled people must receive the funds to hire a personal assistant in the form of direct payments. This form of transferring funds directly to an assistance-user is called a personal budget. Personal budgets are only fully empowering when no contributions from the user´s personal income are needed and the budget covers costs related to the personal assistant.[391]

Today, 24 EU member states have personal assistance schemes. Luxembourg, Hungary and Greece are the only EU countries without personal assistance. An ENIL survey from 2020 as well as other feedback reveal that there is no single personal assistance scheme which is sufficiently developed to make institutions obsolete.[392] Personal assistance schemes are never sufficiently well-resourced to provide every disabled person in need with a personal assistant. Some countries are unable to respond to the increasing demand for personal assistance among disabled people. For example, the number of people using personal assistants in Slovenia rose by 44% between 2020 and 2021. In Belgium, there is a waiting list of up to 23 years to receive the personal budget needed to hire personal assistants. Most countries do not even allow disabled people in institutions to apply for personal assistance.[393] With better access to personal assistance, more disabled people would be able to leave institutions and would not suffer human rights abuses that happen in these places.

To truly advance disability rights, we need to end the biggest human rights abuse against disabled people there is: confinement to institutions. To do so, all institutions must be closed. More importantly, though, we need a massive expansion of disability support services, most importantly personal assistance. This is the direction the European Care Strategy should have taken. Instead of lasting change, we are seeing support for the current abusive status quo. We can do better. In 2023, the European Commission will adopt a Guidance to member states on Independent Living and Inclusion in the Community. Let us make sure this Guidance will follow the proud Swedish social democratic tradition and recommend that EU member states provide personal assistance to all disabled people who need it.

POLICY RECOMMENDATIONS

POLICY RECOMMENDATIONS

Based on the contributions made chapter by chapter, this policy study formulates a set of concrete policy recommendations addressed at progressive policy-makers wishing to make the stated ambitions of the European Care Strategy a tangible reality for everyone across the EU. These can be summarised as follows:

1. RECOGNISE CARE AS A RIGHT IN ITSELF

- **Care needs to be recognised as a right in itself** on the same footing as other values enshrined in the EU Charter of Fundamental Rights such as non-discrimination, equality, justice, human dignity and solidarity. This applies both to care giving and the right to receive care.
- Additionally, the principle of non-discrimination enshrined in article 19 of the TFEU can be mobilised to protect carers, especially when they face 'challenging social behaviour' (e.g. verbal and physical violence, bullying and sexual harassment), which are frequent issues faced by long-term care workers.
- As far as platform carer workers are concerned, the need to specify the relevant fundamental labour rights (e.g. workers' dignity, working and rest time, adequate wage, training, access to social protection, health and safety at work, professional disease and work accidents, etc.) beyond simply referring to the corpus of EU hard laws in the domain of labour (e.g. directive on minimum wage, on transparent working conditions, etc.) as the European Care Strategy currently does, is relevant in situations where workers fall through the cracks of protections nets offered by standard employment conditions.

2. 5R FRAMEWORK FOR A MORE RESILIENCE CARE ECONOMY

There cannot be a resilient care sector without a resilient workforce. Care work – whether paid or unpaid – needs to the be better valued. In doing so the **EU and its member states should follow the ILO's 5R framework for decent care work**[394] based on the principle that: **unpaid care work needs to be recognised, reduced and redistributed** whereas **paid care work has to be adequately rewarded and represented**.

2.1 RECOGNISE

- The European Commission should elaborate a '**European Informal Carers Programme'** defining support measures to recognise the skills of unpaid informal carers and to support their reintegration in the labour market (including care or pension credits).
- Member states need to establish **national registers of care service providers** and to **monitor their compliance with legal requirements and quality controls**, including the provision of whistle-blower channels.

2.2 REDUCE

- Member states cannot take for granted the continued **social contribution of unpaid care work** undertaken by household members (usually women) and **need to prioritise its reduction**.
- When implementing the strategy, much more direct attention must be paid to all forms of physical and social infrastructure provision that would **reduce the need for unpaid care performed within households and communities. Whilst the revised Barcelona targets will hopefully ease the burden of mostly mothers who are searching for good, affordable and accessible ECEC, the fact that comparable targets do not exist for the long-term care sector is a serious shortcoming of the European Care Strategy.**
- The gender pay and pension gaps are attributable to the work penalties that go along with motherhood and care responsibilities. Yet, the European Care Strategy does not provide guidance to the member states on how to address this. **Child-care credit systems can, for example, help to compensate for the losses incurred in mothers' pension entitlements resulting from care leaves.**

2.3 REDISTRIBUTE

- Ensuring affordable and good-quality public care services are the ideal form that would ensure greater equality as well as universal access. However, public provision, while critically important, is not the only way in which public policy influences the redistribution of care work in a society. **This includes challenging gender stereotypes, norms, customary law and institutions in which they are embedded but also changing economic incentives given that**

the opportunity costs for women to assume unpaid care roles tend to be lower than those for men.

- Taxes as well as benefits affect the distribution of the costs of caring for dependents between rich and poor, parents and non-parents, men and women, old and young. It should be added that they also affect distribution between the differently abled and others, as well as across different social categories depending upon how various responsibilities for care work are organised. **Tax systems need to be redesigned to avoid discriminatory effects as it impacts not only the distribution of income between women and men (distributional effect) but also the distribution of paid and unpaid work (allocative effect).**
- Whereas much public policy tends to be focused on the notion that care is provided within a standard nuclear family, an inclusive approach requires taking into account that family formation is both more complex and more diverse, requiring different and possibly more flexible approaches to the internal distribution of paid and unpaid work. Therefore, **member states need to reform their social services and social protection systems to reflect different employment and family models to respond to care needs**.

2.4 REWARD

- **Whether paid or unpaid, carers need training, support, respite, and unburdening of part of the care responsibilities**.
- **In addition to tighter regulation, the care profession needs to be fundamentally revalued, both in terms of pay and conditions.** Paid private carers need clear contracts, fair wages and professional training, analogously to care workers in formal settings. Paid private carers and individuals and families that hire them also need a third party that offers reciprocal guarantees against exploitation and cheating. *This also means reversing the market mentality which breaks care work down into a series of repetitive and standardised tasks, which increases exposure to psychosocial risks.*
- Whilst *the EU Framework Directive on Occupational Safety and Health can to a certain extent be mobilised to cover some of these risks,* ***there is a clear need to develop more specific EU legislation*** **(e.g. specific EU Directive on psychosocial risks).**

2.5 REPRESENT

- **Social dialogue, collective bargaining and collective agreements in the care sector needs to be promoted, whether in residential care settings, at home or in community-based care.**
- As a matter of urgency, workers should be involved in discussions about pay, skills and training needs, and carrying out risk assessments.
- At both national and European level, access to public funds for care providers should be made conditional upon having a collective agreement in place.
- Member states need to ratify the **ILO Convention 190 on violence and harassment in the world of work** as well as the **ILO convention 149 on nursing personnel**.

3. DEVELOP A HOLISTIC CARE POLICY FRAMEWORK BASED ON A CONCRETE ACTION PLAN

- Given the cross-country differences in starting points, political and family cultures, and financial resources, there is a risk that the European Care Strategy remains little more than symbolic. To avoid this, the strategy and the Recommendations that flesh it out should be accompanied by specific actions at the EU and national level. **EU action has a role to play in better anticipating expected demographic trends and coordinating the response through EU action in the form of policies, programmes and investment.**
- Crucial to reaching the potential social and economic positive impacts is a **holistic approach that tackles the entire vicious cycle of care inequalities. The European Care Strategy moves in this direction, but more ambitious action is needed to ensure that the potential gains can be reaped and to put the sector on the path towards sustainability.**

4. CHANNEL PUBLIC INVESTMENT SUPPORTING CARE

- The undervaluation of care work both within households and in the labour market implies the **need for public intervention to recognise its full value for society**. **Doing so could help to ensure that supply of care work is sufficient to meet the demand without creating distortions and reinforcing gender inequalities.**

- Recognising long-term care as a public good, as the European Care Strategy does, is one thing, but ensuring that social protection systems are developed and public services available is another. **To ensure universal access to high-quality, affordable care, EU member states must invest more in integrated public health and social care services. A dedicated investment package needs to be directed to the care sector to guarantee equal access for those in need of care at critical periods over the life course.**

- The instrument of a Recommendation (rather than a Directive) is appropriate, and in any case, the only one available for the time being in this area. It offers guidelines for shared goals that may be achieved progressively, depending on the starting points. However, **member states need to leverage available European funds to invest in a comprehensive care policy approach,** including instruments such as the European Regional Development Fund, the European Social Fund plus, and its Employment and Social Innovation strand, the Just Transition Fund, Horizon Europe, the Digital Europe Programme and the Recovery and Resilience Plans.

- The **European Commission needs to ensure that EU funds can facilitate the transition from institutionalised care to community and family-based care**. In addition to 'gently nudging' countries to develop their care strategies, explicitly including the goals and principles of the European Care Strategy in the guidelines for these funds and in their ex-post evaluation would help in public debates and in negotiations with their governments. **The Country Specific Recommendations in the framework of the European Semester must encourage higher public investment in public health and care services.**

- At the same time, in order to avoid fragmentary measures with little or no impact, coherent and integrated planning should be required when using the diverse resources provided to the different bodies at national level. This implies setting up a complex governance arrangement where, depending on the country, more than one ministry might be involved, as well as both national and regional and/or municipal level bodies. **The appointment of a national coordinator for the national care strategy, as suggested by the European Commission, would be useful**.

- **Higher public investment however should not be allocated to private care providers to take higher profits**. Whilst the European Care Strategy calls for tighter quality mechanisms, given the gravity of recent human rights abuses in for-profit facilities, this does not go far enough. Serious questions need to be raised about the ethics of private investors making millions from the basic needs of the very elderly, while care workers are so underpaid and many Europeans with long-term care needs fall below the poverty threshold. **Rigorous EU and national regulatory frameworks are needed that enforce transparency and accountability - and limit the level of profit-making from care services.** One example would be to **place profit caps on all care providers regardless of legal form to ensure that any profits are reinvested into the service**. **The Country Specific Recommendations can also be used as a tool to ensure that public funding for care services is put first and foremost towards public care and not-for-profit care.**

- An important missing link in the strategy is gender budgeting, which would have been a powerful way of addressing the gendered and discriminatory nature of the way care is organised. **Both gender mainstreaming and gender budgeting need to be considered as integral tools to ensure adequate care investments.**

5. FACILITATE CARE WORKERS' INTRA-EU MOBILITY AND ADDRESS THE SITUATION OF DOMESTIC LIVE-IN WORKERS

- y and conditions, many EU countries have instead relied on low-paid migrant workers to fill the gap. Whether documented or undocumented, migrant care workers are more likely to be subject to job insecurity and substandard working conditions, and less likely to be covered by collective bargaining agreements. **In light of the high extent of workers mobility in the care sector and the share of migrant workers being higher in the care sector than in the overall economy, the EU needs develop a European framework regulating the cross-border provision of live-in care.**

- **Member states need to ensure the full application of EU employment law to domestic workers, including in the areas of working time, occupational health and safety and minimum wage.** This should be accompanied by measures enabling labour inspections within private households in order to supervise the effective enforcement of labour law legislation, while ensuring the privacy of the domestic employer.

- **The EU needs to regulate the live-in care arrangements in line with EU employment law, in particular with the EU Working Time Directive,**

amending the '24-hour care work' scheme to ensure limits to domestic workers' working time (including stand-by) and appropriate rest time.

- One of the biggest barriers to protecting the rights of live-in carers is the fact that they work alone, in a private space, and often have little contact with other people. Live-in care workers face especially low unionisation rates and are particularly vulnerable to exploitation. **Trade unions can help to ensure legislation is strengthened and more rigorously applied to protect live-in care workers from exploitation.**

- The strategy is right to recognise that specific measures should be taken to increase the protection of live-in carers and to support the ratification and implementation of the **International Labour Organisation Convention No. 189 on the Rights of Domestic Workers across EU member states.**

- The occupational health and safety of live-in care workers, particularly those who are mobile and migrant workers and employed through complex chains of agencies posting workers, should also be better protected via **improved coordination between the European Agency for Safety and Health at Work (EU-OSHA) and the European Labour Authority**.

- **Member states need to favour migrant workers' ability to enforce their rights by promoting regularisation procedures, establishing effective firewalls between labour inspections and immigration services, and establishing formal redressal mechanisms specifically designed for domestic workers.**

- **Legislation at EU level must also be strengthened to ensure that EU domestic workers are treated equally with other workers, making sure that they are not excluded from relevant member states' employment-related regulations**. The EU Directive providing for minimum standards on sanctions and measures against employers of illegally staying third-country nationals, known as the 'Employers Sanctions Directive', recognises the labour rights of undocumented migrants in EU law and includes some important protections, such as the provision that undocumented migrant workers are entitled to the same salary that nationals would receive for doing the same work. The Directive's implementation revealed major gaps in the full and meaningful transposition and implementation of the Directive into national law and practice. **To improve the conditions of undocumented live-in care workers, member states must fully implement complaints mechanisms and procedures for workers who have been exploited, as required by the Directive.** Labour inspectorates should also be more rigorous in carrying out inspections and imposing sanctions, and member states should collect data on the number of inspections carried out, the number of complaints lodged by workers and the number and types of sanctions imposed on employers.

- Recognising the significant role played by undocumented migrant care workers and non-EU nationals, the European Care Strategy calls for pathways to regularise their employment status so that they can officially work in the care sector, while helping to address gaps in the labour market. This proposal is also made in the **Skills and Talent Package**, which includes a legislative pillar, to revise the **Long-term Residents Directive and Single Permit Directive**, an operational pillar, to develop EU talent partnerships and an EU talent pool, and a 'forward-looking pillar', to explore avenues for legal migration in three areas: care, youth and innovation. While protecting the rights of undocumented migrant care workers is of utmost importance, the Skills and Talent Package poses a number of risks. **The focus should not simply be a question of 'matching' skills, but rather about helping migrant workers to access decent and good quality jobs based on the principle of equal treatment.** Rather than prioritising the development of talent pools and talent partnerships, the European Commission and member states should promote fair recruitment standards, including bans on abusive practices and recruitment fees.

6. ENSURE UNIVERSAL ACCESS TO EARLY CHILDHOOD EDUCATION AND CARE

- It is important and welcome that the Council Recommendation on ECEC highlights the educational, not exclusively care, dimension, and, following the principles of the Child Guarantee, identifies, among its goals, the inclusion of children of disadvantaged households, of ethnic minorities as well as children with a disability. However, the discursive framework does not properly address the work-family imbalance. **To be truly inclusive, the argument in favour of an expansion of good quality and accessible ECEC services should be based on the universal right of children to resources of early non-family education and care, irrespective of the characteristics of their parents**.

- **Through the revised Barcelona targets, the EU needs to ensure upward convergence across the member states while raising the level of ambition of the targets.** It will be crucial that in implementing

the European Care Strategy, the EU and its members states make sure that the revised Barcelona Targets go beyond a numerical threshold setting exercise.

6.1 FINANCIAL

- **Increase childcare funding through direct provision as well as through support of employers and local governments.**
- **Given the persistence of class-of-origin education gaps, prioritise affordability for low-income households.**
- **Make sure that local governments – which disproportionately carry the burden of childcare – are well equipped to do so.**

6.2 QUALITY-RELATED

- **Provide adequate attention by lowering the children-to-staff ratio.**
- **Build the prestige of the teaching profession both financially and symbolically.** The explicit definition and institutionalisation of the educational character of these services is also needed in order to avoid trading the professional quality of workers with quantity, a risk that has been documented in some countries. Towards this end, **member states should be required to set clear rules concerning the professional profiles and qualifications required as well as the standard wage level.** These rules should be enforced across all institutional forms of ECEC services, be they public, third sector or market. They should also become the basis for a levelling of wages across public, third sector and private ECEC services and for the calculation of costs when the implementation of ECEC services is fully or partly allocated to the third sector or the market, with or without some public funding. **These aspects should be part of the EU monitoring process.** Only if wages are decent and acknowledge the professional profile of ECEC workers across all ECEC services irrespective of them being publicly or privately provided, there would be some guarantee concerning their quality, while unfair competition and social dumping as well personnel shortages may also be avoided.

6.3 LEGAL AND PRACTICAL

- **Align the end of parental leave with availability of childcare and increase the hourly allowance of free access to childcare to make it compatible with full-time employment.** The more services are offered on a universal basis and as an opportunity for all children, the more they are accepted as beneficial in the process of growing up. Intensity in attendance may differ depending on individual needs and circumstances. **Flexibility in time schedules is, therefore, advisable.** The monitoring exercise should pay particular attention to the degree to which the gap in attendance by social class, citizenship status, ethnicity, presence or not of a disability, parents' education and occupational status is reduced at the national and intra-national level.
- **Remove unnecessary hurdles and regulations that aren't conducive to child wellbeing to avoid situations where low childcare access reflects bureaucratic hurdles.**
- **Attendance to ECEC services, including those for children under three, should become a legal entitlement**, as suggested by the Recommendation from the European Commission. The educational dimension of these services should also become explicit at the institutional level. Entitlement should include a (substantial) minimum of daily or weekly hours. While leaving parents freedom of choice in whether and with what intensity to use these services, the presence of a legal entitlement would incentivise national and local governments to provide, directly or through cooperation with the third sector, an adequate number of places.

6.4 PSYCHOLOGICAL AND CULTURAL

- Understand the loss that parents may face and refrain from value judgments and respect people's choice enabling all families to opt for their own preference between earning, using informal childcare and using ECEC.
- Offer ECEC solutions in different forms to strive for a bipartisan consensus avoiding the division into career-oriented parents and stay-at-home parents.
- Consult widely and strive to make childcare universal without making it compulsory.
- **The offer of ECEC services, in addition to being coherently integrated with the duration of parental leave in each country, should be accompanied by activities that support parents, both mothers and fathers** (starting before birth, taking advantage of the courses that prepare for delivery) **in their relationships with children, in developing the attitudes and behaviour that the literature calls 'responsive parenthood'**. These activities should be staffed by an interdisciplinary team,

that works in close collaboration with ECEC services and paediatricians. Given the importance of the first 1,000 days in the child's development, supporting parents in their care and education responsibilities in this crucial period should be considered a crucial dimension of any childcare strategy. It may also be an important means to help parents to understand the importance of ECEC services for their children's development and well-being.

7. ADDRESS DEMOGRAPHIC CHALLENGES FOR SOCIAL COHESION

- The very fact that the European Commission feels that it should state that long-term care must grant the dignity of those who receive it is an indication of how often this does not happen. **There needs to be a clearer public discourse on the right to be adequately and holistically cared for - as well as the right of unpaid family carers to be supported and acknowledged; and of paid carers to be properly trained and paid a fair wage.**

- **While the Recommendation on LTC offers good elements for this discourse, it is too timid with regard to the long- and medium-term coverage goals of the different measures envisaged, the reduction of inequality in access to good quality care and non-family care.**

- Concerning a policy field that, at least in some countries, has a low legitimisation, **this absence of targets (and of an impact assessment) opens risks of no or marginal impact.** It also complicates the construction of indicators for monitoring. In this perspective, **it might be useful to ask countries preparing their national action plans in LTC to indicate their goals (and the relative timing) across all the relevant dimensions**: home care and community-based care, closing territorial gaps, rolling out accessible innovative technology and digital solutions, ensuring accessibility for persons with disabilities, supporting family carers, ensuring fair wages and training for care workers in formal services, supporting the contractualisation of privately (family) paid workers.

- **In providing services, more attention should be given to the different needs of dependent individuals (and their families), given the different causes and forms of their dependency**. As with disability, although long-term care involves mainly old individuals, long term dependency does not come only in one size and it is not only a matter of degree, even among the old. **In order to prevent or slow the road to long-term dependency, care must be tailored to the specific form of dependency.** In this perspective, more attention should be given to the specific needs of severely disabled children and adolescents and people with dementia or Alzheimer's, and the offer of services should be as precocious as possible.

- **In order to improve the availability of meaningful relationships for dependent people, including at the intergenerational level, opportunities for young civil servants might be considered favourably**: this would not be a substitution, but an integration of professional carers as a support for family carers. If adequately prepared and monitored, it would be a learning experience for the young involved - and it would enrich everyday life for the dependent persons, be they old, adolescents or adults.

- **Coordination between health and long-term care providers should be promoted to avoid any shifting between the sectors based on financial or organisational motives** (rather than the needs of the person involved). Coordination should also aim to develop a coherent approach that takes account of the dependent persons themselves and their family carers, giving them the responsibility to make sense of different interventions, approaches, logics.

8. FOSTER A HOME CARE AND RECONISE INFORMAL CARERS

- **Prevention**: Reducing dependency and the associated costs, as well as increasing the well-being of elderly people, requires an investment in preventive measures. The adage 'prevention is better than cure' is particularly true when it comes to ageing. Adapting homes for an ageing population is crucial in this respect, alongside preventive medicine, exercise and the dissemination of best practices, particularly when it comes to diet.

- **Development of LTC Services:** In view of the future growth in needs, even where an effective prevention policy exists, member states need to adapt their LTC policies: in the short term, to cover people in need of LTC who do not receive care services, and in the longer term, to cope with the increase in the number of people in need of LTC. This increase in budgetary resources must go hand in hand with actions to make these care activities attractive, to retain workers in the sector and to professionalise them. If not, LTC provision will be inadequate.

- **Development Policy for Indirect Care:** For informal carers, the possibility of reducing their domestic workload or indirect care responsibilities would be invaluable in improving their well-being and enabling

them to work more or return to the labour market. Similarly, support with those responsibilities for severely and moderately dependent elderly people would provide respite for informal carers, who could thus be relieved from having to carry out these activities for their parents.

- **Clarify the use of 'informal carers':** The term 'informal care' as it appears in the European Care Strategy needs to be used with caution. It can be misleading in that it can simultaneously cover very different situations (care provided by a family member, by volunteers and by non-professionals, with or without a contract). These must be carefully distinguished. In particular, family carers (mostly women) are far from 'informal': they are expected to provide care, because of their legal family role and relationship. Defining them as 'informal' is another way of hiding them and their work, which is often, de facto, experienced as, morally or socially, compulsory, differently from that of a volunteer or a privately paid person. Therefore, **it is necessary to clarify the different figures, relationships and statuses included under the generic and imprecise term 'informal'.**

- In the longer term, it is essential that we improve the professionalisation of informal carers. They must be recognised as professionals who offer more quality or are more productive than unpaid care workers. People are only willing to pay more than the opportunity cost between doing and getting done if the work performed is different from their own. Training in the care professions and the introduction of new technologies must be integral to any care strategy, together with the aim of reducing undeclared work.

- In the medium term, preventive actions must reduce the proportion of dependent elderly people. Those actions must focus on lifestyles (such as diet and exercise), preventive medicine and home adaptations for the elderly. A major prevention effort aimed at people on low incomes could have a decisive impact on the level of dependency, given that the number of dependants in the least affluent section of the population is twice as high as in the most affluent section.

- **A three-pronged action plan focusing on prevention, the development of LTC services and an indirect care support policy should be a central tenet of a European Care Strategy which all member states would have to implement**. It is worth recalling that in the adopted EU Council Recommendation on access to affordable high-quality long-term care, **member states are recommended to submit to the Commission a national action plan within 18 months of the adoption of the Recommendation.**

- The development of publicly funded LTC services is essential, given that more than 63% of people aged 65 and over living at home and in need of LTC do not have access to publicly funded services, and the inevitable prospect of ageing, which will lead to a 33% increase in the number of older people with a high level of dependency.

- **The development of indirect care is essential to help elderly people, whether dependent or otherwise, as well as informal or family carers**. It is particularly a question of helping women cope with the difficulties of reconciling personal and professional life, so that they are free to choose between paid and unpaid work. The cost of this development is much lower than it appears at first glance if the various feedback effects are taken into account. Any such development must factor in the level of solvency of demand, the simplification of the system put in place and the professionalisation of indirect care jobs. The recommendation on access to affordable high-quality long-term care indicates that member states should support (informal) family carers in their caregiving activities by providing them with adequate financial support, while ensuring that such support measures do not discourage their participation in the labour market. The proposed development of indirect care satisfies this requirement.

9. ADDRESS THE DIGITALISAITON OF CARE WORK

- **The European Care Strategy acknowledges the digital transition. Nevertheless, it needs to go further by specifying digital care rights for care receivers** (e.g. in the framework of a new digital care public service) **and digital labour rights for caregivers** (e.g. through the building of an emerging EU digital labour law).

- Whereas the European Care Strategy refers to the 'digital transition' mentioning innovative digital solutions, it does not go beyond this factual assessment to measure its impact. It should be tackled as such in order to ask the question of whether digital care services should be seen as an opportunity, and/or as a threat calling for regulation.

- The strategy's section about ECEC completely overlooks considerations related to the digital transition. It is crucial to recognise that digitalisation has a lot to offer in terms of education, as emphasised in the Digital Education Action Plan (2021-2027).

Beyond offering new tools for the improvement of the educational system as such, it can also help better overcome mobility challenges (e.g. for children with long-term diseases or physical disabilities).

- Similarly, the **European Commission should tackle the questions of the accessibility of digital public services and the creation of a European Health Data Space**. The strategy too timidly affirms new fundamental digital rights and the need to develop safety nets for citizens in Europe. This reasoning could be pushed further to reflect the reality of digital care services. Creating a digital public service that is inclusive and accessible is a major challenge for the future. Digitalisation and platformisation should not hide or hinder the need for quality care services – whether provided by public or private actors – whether serving the private or public interest (like the majority of schools).

- By framing platform work as a challenge rather than an opportunity, the European Commission analyses the digital transition as 'a structural challenge' which has caused workforce shortages in an already undervalued and underpaid care sector. **It would have been interesting to add that the digital transition can also be understood as an opportunity to modernise the job of professional carers**.

- Digital labour rights are ignored in the strategy. We are thus confronted with a missed opportunity to include the specific rights that have come to existence: caregiver data protection, protection of their private life, protection of their online conversations, protection in case of disconnection or end of contract, right to access data, right to appeal, protection in case of harassment online or via the internet, etc.

10. INDEPENDENT LIVING FOR DISABLED PEOPLE AND PERSONAL ASSISTANCE

- We need an EU policy agenda that unambiguously supports deinstitutionalisation and an expansion of disability support services such as personal assistance. To achieve this, we need to overcome the medical model of disability by defining it as more than a mere subtopic of long-term care. Likewise, it is crucial to recognise the proven harmful effects of the traditional approach to institutionalising disabled people.

- The proposed Recommendation on early childhood education and care is an example of good practice in policies to improve the inclusion of disabled people. **What succeeded in the ECEC Recommendation fails drastically when it comes to long-term care**.

- **The EU needs to align with the principles of the UNCRPD calling for deinstitutionalisation.** In 2006 the General Assembly of the United Nations adopted the UN Convention on the Rights of Persons with Disabilities (UNCRPD), codified the right to equal participation in every conceivable area of life. Article 19 on independent living and inclusion in the community was included with the aim of ending the inherently abusive system of institutions. It confirmed that disabled people have the freedom to live independently in the community, outside institutional settings such as nursing homes, psychiatric hospitals or orphanages.

- To overcome the predominant, dependency-driven model of disability care, assistance has to function according to the concept of disability support as defined by the UN Special Rapporteur on the Rights of Persons with Disabilities. Disability support aims to enable disabled individuals to live their life with the same self-determination and the same choices as non-disabled people. Disability support needs to be organised in such a way that access to all areas of life, for example, work, education, leisure or family, is possible. If a disabled person has these opportunities, this is called 'independent living'. The most important disability support service to allow disabled people to live independently is personal assistance.

- As the European Commission prepares to adopt a Guidance to member states on Independent Living and Inclusion in the Community, this needs to be seized as a new opportunity to craft a good guidance following the proud Swedish social democratic tradition and recommend that EU member states provide personal assistance to all disabled people who need it.

11. FURTHER ROOM FOR IMPROVEMENT

- **Unpaid care**: The European Care Strategy clearly outlined the gender trap of unpaid care work and its contribution to the continued inequalities that women suffer. While the solution given seems so common sensical – revalue care – the tools proposed in the form of a campaign addressing inter alia unpaid work, are a far cry from providing relief. Addressing unpaid work should be a central element of such a care strategy. This is a lost opportunity.

- **Data collection on care**: The EU needs to fine-tune a comprehensive, gender-disaggregated and

intersectionality-proof set of care indicator for better statistics to measure the economic contribution of care in European economies.

- **Monitoring:** Policy coherence and linkages are key to promoting positive outcomes, which in the case of the European Care Strategy can be considered a success as the strategy is bringing together various instruments related to care. But it can present challenges for the implementation of policies if the instruments relied on are diverse and require multiple and oftentimes overlapping guidance and monitoring. Monitoring and guidance is indeed foreseen for the various initiatives under the strategy including through technical support instruments, EU funds and the European Semester. How and with what criteria and indicators such monitoring will be done, remains for the moment unknown. Likewise, its implementation will need to rely on the continued efforts that EIGE is undertaking to make the realities of women visible and understandable.

- **Gender mainstreaming:** The most important policy issues missing from the strategy may not be available, but they should have been at least mentioned in some contextual detail: the lack of a coherent and inclusive gender mainstreaming approach. When it comes to concrete policy proposals, the neutered approach to care once again made women invisible, both as carers and receivers of care.

- **Right to training**: The strategy dedicates an entire section to training. Yet, it does not sufficiently differentiate between the training of care receivers and caregivers (professionals and non-professionals) who need to develop their digital competences. On the one hand, care receivers and non-professional caregivers need help to master technology. It is particularly true for old age persons who can be deprived of internet access. On the other hand, when the strategy proposes that 'all kinds of care staff are able to participate both in high-quality initial education and training as well as continuing professional development programmes over the course of their careers', it addresses paid professional carers. It insists more specifically on digital competences. Here again, incentive measures are preferred as well as financing of masters**. As welcome as these policy actions are, they could be completed by the recognition of a justiciable right to training drawing on Article 14-1 of the Charter of Fundamental Rights and the Digital Education Action Plan.**

- The above policy priorities for the care economy also have to apply to the **external dimension of EU policies,** including in pre-accession and official development assistance.

END NOTES

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ABOUT FEPS AND FES

THE FOUNDATION FOR EUROPEAN PROGRESSIVE STUDIES (FEPS)

The Foundation for European Progressive Studies (FEPS) is the think tank of the progressive political family at EU level. Our mission is to develop innovative research, policy advice, training and debates to inspire and inform progressive politics and policies across Europe. We operate as hub for thinking to facilitate the emergence of progressive answers to the challenges that Europe faces today. FEPS works in close partnership with its members and partners, forging connections and boosting coherence among stakeholders from the world of politics, academia and civil society at local, regional, national, European and global levels. In addition to this network of organisations that are active in the promotion of progressive values, FEPS also has an extensive network of partners, including renowned universities, scholars, policymakers and activists.

FRIEDRICH EBERT STIFTUNG

The Friedrich-Ebert-Stiftung (FES) is a non-profit German foundation funded by the Government of the Federal Republic of Germany, and headquartered in Bonn and Berlin. It was founded in 1925 and is named after Germany's first democratically elected President, Friedrich Ebert. FES is committed to the advancement of both socio-political and economic development in the spirit of social democracy, through civic education, research, and international cooperation. Friedrich-Ebert-Stiftung is the oldest political foundation in Germany

ABOUT THE PROJECT

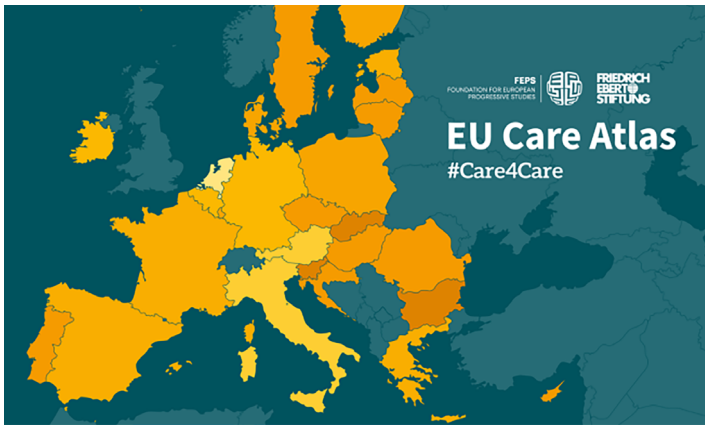
It took us a global pandemic to realise that we depend on care. But despite all the clapping from the balconies, caregivers continue to live and work in precarious and vulnerable conditions. It is high time for a care revolution! We need to move away from a profit-driven model of growth to a care-driven model. In this spirit, the Foundation for European Progressive Studies and the Friedrich-Ebert-Stiftung launched a Social Democratic Initiative for the EU Gender Equality Strategy, placing the role of care work and care jobs at the centre of our common activities. By raising the question 'Does Europe Care for Care?', we focus on care as a cross-cutting issue and promote the cross-fertilization of progressive thinking between stakeholders across Europe. In a series of publications such as the Care4Care Policy Brief Series and conferences all over Europe, we give centre stage to a long overseen phenomenon that deserves the fullest political relevance and attention. The project identifies common challenges and possible good practices across countries, whilst drawing concrete recommendations with the objective of feeding into national and EU level policy responses.

Project page: https://feps-europe.eu/theme/care-inequalities/

PUBLICATIONS OF THE SAME PROJECT

EU CARE ATLAS

The Foundation for European Progressive Studies (FEPS) and the Friedrich-Ebert-Stiftung (FES) launched the EU Care Atlas, a new interactive data map to help **uncover what the statistics are often hiding**: how care deficits directly feed into the gender earnings gap and contribute to gender inequalities. Besides the pay gap, the Atlas also looks at the **employment and hours gaps** and provides a picture of **unpaid work** across Europe. Behind all these indicators lie the disproportionate burden of care work carried by women – paid and unpaid. It illustrates the urgent need to look beyond the mere gender pay, by showing the full picture of gender economic inequalities and their **interplay with care imbalances**.



Today Europe might be standing at the crossroads of a new care paradigm shift as the European Commission has presented its 'European Care Strategy' in September 2022. A particular focus is laid on childcare and long-term care through two Council Recommendations on the revision of the Barcelona targets. By taking leadership in this under-explored policy area, the EU may take a more proactive approach to rebalance persisting inequalities attributable to the neglect of care. The true question lies, however, in how this recognition translates into wide-reaching answers addressing the challenges faced by women whose individual situations are as diverse as Europe itself. The EU plays a crucial responsibility in initiating transformative policies towards a change of social and gender norms and incentivising public investment in care.

By gathering a diverse set of voices from academia, civil society and policymaking, this policy study thus makes the case for strengthening care policies across the EU and provides policy recommendations. It seeks to feed and guide the discussion by critically assessing whether the European Care Strategy can be seized as an opportunity to trigger a new approach to care that is truly inclusive and fair for all. In other words, this publication explores whether the EU is sufficiently equipping itself to live up to the claims that European values "can only flourish in a caring society". On the one hand, it offers an analysis of the positive developments welcomed by the key stakeholders. On the other hand, it also serves to better understand the remaining blind spots of the Strategy.

Care being such a complex and multifaceted policy field, each chapter thus dives into a different dimension relevant to understand how the Strategy can give itself the means to ensure that care-givers and -receivers do not fall short of the EU's fundamental values and the fulfilment of social rights.

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