Long-term care as a policy issue for the European Union and United Nations organisations

Mary Daly, mary.daly@spi.ox.ac.uk
University of Oxford, UK

This article critically assesses the recent European Care Strategy, the European Union's most significant policy statement yet on long-term care. Using a framework that differentiates between economistic, social protection and configurational approaches, the European Care Strategy is adjudged to rely on an economistic approach. This sees it suggest some important measures for better services and working conditions for care workers but not enough on social protection rights and too little to disrupt the reliance on unpaid carers. Comparing the European Union approach with that of several United Nations entities – the International Labour Organization, World Health Organization and UN Women – indicates that other approaches are possible, though all need improvement.

Key words long-term care policy • transnational organisations • European Care Strategy • care configurations • gender inequalities

To cite this article: Daly, M. (2023) Long-term care as a policy issue for the European Union and United Nations organisations, International Journal of Care and Caring, XX(XX): 1–16, DOI: 10.1332/239788221X16887213701095

Introduction

On 7 September 2022, the European Union (EU) issued the European Care Strategy (ECS), intended to respond to calls for a strategic and comprehensive EU response to care. As the first legislative initiative, it is without doubt the EU’s most significant direct engagement ever with long-term care (LTC). For these reasons alone, the ECS merits review and analysis, but it is also significant as part of an intensified engagement by transnational organisations with how care is conceived for policy purposes and the relevant set of needs that should predominate for policy. In the process, LTC is being reconstructed as a challenge for ‘building back better’, cast as vital to economic and societal resilience, and as at the front line in the struggles of ageing societies. This type of framing is amplified by policymaking in the wake of the COVID-19 pandemic, which revealed signature weaknesses in the care infrastructure. The considerable power of the EU and other transnational entities as policy shapers strengthens the case for analytic attention. While frequently a so-called ‘soft power’, they exert considerable influence through framing issues as policy problems, undertaking analyses of cross-national trends and disseminating ‘policy fixes’. In effect, these actors are involved
in establishing ‘social institutions consisting of agreed upon principles, norms, rules, procedures and programs that govern the interactions of actors in specific issue areas’ (Zwingel, 2012: 116). They also play a significant role in global social governance (Martens et al., 2021).

This article focuses on the latest policy statements and interventions, with the ECS as its centrepiece. For comparative purposes and in order to survey the broader field, the decent work agenda of the International Labour Organization (ILO), the World Health Organization’s (WHO’s) approach to care and the approach of UN Women and the Sustainable Development Goals (SDGs) are also considered. Looking at the different organisations together will also help to identify the international conversations around care. However, to be clear, the EU’s approach is front and centre, analysed both in its own right and through a complementary, shorter analysis of the position taken by the United Nations (UN) organisations that have issued significant policy statements on the matter. The EU is the focus for another reason as well: it is the most powerful of those considered, more a supranational form of government than a transnational organisation given its constitutional make-up, wherein the member states have delegated sovereignty to the common institutions. The UN does not have the power or authority that the EU has over its constituent entities, and it aims more for common standards than policy integration.

Where does the existing literature point us to for an analytic framework? According to Daly (2021), the academic scholarship can be thought of as having four main strands: care as labour, a feature of close relationships and a particular value orientation; care as a component of welfare state policy; care in the context of the organisation and effectiveness of service provision; and care as embedded in global processes. Each makes its contribution to a vibrant field of research that underlines complexity, whether one views care in terms of meeting need arising from frailty or as a much broader feature of human life and relationships. For the purposes of a review of policy, though, the analytic scope has to be narrowed, being mindful of both the existing policy landscape and the types of the policy challenges that policymakers recognise and respond to. Looking across the systems in place in the EU, Pavolini (2021) identifies a trilemma for countries in terms of coverage, funding and how much to rely on informal care.

Thinking in terms of perspectives on how states might address these and other LTC-related problems, three possible policy approaches might be differentiated. They differ in terms of breadth and depth. An economistic perspective would view the issues in terms of costs, spending and service capacity, focusing on funding, the service infrastructure, how well supply meets demand and the respective roles of different types of provision (Costa-Font and Courbage, 2012). Its purview may also extend to governance issues. A social policy/protection perspective goes beyond cost and health service infrastructure, harnessing the role of the welfare state in providing support through cash as well as care-centred services (Ranci and Pavolini, 2013). This perspective would see care as involving different types of support needs (for instance, those of the person needing care and those of the caregiver) and engage a social policy model that recognises informal as well as formal care as part of the picture and envisages a care-related social service pillar as associated with the welfare state. A point of policy tension here is what caregiving or care need entitles people to in terms of social protection and public support more generally. In a third perspective, care can be viewed as embedded in a wider system of relationships, resources and practices. This perspective emphasises complexity in care-related
arrangements, thinking in terms of a configuration of provision rather than a single axis or set of institutions, and linking care with outcomes like inequalities. The ‘care diamond’, which identifies four main institutional sites as mediating care – family, state, market and the not-for profit sector (Razavi, 2007) – conveys a configurational approach. From this perspective, policy has to address challenges associated with the distribution of responsibility for, and the provision of, care across individuals, fields, institutions and levels, and address gender and other inequalities associated with care through, for example, citizenship rights perspectives (Knijn and Kremer, 1997; Williams, 2018; Kröger, 2022). It should be noted that the perspectives may coexist and are not, in any case, mutually exclusive.

Within this general analytic framework, the overarching research question asks which perspective(s) are evident. To guide the analysis, we utilise the ‘What’s the problem represented to be?’ approach of Carol Bacchi. This approach provides tools to reveal a policy’s conceptualisation of the subject matter, interrogating underlying premises, assumptions and relative silences in terms of what is not problematised in both the representation of the problem and the set of ‘solutions’ offered (Bacchi, 2009; Bletsas and Beasley, 2012). Bacchi sets out six questions: ‘What’s the “problem” represented to be?’; ‘What presuppositions or assumptions underpin this representation of the “problem”’, and where are the silences in the representation?’; ‘Can the “problem” be thought about differently?’; ‘How has this representation come about?’; ‘What effects are produced by this representation of the “problem”?’; and ‘How/where has this representation of the “problem” been produced, disseminated and defended?’ As our purpose is to critically assess the approach taken to LTC (rather than engage in a discursive type of analysis), we mainly use the first three questions but bring in some information pertinent to the other questions throughout in a more transversal manner.

Analysis of the different texts was undertaken manually, using Bacchi’s questions as guides. The article proceeds to consider, in turn, the ECS, the ILO’s decent work agenda, the WHO’s approach and the approach of UN Women.

Policy positions

**ECS**

The ECS is the signature piece of the EU’s policy on care and, arguably, the most significant and evolved EU policy programme ever in the field of ‘care’. It encompasses both early childhood education and care (ECEC) and LTC. Here, we concentrate on the latter, but not before noting the significance of the use of the term ‘care’ as an overarching concept, suggesting, perhaps, some recognition by the EU of care as a broader social phenomenon. To our knowledge, the EU has not spoken in such terms before.

On the LTC side, the ECS consists of five relevant documents, including a communication from the Commission (European Commission, 2022a), a draft of the proposed council recommendation (European Commission, 2022b) and a staff working document (European Commission, 2022c). The analysis to follow is based mainly on the recommendation proposal, as that sets out the official set of actions proposed. However, since the background documents (especially European Commission, 2022a; 2022c) present the analyses that inform the set of measures adopted, they too are considered as part of the analytic canvas. Strikingly, while the
background documents scope the field in a broad-ranging and ambitious manner, the proposed actions encircle a much narrower terrain.

In terms of policy inspiration or impetus, the ECS follows up on the European Pillar of Social Rights, which set out 20 principles for ‘well-functioning and fair labour markets and welfare systems’ and is, arguably, the master document for social policy reform in the EU at the present time (European Commission, 2017). The proposals for LTC are rooted in Principle 18: ‘Everyone has the right to affordable long-term care services of good quality, in particular home care and community-based services’ (European Commission, 2017). This helps to define the mission of the ECS, which centres on ‘integrated and person-centred long-term care that is accessible, affordable and of high quality’ (European Commission, 2022a; see also European Commission, 2022b; 2022c). An important aspect of the context is the significant variation in member states’ models of LTC. Pavolini (2021), for example, identifies as many as six main LTC social protection models in the 27 member states (assessed in terms of their respective focus or performance as regards containing public expenditure, covering LTC needs and the degree of reliance on informal family carers). The ECS attempts to manage such diversity by identifying four common challenges for member states: providing affordable and adequate access to LTC services for all in need; providing LTC services of good quality; ensuring an adequate LTC workforce with good working conditions and supporting informal carers; and financing LTC in times of rising demand for care. One can already see evidence of an economistic perspective.

To achieve its aims, the main action is a proposed Council recommendation on LTC (European Commission, 2022b). Although couched in the language of social protection, the energy is in care-related service provision, the working conditions of paid carers, and governance, monitoring and reporting. Member states are expected to do the ‘heavy lifting’ in taking three types of action to reform and improve their service systems, with the Commission offering some technical or enabling support. In regard to care services, the first recommended action for member states is to improve adequacy and availability so as to have in place a service system that offers services that are timely, comprehensive and affordable. In addition, the offer or volume of services should be increased while providing a balanced mix of LTC options, with home care and community-based care specifically mentioned. Furthermore, member states should establish principles and criteria to ensure quality in all LTC settings, and put in place appropriate quality assurance mechanisms (drawing from specified quality principles that are identified in an annex to the recommendation). A second major line of action is for member states to ensure fair working conditions in the LTC sector. This receives a good deal of attention, with emphasis on the promotion of social dialogue and collective bargaining in the LTC sector so as to put in place the highest standards of health and safety for services, address the (largely unspecified) challenges of ‘vulnerable’ groups of workers (such as live-in domestic workers and migrant care workers), address skills needs and worker shortages in LTC, and establish clear procedures for identifying informal carers and supporting them through such measures as, for example, enabling access to training, counselling and support services, providing them with adequate financial support, and ‘facilitating their cooperation with long-term care workers’. The third course of action addressed to member states in the recommendation relates to governance, monitoring and reporting. Here, member states are asked to, among other things: appoint a national LTC coordinator; produce and submit a national plan of action to the Commission for the assessment of progress.
on an annual basis (with the LTC coordinator as the lead); involve stakeholders at national, regional and local levels in policy development and evaluation; and develop a national framework for data collection and evaluation, as well as a mechanism for forecasting LTC needs.

To pose Bacchi’s first question regarding the problem representation, what the ECS problematises above all is Europe’s lack of an adequate, functioning LTC service system, with adequacy, access, availability and quality all spotlighted. This is in key respects treated as a technical problem: a gap between demand and supply in service provision. An emphasis on infrastructural weaknesses follows, including systemic fragmentation and matters of governance and monitoring, all of which are recommended to be addressed to promote, among other things, the better targeting of resources and improved functionality. Therefore, the solution stays mainly within an economistic frame, emphasising an increase in services but with an eye to cost, availability, mixed form or type, quality, maximising the use of technology, better governance and better conditions for some carers. A functioning and adequate LTC system is seen to require a clear understanding of purpose and role. Hence, for its part, the Commission undertakes to strengthen capacity by providing funding for research and some developmental activities to systematise understanding of, and evidence on, the field of LTC. In a knowledge-generation vein, the recommendation and other documents devote considerable attention to definitions. Paragraph 3 of the recommendation, for example, having defined LTC (mainly in terms of need in regard to activities of daily living), also clarifies the meaning of formal LTC, home care, community-based care, residential care, informal care, independent living, domestic LTC worker and live-in carer.

What about social protection and the role of social policy? Although social protection is strongly present rhetorically and Article 153(1) of the Treaty on the Functioning of the European Union on the modernisation of social protection systems is one of the ECS’s underpinning legal bases, only limited recourse is made to the social protection system in supporting or redistributing care. Reference is made to the possibility that carers in non-standard forms of employment may have better social protection through the European Council Recommendation on Access to Social Protection for Workers and the Self-Employed of 2019. A second relevant reference is to the proposed revision of Regulation 883/2004 on social security coordination. This would clarify what LTC benefits are and where mobile citizens can claim them, bringing more legal certainty. However, it has proven difficult to reach agreement on the proposed revision, and in any case, the potential reach of the measure for LTC carers is limited to workers. The silences are significant here also. Notably, there is no discussion of social insurance for care or a dedicated social protection branch for LTC, or indeed the adequacy of pensions. The affordability challenge of LTC from a rights perspective (as it is framed in Principle 18) is not developed directly. All of this makes the ECS ‘patchy’ on social rights and weak on considering LTC as a social risk that needs protecting against, or giving people the rights and resources to choose the type of LTC they desire – it seems to be the market that is attributed the latter role. Comparison with what the ECS proposes for ECEC is insightful. In particular, the ECS recommends the establishment of a legal entitlement for children to ECEC – equivalent to a rights-based approach.

There are other notable elements to it, though. The ECS potentially goes beyond an economistic approach by including both caregivers and those who need or receive
care in its considerations. Placing value on better integration between the health and LTC systems might be interpreted as other evidence of a broader approach. The ECS has another claim to a configurational approach in specifically including ECEC and LTC together. However, there is a limit to deeper thinking, clear in two ways at least.

First, counter to a holistic or configurational perspective, the public–private split in care is assumed to continue (whether conceived in terms of market/state or formal/informal provision). To be precise, the ECS does not question the sustainability of the reliance on informal care, even as it estimates informal care to comprise up to 80 per cent of LTC in the EU (European Commission, 2022b: 3). If it has one, the ECS’s solution (largely implicit) pivots towards reducing demand on informal care by increasing services and offering some support to unpaid carers. If we think of care provision/providers as involving a trinity – paid care workers, those needing care and informal carers – the Council recommendation homes in on the situation of the first two only and has most to say about the first. For paid caregivers, the ECS addresses some real problems, including workplace conditions (with social dialogue suggested as a means of improving this) and skill levels (to be improved through the European Skills Agenda), along with better services and improved governance. In this, two groups of relatively marginal workers are brought to the fore – live-in carers and domestic care workers – and these are the only two types of caregiver who are defined in the recommendation (European Commission, 2022b). However, when it considers people needing care, it mainly treats them as undifferentiated needs holders rather than, say, as persons with agency and rights. It is striking in this context to note the relative lack of attention to disability in the ECS overall.

Second, while there is some concern – rhetorically anyway – in regard to gender factors (to be seen in the ECS’s references to women caring, women’s access to services, women not in the labour market because of care responsibilities and women as affected by the conditions in care work), the extent of follow-through on gender equality is limited. In particular, there is no significant attack on prevailing gender norms, the feminisation of the sector or the widespread gender-asymmetrical distribution of care. In essence, the underlying model of the distribution of care is largely status quo. Among other things, this spells a continuing reliance on the ‘third arm’ of care provision: Europe’s 52 million unpaid caregivers. The particularity of their situation is under-recognised. While informal carers are namechecked as requiring support and counselling, the main hope for them is placed by the ECS on the 2019 Work–Life Balance Directive. The Directive’s main orientation is towards parental labour market participation and childcare, and other provisions, such as work-related leaves, to enable that. There is some potential in it for unpaid LTC carers (who tend to be a different group to parental carers), in that the Directive also provides opportunities for workers to be granted leave to care for relatives who need support. However, this is just one type of measure and one has to be employed to avail of it – in essence, rights for carers in the EU are employment–related rights (Caracciolo Di Torella and Masselot, 2020).

Another very important silence in the ECS is in regard to the additional funding needed and how affordability (one of the keywords in Principle 18) is to be achieved. There are several significant points here. First, the recommendation assumes that member states will provide the funding and undertake the main activities, while the Commission will make (relatively minor) funding available through existing initiatives (the EU Multiannual Financial Framework, for example, especially the EU Social Fund+) for developing knowledge-based resources, such as research and
monitoring, regarding LTC. Second, the question of access is under-considered in the ECS generally, for example, there are no targets set regarding access (unlike for ECEC, where specific access targets are set). Moreover, the significant (re)investment needed to undo the service and other cuts of the austerity knife is hardly mentioned, thereby going against the European Parliament’s (2022) call for a dedicated LTC investment package (Thissen and Mach, 2023). Third, the ECS has few, if any, remedies for the costs and affordability of care, which are continually rising. Hence, there is no redress for the 75 per cent of older persons in need of LTC who report that they would find themselves below the at-risk-of-poverty threshold if they were forced to purchase homecare services at full market cost (European Commission and Social Protection Committee, 2021). The ILO’s approach is very different.

**The ILO’s 5R framework for decent care**

In the foreground here is the 2018 report on Care Work and Care Jobs for the Future of Decent Work, and the background is the ILO’s long-term interest in decent work and associated inequalities, as well as protection for more marginalised workers/sectors. The decent work agenda, which dates from 1999, is based on four normative pillars: job creation, rights at work, social protection and social dialogue (ILO, 2006). Already, it can be seen to invoke elements of both the economistic and social protection perspectives. The ILO defines decent work as ‘productive work for women and men in conditions of freedom, equity, security and human dignity’. The decent work concept is a rights-based approach that concerns itself with pay rates, the security of work, social protection, working conditions, access to labour rights and the promotion of social dialogue, encompassing the actions of governments, employers and trade unions. In more recent work, the ILO has placed care work at the heart of both the Women at Work Initiative (in identifying the lack of recognition, unequal distribution and undervaluing of care work as some of the main barriers towards women’s employment) and the Future of Work Centenary Initiative (which, among other things, elaborated a vision of the future of work without gender inequality). Recent research by ILO staff members – and especially the 2018 report (ILO, 2018) – have sought to deepen the organisation’s engagement with care, both to apply the concept of decent work to care and also to develop a distinct ILO approach to care.

The 2018 report (ILO, 2018) configures unpaid and paid care work as closely intertwined. Like the EU, it incorporates both LTC and ECEC. In focus are the persistent gender inequalities in households and labour markets, which are seen to be inextricably linked with care work. It suggests that the ILO’s mission statement of ‘decent work for all’ means little without addressing gender imbalances in the performance of care (inside but especially outside the labour market) and other labour. The report conceptualises a ‘low road’ and a ‘high road’ to decent care work (having undertaken a 99-country analysis that identifies eight distinctive models of care employment). The high road (or virtuous circle) consists of gender-responsive and human-rights-based policies. The low road is not developed as such but appears to be some mix of residual or status quo positions in the countries identified as relying extensively on unpaid carers and having minimal or inadequate service provision. The report uses the term ‘transformative care policies’ for those, which ‘guarantee rights, agency and well-being of both unpaid carers (whether in employment or not)
and care recipients’ (ILO, 2018: 111). This framing encompasses some of the main elements considered here as a configurational approach.

Developing the UN’s extant 3R (recognise, reduce and redistribute)\textsuperscript{12} framework on unpaid work as a strategy to achieve women’s economic empowerment, the ILO report highlights a strategy of action focused on five Rs:

- recognise
- reduce
- redistribute
- reward
- represent

The perspective is centrally focused on care as a societal exigency, which is interpreted as both a structural and interpersonal phenomenon, and calls for major change in how it is organised and valued. The first three Rs – recognition, reduction and redistribution – relate to unpaid work, while ‘rewarding’ and ‘representing’ mainly pertain to paid care and paid care workers. A total of 15 policy measures are deemed to be necessary in a policy package that specifically encompasses five policy areas: macroeconomic policies, care-related policies, social protection, labour and migration policies. Hence, the position taken is that policy should strive to give care work recognition and value, to reduce its volume as unpaid work, to redistribute it among institutional spheres and between individuals, and to appropriately reward those who do it – especially paid carers – and enable them to be politically represented.

The contrasts with the ECS discourse and mission are striking, and applying Bacchi’s framework serves to reveal them. In terms of how the problem/problematic is constructed, it is the connection between care and gender inequality that is the root concern in the relevant ILO work. The ILO critiques the lack of a ‘configurational’ (as conceived here) perspective that connects paid and unpaid care, whereas any such critique in the ECS is implicit rather than explicit. It is from this position that the ILO’s five necessary policy fields (seen as interconnected) and five necessary sets of actions (the 5Rs) derive. Unlike the EU measures, the ILO document deepens aspects of what we call a ‘configurational approach’ by, for example, underlining the need for cultural change and measures to address inequality. Key actions included here are eliminating discriminatory social norms and gender stereotypes, encouraging positive masculinities, and enacting care-friendly employment policies to balance work and family commitments, facilitated by culturally relevant education curricula and media and advocacy campaigns.

Examining the underpinning principles identified for transformative care policies is insightful about assumptions. A first identified weakness of existing policy and provision is the relative absence or downplaying of gender-responsive and human-rights-based measures. The change needed in this regard is policies that actively and systematically expand the rights, capabilities and choices of women and men, and mitigate other dimensions of inequalities related to ethnicity, origin and disability. A second perceived weakness is the lack of universality in regard to supportive policies on care. In this regard, it is argued that care policies should reach the entire population with similar, high-quality services and generous transfers. A third identified weakness is in the degree of state responsibility. Unlike the ECS, the ILO argues strongly for state responsibility in regard to care policies, a position that is grounded on the principle
of care as a social good. A final part of the ILO’s problem–solution construction is social dialogue and worker representation (taken up by the EU too). This is necessary to empower and guarantee the rights, agency, autonomy and well-being of care recipients, as well as both unpaid caregivers and care workers.

The ILO report places great faith in social protection (offering a much more elaborated version of the relationship between social protection and care as compared with the ECS). In the ILO view, social protection systems, including floors, have the transformative potential to promote a ‘universal carer model’, in which both women and men undertake unpaid care and paid work. This implies a universal rather than a targeted approach to cash transfers and service access. The 2018 report argues that social protection should recognise care provision and care responsibilities as a social risk for all individuals across the life cycle. The universal human right to social security should be recognised as individual based, an approach that is interpreted to move away from the male-breadwinner model. This again brings the ILO back to the state and its role in providing financial support for unpaid care work through care-related social security benefits, public services and social infrastructure (here, reference is made to SDG Target 5.4 – which will be discussed in the next section).

There are relative silences here too, though. The ILO is not fully clear whether it wants to eliminate unpaid care work (as in the proposals to guarantee the right to universal access to quality services and the focus on employment/care-friendly leave policies, family-friendly work arrangements and active labour market policies to promote and enable the labour-market reintegration of unpaid carers) or make it more equal (as in better gender distribution of labour in the family and the ideas underpinning its wish to see a universal carer model). Furthermore, it does not provide sufficient detail on how social protection should support care or attention to the risk that supporting care through social protection benefits (such as credits and cash for care) reinforces women’s role as providers of care. Finally – supporting the point made earlier about the difference between the ILO and EU initiatives – it is unclear about how the recommended changes are to be paid for.

The WHO’s framework on integrated care

The WHO’s main relevant concern is to aid and promote LTC systems across the world, with a particular focus on countries where the establishment and consolidation of such systems requires major thinking and investment (in cases where the family is seen as the appropriate LTC provider, for example, or where a disease-oriented approach to ageing and LTC prevails). The overarching relevant UN framework is that of healthy ageing and, associated with that, the UN designation of a decade of healthy ageing (2021–30). To establish such LTC systems, the WHO has proposed three interrelated strategies that were accepted by all 194 member states in 2016 (World Health Assembly, 2016). The first is to develop and improve system infrastructure. This is said by the WHO to require a plan and legislation, informed by country-based assessment (which should include multi-stakeholder consultation and analysis). The second strategy is to build the capacity of the workforce and support families and communities by providing training and support to family and other unpaid carers. Developing training and career opportunities for the paid LTC workforce is also part of this strategy. The third action strategy is to ensure the quality of LTC with the provision of person-centred and integrated care, and through the establishment
of minimum standards and accreditation for care providers. In a follow-up initiative in November 2021, the WHO launched a framework for countries to achieve an integrated continuum of LTC (WHO, 2021), and it is that document that is the main focus of attention in the paragraphs that follow.

In terms of what is being problematised, the ‘problem’ concerning the WHO is healthy ageing, which is seen to be hindered by weaknesses in care provision. Highlighted here especially are the lack of ‘joined-up’ care, the poor integration of LTC into health and social care systems, weaknesses in addressing chronic and complex needs, and the lack of technical capacity in many countries/regions. Like the EU in some respects, the WHO takes what we call an ‘economistic approach’ and seeks to institutionalise and strengthen LTC as a field of policy. A particular WHO fear is that countries are ill-prepared to address growing chronic and complex care needs – for example, only 89 out of 179 countries globally have statutory provision of public LTC services for older people (Tessier et al, 2022).

In regard to the assumptions underlying the approach adopted, the WHO appears to believe that the lack of education or knowledge and tools is a key reason why countries’ LTC systems are inadequate. It therefore undertakes an educational role. LTC is treated as a cognitive or knowledge problem (as well as a problem of service provision), in that to address it, there is a perceived need to provide knowledge and understanding of what LTC is and what an LTC system involves. An important part of the context here is a general lack of an LTC research and knowledge base in low- and middle-income countries; in the WHO’s view, this hampers evidence-based policy planning, formulation and evaluation (Lloyd-Sherlock, 2014; Glinskaya et al, 2022). One of the recommendations follows from this: create an expert advisory commission for the long-term care research agenda that includes researchers and key stakeholders, as well as older people and carers.

The educational role of the WHO, then, is uppermost, with a stated aim of the 2021 framework being to promote a global common understanding of LTC. The WHO’s strategy is (partly anyway) conceptual: it offers the concept of an ‘integrated continuum of long-term care’. This is a very interesting concept, in some ways embodying a configurational approach as conceptualised here. For the continuum concept to be realised, six key systemic elements are essential: governance; sustainable financing; information monitoring and evaluation; workforce; service delivery; and research. For the WHO, the continuum is effected by mainstreaming LTC through the primary healthcare systems in the context of universal healthcare provision. In practice, the WHO highlights person-centred care provided in the community and offering integrated services on a continuum, as well as support for carers and care workers. Providing tools is also part of the WHO’s strategy and role. The framework document, for example, offers a checklist of 84 key action points, whereby individuals/agencies/countries can evaluate their progress and build assessment into their operating systems.

Another assumption on the part of the WHO is that informal care and those who provide it must be supported. While it tends to couple together those receiving or in need of care and carers (by which it references especially unpaid carers), attention is devoted to the needs of unpaid carers. Among the 84 key action points are: measures to support carers and promote their mental and physical well-being; legislation to ensure the protection of rights and entitlements of both older people and carers; labour standards, procedures and regulations for carers and care workers (including compensation mechanisms and strategies to overcome informality); training
programmes for carers (whether unpaid or paid), as well as legislation for training and certification requirements to accredit people’s caregiving expertise; measures and subsides for reducing costs experienced by informal carers (for example, cash allowances, paid leave, respite services or informal care leave); mechanisms to ensure gender equity in care provision; and standardised person-centred assessment protocols, including degrees or levels of dependency categories, health criteria assessment to qualify for services, preferences and older adult and carer needs.

In terms of relative silences, the WHO fails to deepen a rights perspective in LTC. While a rights perspective is present, LTC is seen not as rights based in itself but rather as respecting human rights. In addition, the WHO avoids the ‘how’ question required by an economistic approach.

**UN Women**

Kate Bedford’s (2010) research suggests that the 2009 meeting of the Commission on the Status of Women was very significant in advancing the concept of care and facilitating advances in care policy at the 53rd session of the UN that year. In her narrative, this contributed to generating consensus among member states and other actors on three things: the significance of care across the UN system; the importance of state responsibility; and the centrality of caregivers’ participation in debates over policy. UN Women has taken a leading role in regard to care.

UN Women’s starting point is gender equality and women’s empowerment. It approaches this through a range of entry points, one of which is care. Unpaid care, understood to refer to both care for children and care for adults, is a dominant concern that has been taken up in a number of ways. UN Women’s overarching framework is that of the UN’s original three Rs, but it has also more recently began using the ILO’s five Rs, and in a recent publication, it seeks to integrate and develop the additional two Rs (reward and representation) added by the ILO to the original three Rs (recognise, reduce and redistribute) identified by the UN in 2016 (UN Women, 2022). The organisation has employed the concept of the care economy – understood to involve both paid and unpaid care – and emphasised its transformative potential as a way of promoting gender equality, human development and inclusive and sustainable growth (UN Women, 2018). A perceived crucial intervention towards the reduction of unpaid work is public investment in social care service infrastructure and in time-saving physical rural infrastructure.

However, UN Women has a delimited field of action given that care hardly appears in the SDGs (United Nations, 2015). It is not there under health, for example, nor is it explicitly there under the decent work goal. When one searches, it is to be found under Target 5.4 which commits to: ‘Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate’. Care, then, conceived primarily as unpaid care, is mainly placed under gender equality (Goal 5) where it is one of six targets. SDG Target 5.4 highlights four priority policy areas in addressing unpaid care work: public services, infrastructure, social protection and the promotion of shared responsibility within the household and the family. Target 5.4 is associated with a single indicator (Indicator 5.4.1: ‘Proportion of time spent on unpaid domestic and care work, by sex, age and location’), which is also among the Global Minimum Set of Gender Indicators.
Taken as a whole, while the focus on unpaid care and the care economy brings to the debate important insights and an understanding of care as situated in a configuration, one critique of UN Women and the SDGs is a lack of attention to the economics of LTC provision and how addressing unpaid care can be extended beyond gender inequality. Moreover, the generic treatment of care in the UN underplays the specificity of different types of care and carers and the complexity of LTC as a challenge for policy (Daly, 2021).

Discussion and conclusions

This article has had two aims: to critically assess the ECS in its own right and in the context of the positions taken by other international organisations; and to examine how LTC is addressed by a range of international organisations. In regard to the ECS, its presence in the EU programme is significant. It helps put LTC as a concept and policy problem on the EU map, and it devotes welcome attention to LTC services and, especially, the work conditions and resources of paid care workers. In this and other regards, it can be considered as progress, helping to broaden the existing policy response, which was fragmented and did not generally devote attention to better services and pay (Zacharenko and Elomäki, 2022). For heuristic purposes, we developed three hypothetical models: an economistic model, a social protection model and a configurational model. Analysis shows that the dominant approach in the ECS is economistic, as confirmed by the dominance of service provision, the failure to develop the rights basis of care (as emphasised in the European Pillar of Social Rights) and a rather shallow understanding of care as part of a configuration. The ECS does consider the broader infrastructure – especially from the perspective of a service mix – but it is largely accepting of the status quo in regard to social protection and deep systemic reliance on informal care and unpaid carers. In contrast, the UN organisations focus much more strongly on social protection and reforming the broader care configuration (though it must be said that their remit allows them to be more light touch in regard to the details and implementation of provision). The question can genuinely be posed as to whether the EU recognises the nature and depth of the care crisis. Two things about the ECS suggest not: the first is the relatively piecemeal nature of the ECS reform programme; and the second is the weak recognition (if any) of how neoliberal, market-promoting policies have contributed to a crisis of care and continue to create a contradictory policy environment. As it stands, the ECS leaves some profound questions unanswered: what would an appropriate European care landscape look like, especially in terms of the balance of responsibility between actors (especially the state, market and family) and between services, as well as income support and the universality or targeting of provision?

Turning to the second aim, LTC is clearly present in international conversations on care, though the mission, legal and policy remit, and intended audience of the different organisations vary. Taken together, there are four commonalities across the different institutions.

First, the organised LTC service system dominates concern; it is widely considered to be inadequate or inefficient, or both, with particular problems varying locationally, but in almost all cases, being faced with either an absolute lack of resources for services or less-than-optimum organisation of resources. A second shared feature indicated by the comparative overview is of considerable
Long-term care as a policy issue for the European Union and United Nations organisations

consensus on the constituent elements and values of an ideal care system: person-centredness; integration with or into the healthcare system; service accessibility; affordability and availability; and improved conditions for care providers (with a main focus here on paid workers, but with unpaid carers also included to some extent). The extent of change involved to realise this kind of system – even a person-centred one, as against a provision-centred approach – should not be underestimated. Third, in one way or another, they all pick up on the lack of shared understanding and terminology, and while there are different concepts in use (for example, the continuum of care and the care economy), they all devote attention to clarifying concepts and terms. In a sense, then, we could say that they together make progress towards an international LTC lexicon. A fourth striking commonality is on ‘integration’ as a solution. The exact meaning and form of integration varies, but all the organisations considered evince recognition of care as part of a broader ecosystem. Health dominates the integration narrative, but the care ecosystem is recognised to involve unpaid care also.

There are also significant variations between the policy positions, which are, of course, to some extent to be expected. In particular cases, though, these variations connote silences or unquestioned assumptions. One variation is in the depth of commitment to addressing inequality and, more broadly, the nature and depth of the reform needed. The ILO and UN Women have the deepest reform agendas, calling for the fundamental redistribution of care, strong social protection, the better representation of workers and a variety of better connections between paid and unpaid care. In contrast, the ECS reads as if it will be content with a somewhat-reformed status quo, albeit one in which LTC services and the conditions of paid care workers are improved, and social dialogue in the care sector is introduced. The respective narratives on inequalities feature gender strongly and income or socio-economic background to a lesser extent (as in the costs of care/caring). The UN organisations – especially the ILO and UN Women – have the strongest understanding of care inequalities and, in another difference from the EU, are better able to see gender inequality as unreachable if care is not significantly reformed.

As a final word, we should note that all the policies and entities considered face two major challenges. A first is to understand and embed a rights perspective in care, especially one that goes beyond a concept of rights based on personal autonomy only and incorporates valuing and recognising the relationships and interdependencies inherent in fully person-centred care (Caracciolo Di Torella and Masselot, 2020). A second is to promote what we would call a ‘care-first’ perspective, which would, for example, move beyond production-centred notions of value and towards a society wherein people would give and receive care on the basis of their capacities and needs, and where there would be action from governments at all levels to support and value care as labour activity and a relational orientation.

Notes
1 The actual papers are a Commission communication, a proposal for a council recommendation, an annex to the proposal (mainly consisting of definitions of key terms) and two Commission staff working documents: one – SWD(2022) 441 – providing the supporting analysis; and the second – SWD(2022) 440 – summarising the consultation activities that fed into the ECS.
The six models and respective countries are: very strong state intervention through services (Denmark, the Netherlands and Sweden); strong state intervention through cash benefits (Austria, Czech Republic, Germany and Italy); strong state intervention through services (Belgium, Finland and France); mild state intervention through cash benefits (Lithuania, Poland, Slovakia, Slovenia and Spain); mild state intervention through services (Ireland, Luxembourg and Malta); and limited state intervention (Bulgaria, Croatia, Cyprus, Estonia, Greece, Hungary, Latvia, Portugal and Romania).

A Council recommendation is an instrument of indirect action aiming at the preparation of legislation in the member states. It is without legal force and differs from the more binding regulations, directives and decisions. Although not binding, recommendations do carry political weight.


See: https://ec.europa.eu/social/main.jsp?catId=1223&langId=en

The estimate of 52 million is based on those aged 18 to 74 who provide informal LTC to family members or friends on a weekly basis (European Commission, 2022b: 3).


Measured on the basis of the proportion of employment in health/social work and the proportion of employment in domestic work.


See: www.un.org/womenwatch/daw/csw/53sess.htm

**Funding**

This work was supported by the John Fell Fund of the University of Oxford (Grant Number 0010496).

**Conflict of interest**

The author declares that there is no conflict of interest.

**References**


UN Women (2022) *A Toolkit on Paid and Unpaid Care Work: From 3rs to 5rs*, New York: UN Women.


