European Economic and Social Committee

OPINION

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Towards a new care model for older people: learning from COVID-19

Towards a new care model for older people: learning from COVID-19
(own-initiative opinion)

SOC/687

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1. Objectives and scope of the opinion: care for older people, particularly those who are dependent

1.1 This own-initiative opinion focuses on: analysing the various models of long-term care for people over the age of 65 who have lost their autonomy or are dependent, particularly in institutional care homes; assessing the impact of the COVID-19 pandemic on the various care models – institutionalised care, home care and other forms of care provision – in the Member States; drawing conclusions in this regard and calling for action that is consistent with the shortcomings identified and coordinated in both European and national policies.

1.2 Longer life expectancy poses both challenges and opportunities in the area of demographic, social, economic and housing needs and of respect for fundamental rights, which go beyond care for older people. This is also linked to other issues relating to dignified, autonomous, active and healthy ageing. However, this more multifaceted approach will have to be developed in more detail in other EESC opinions.

2. Conclusions and recommendations

Care models

2.1 The EESC believes that more attention should be devoted to care for dependent older people with long-term care needs[1], and that this should be mainstreamed into EU policymaking in view of the demographic transition. This is particularly important given that by 2050 – according to pre-pandemic data – more than a quarter of the population will be over 65, and the number of people over 80 will double.

2.2 The EESC proposes setting up a European Observatory for care for older people, which would, for instance, make it possible to collect sufficient statistical data, compare good practices between different state models, identify structural weaknesses in national systems in terms of capacity to meet the demand for assistance and funding, provide technical support to facilitate the adoption of EU political guidelines aimed at developing the third report on care for older people, implementing the European Pillar of Social Rights Action Plan and contributing to the development of the EU strategy on long-term care, including for older people. This will be guided by a greater effort to help and motivate older people to remain active, independent and in good physical and mental health for as long as possible.

2.3 The EESC deems it essential to establish a strategic framework, for the purpose of medium-term forecasting with a holistic approach, in order to respond to the challenges of caring for older people in the EU, by laying the foundations for a long-living, healthy society and an intergenerational solidarity pact in the EU. The pandemic has revealed failures in forecasting,

[1] It should be pointed out that when the opinion talks about "care", it is referring to all types of care for older people. Sometimes, for reasons of linguistic interpretation, confusion arises, for example with the French term "*soins*" being taken to mean "healthcare", whereas in English "care" covers all types of care, including support with tasks such as: helping older people through conversation, walks, mobility assistance, shopping , household cleaning, and other domestic chores such as cooking or help getting dressed, etc. The term "care" is used in this wider sense in the opinion. It therefore also covers the concept of "support".

coordination and planning in areas affecting essential community services (such as healthcare and social services) and biomedical research policies. These failures must be addressed quickly.

2.4 The EESC therefore welcomes the Commission's initiative to establish a new European Care Strategy. It calls for it to be implemented as soon as possible and to involve the European consultative institutions and European social dialogue at the various levels, taking into account agreements approved by the parties. Civil dialogue may also take place with European civil society organisations representing older people (AGE Platform Europe and its various members, among others), without excluding the development of a specific European strategy for older people in the EU over the coming years. Similarly, the EESC proposes to include care for older people among the strategic aspects of the debate at the Conference on the Future of Europe given the importance of the demographic issue. At the same time, it supports prioritising integration of a "Europe of health", including long-term care for older people.

2.5 We also propose that an *ad hoc* group be set up within the EESC before the end of the current term, to implement various initiatives relating to care for older people, ageing and the challenge of people living longer, in step with the EP Intergroup on Demographic Challenges and, among other initiatives, the United Nations World Assembly on Ageing scheduled for 2022.

2.6 The EESC urges the European Commission and the Member States to develop in the short term the principles relating to care for older people within the European Pillar of Social Rights Action Plan.

2.7 The EESC believes that long-term care should be included in the "stress tests" provided for in the EU regulation on serious cross-border threats.

2.8 The pandemic has helped to highlight conceptual, structural and functional shortcomings in care models for older people, whether care is provided through care homes, home care services, family or professional carers.

2.9 We believe the Member States need to establish or update existing laws on supporting and protecting older people's autonomy, in accordance with Article 12 of the convention on the dignity and human rights of persons with disabilities, which has been ratified by the 27 Member States and the EU. They also need to develop areas within social protection systems to deal with prevention, loss of autonomy and the self-determination of older people. With a view to ensuring social protection for all and other social rights, such as unemployment insurance, family protection, access to housing and care for dependent persons, the EESC believes that older people's autonomy must be ensured on an equal footing and be recognised as a subjective right for all citizens, as part of the development of the pillars of the welfare state.

2.10 COVID-19 has revealed the insufficient supply – and, particularly, the accessibility problems – of high-quality long-term care for all older people at prices that are affordable for a large number of Europeans and their families. In this regard, the EESC considers that devoting attention to and identifying the number of older people who need care but cannot access it for various reasons is a priority.

2.11 To promote and provide a framework for such national regulations and policies, the EESC suggests that the Commission draw up proposals on anticipation, prevention and the loss of autonomy of older people to include them in the healthcare strategy and the forthcoming guidelines on independent living for older people under the European Disability Strategy.

2.12 During the pandemic, older people were only partially taken into account, were undervalued and even suffered discrimination. Care for older people is not the problem, the lack of it is.

2.13 The EESC proposes that the EU establish, as requested in previous EESC opinions, as well as in the EP report on an old continent growing older, a standard definition to better define the concepts of dependence and the need to provide care for others as they lose their autonomy, taking into account the variety of approaches taken by the various countries and their freedom to choose how to design their social protection systems. Age is not an identity, not all older people are dependent or have imperative external care needs, and dependency resulting from a disability is not the same as the loss of autonomy caused by dysfunctions that may arise as a result of growing older. However, in a significant proportion of cases, the two circumstances coincide.

2.14 The EESC requests that, as recognition of the fundamental rights of older people and as an expression of their contributions to society, as laid down in Article 25 of the EU Charter of Fundamental Rights, the European Commission organise a European Year of Older People.

2.15 In a number of EU countries, complaints or lawsuits have been brought before the courts relating to the treatment received in care homes or possible cases of violence or violation of older people's fundamental rights. The EESC therefore calls for the principles of the European and UN Treaties that have been ratified by the EU and the Member States to be enforced in order to guarantee the fundamental rights and dignity of older people, and for measures to help older people take decisions to be put in place, with legal protection measures – both judicial and extrajudicial – provided in care services for dependent older people. Consideration could also be given to creating the position of legal administrator or mediator or a corresponding function (depending of the legal system of the country concerned), determined to act in empathy and to the best interest of the dependents, which could have positive effects according to analyses in some countries. In this context, the EESC proposes, in line with the UN proposals, support for the adoption of a Convention on the dignity and rights of older people.

Structures

2.16 Responding to the call to generally deinstitutionalise care for older people in care homes involves promoting dependent older people's autonomy, independence, ability to look after themselves and social relations. This means providing them with local social and health resources, much more structured and efficient home support, as well as new housing alternatives, such as sheltered, supervised or community-based housing, cohabitation units or other alternatives that exist in various EU countries, according to the needs and preferences of the older people losing their autonomy. For more dependent persons, traditional care homes need to be redeveloped to make it seem more like living at home. Shortcomings in care systems exposed by the pandemic need to be addressed through the EU Structural and Cohesion Funds,

the Recovery and Resilience Facility and the EU health programme (EU4Health) by means of recommendations on funding integrated into the European Semester.

2.16.1 To that end, the EESC calls for the Member States to use the EU Structural Funds and Recovery Fund to provide funding to adapt housing, create cohabitation units, redevelop the various types of care home and invest in labour and services. Such adaptations need to be carried out in compliance with the highest accessibility requirements, as regards both the built environment and the accompanying digital ecosystem.

2.17 The EESC believes that, as a person-centred sector, the social economy (cooperatives, mutual societies, associations and foundations) should be considered and supported as a key player and a driver of innovation and the transition towards this new model, in line with the EU Action Plan for the Social Economy.

Resources

2.18 The main shortcoming here, which is the root of many others, is insufficient funding. This factor varies substantially between Member States, ranging from 0.3% to 3.7% of GDP. This is undoubtedly linked to the individual care models themselves, but also to the impact of policies resulting from the recent crises, which significantly affected funding.

2.19 The EESC believes that, bearing in mind the consequences of the debt crisis, the rules that contributed to this situation must be revisited and that sufficient public funding must be ensured within social security systems in line with existing demand and while ensuring high-quality services.

2.20 The EESC thinks – and the experience of several Member States bears this out – that the various care packages for older people need to be properly regulated, with public procurement systems in which the decisive factor is quality of service rather than price.

2.20.1 The EESC therefore recommends that in those member states where it is applicable, taking into account the mechanisms and procedures specific to each member state, both the allocation of places at state-assisted care homes and the renewal of these public contracts be conditional on complying with staff ratio requirements, providing workers with ongoing training, ensuring suitable working conditions and meeting tax obligations.

2.20.2 Similarly, public-private partnerships and private services – as well as public services – must be subject to clear and effective evaluation, supervisory and inspection mechanisms, both as a requirement linked to the public resources allocated to private or state-assisted care homes, and as a public responsibility to protect the rights of older people.

2.21 The EESC considers that a well-structured debate at various levels and between various actors is needed to address funding care for older people to which all have access. The discussion should include not just expenditure but also investment. To this end, consideration should be given to the way in which the various Member States operate, the funding models and the various possibilities for sourcing funding, whether through public, state-assisted or complementary

funding. This analysis should include positive externalities in terms of savings which may be the result of, among other things, deploying new technologies, investments in active and healthy ageing policies or health promotion and disease prevention, always prioritising the objective of quality of life.

2.22 The EESC proposes that measures be put in place to ensure adequate training for carers, with specialised, institutionalised training pathways being developed for care staff, and that an official certificate for basic skills be required in order to be able to work in social care services for older people. It also recommends using systems for recognising such qualifications between countries and that the European Social Fund earmark funding for the training of carers for older people.

2.23 The EESC believes that the issue of EU care workers and all related aspects, including the right to collective bargaining, should be incorporated into European social dialogue, as has already begun to happen with the European social partners' autonomous framework agreement on active ageing and an inter-generational approach (2017). Social dialogue should take place also in the inter-confederal, federal and sectoral spheres (personal care and social services sector).

2.24 In line with the Council's request (COM(2013) 152 final), the EESC agrees that the Member States should ratify the ILO Home Work Convention, 1996 (No. 177), the ILO Domestic Workers Convention, 2011 (No. 189) and Recommendation 201, which supplements Convention 189.

2.25 Technological changes, in turn, can provide essential support for care for older people, although this can never replace human labour. Examples include telemedicine or telerehabilitation, training of professionals, the maintenance of social relations through video calls, etc. Other examples include the use of bed or body-worn sensors to detect vital signs or prevent falls, or of infrastructure and architecture, such as home automation, to create friendly environments or mobility solutions for older people.

2.25.1 The EESC therefore thinks that all stakeholders involved in caring for older people should make better use of innovations arising from digital technologies; incentives for this could be provided by Structural Funds programmes. The EESC also proposes that consideration be given to training older people needing long-term care in the use of digital technologies.

2.26 Moreover, contrary to what is sometimes argued, protecting older people with care needs is not incompatible with taking care of young people. The EESC believes that this false reasoning needs to be rejected. Just as the green and digital transitions must go hand in hand with the social transition, demographic challenges and opportunities must be based on an intergenerational pact with fundamental objectives of access to quality education for all, to regulated employment with decent jobs and to extensive social protection systems covering all members of society. This applies particularly in societies such as those in Europe, where the social pact is based on intergenerational solidarity. This is why the intergenerational cooperation pact is a basic foundation for the renewal of the European social compact. Neither the current transformation of society nor recovery after the pandemic will be possible without a bond between the generations.

2.27 The EESC believes that a wide range of strategies need to be developed for policies and measures directed towards support and care for older people in order to: a) identify in advance weaknesses likely to cause future loss of autonomy and focus on anticipation, prevention, rehabilitation and funding to combat the process that leads to loss of autonomy and dependency; b) delay the onset of dependency through healthy behaviour in relation to diet, physical exercise and working conditions; c) anticipate the impact of disruptive events (unemployment, separations, changes in job, the transition from work to retirement) and loneliness on health; d) identify the most vulnerable people and deal with specific situations (neurodegenerative diseases, depression and suicide risk, cancers, etc.); e) sufficiently and permanently fund collective responsibility for the care of older people; and f) assist and support family carers with instruments, training, measures to balance work with caring, taking into account the fact that acting as carers can lead them to lose their own autonomy and their entitlement to protection when they are older.

3. Background and context

Developments

3.1 Discussions on the care needs of dependent older people have been taking place in the EU for decades.

3.2 A number of aspects have contributed to changes in the initial design of long-term care. It has been moving from a purely care-based approach to a more integrated, person-centred and high-quality approach, combining health and social care, and with service provision for all, which, in the view of the Council and the European Commission, should meet three key criteria: access for all, irrespective of income or assets; quality care; and sufficient funding for health and social care systems.

3.3 Sociological changes have helped to reinforce this trend, such as the ageing of the population itself, the percentage of older people who are dependent or losing autonomy, a rise in mental illnesses in the upper sections of the population pyramid, the massive increase in the number of women in paid work, the rise in the number of people living alone and changes to family models.

3.4 The impact of these changes called into question both the care-based nature of social services and the central role of the family – mainly women – in such care, creating the need to develop – alongside pensions, education, healthcare and dependency – a new pillar of the welfare state, which refers to social services.

3.5 Nevertheless, particularly since the debt crisis and the adoption of austerity policies, which, among other things, resulted in budget cuts in healthcare and social services to varying degrees in the EU Member States, different trends have been observed in different Member States, including a shift back towards a more care-based approach and towards increasing prioritisation of the most severe levels of dependency or of people with limited economic resources, a curbing

of the trend towards non-family care as the basis for the system, and the further commodification of the provision of care, with or without public funding.

3.6 This can all be observed to varying degrees in the various Member States and comes against the backdrop of greater budgetary pressure on old-age pension systems, a sharp increase in the demand for long-term care, rising unemployment in some Member States, less stable forms of work and discontinuous career paths, and the prioritisation of the over-50s in company staff reduction plans. Without the support of decisive public policies, this situation threatens to lead to lower pensions than current levels and greater inequalities in access to care.

3.7 Another key aspect is ascertaining whether care and support should be provided and cohabitation take place at home or in care homes. According to many surveys, the majority of those affected would prefer to stay at home in their community environment.

3.8 This preference also meets a structural demand, which also has an economic basis, to increase the active population: in the EU, 25% of women say that they cannot work or are forced to work part time due to care duties, including care for older people, compared to 3% of men. As families are smaller and a single salary is often not enough to meet household expenses – except in single-person households – it is becoming increasingly unsustainable for families to take on care duties. To ensure that access to care is not limited to higher-income groups, funding will have to be increased.

3.9 Therefore, the positive effects – in social and economic terms – of an inclusive, high-quality and compassionate care system must be highlighted, starting with the fact that funding care services must be seen as an investment with great, multifaceted returns. It reduces the negative externalities of insufficient or inaccessible care in terms of healthcare and social spending. The social dimension is better in terms of support for families, work-life balance, care for other family members, emotional support, the performance of solidarity-based activities and historical memory. In economic terms, it facilitates the creation of millions of jobs, the financing of a large percentage of low-income households, an increase in tax revenues, consumption, the handing down of savings to descendants, production support and productive entrepreneurship. Moreover, home care is generally not only much more comprehensive and individualised, but also cheaper than care in residential settings, except in certain cases, such as people with a high loss of autonomy who are staying in care homes.

3.10 Care staff are an essential pillar of institutional care home systems and forms of care at home. In some cases, there is a shortage of such staff and they have precarious contracts, lack the necessary training support, have little professional recognition and are underpaid or irregular workers (in some countries in significant proportions). For this reason, among other things, it is essential to include training programmes for the care of older people, including dependent persons, in the various stages of vocational training, opening the door to dual modes of study.

Effects of the pandemic and lessons learned

3.11 Largely through the damage it has caused, the pandemic has helped to further highlight that population ageing is a key strategic challenge for the EU and its Member States. It has

highlighted the care requirements of older people because of their loss of autonomy and dependency. Indeed, according to the 2001 Long-term care report drafted by the European Commission and the Social Protection Committee, in 30 years' time, there will be 130.1 million people over the age of 65, 41% more than the current figure. As disability situations and long-term care and support needs increase with age along with healthy life years, the number of people who may need long-term care in the EU-27 is expected to rise from 30.8 million in 2019 to 33.7 million in 2030 and 38.1 million in 2050.

3.12 Several things have contributed to this greater collective awareness of the challenges associated with increasing life expectancy. There has been higher relative mortality caused by the COVID-19 pandemic, particularly in older people and, among them, the most vulnerable living in residential homes. Prejudices and stereotypes relating to older people, discriminatory decisions in health screenings and implicit or explicit questioning of the value and contribution of this group to society have been observed during the pandemic.

3.12.1 Similarly, a distorted account of alleged opposition between the interests of young people and those of "old" people has characterised the public debate. There has been evidence of conceptual, structural and operational failures in care models for older people. There has been a growing desire to focus more on access to and affordability of quality care, to respect older people's dignity and rights, to maintain as much as possible their living autonomy and social environments, to ensure coordination between social and health services, and to secure their financing (public expenditure represented on average 1.7% of European GDP and is expected to double by 2050 if there is upward convergence between Member States).

3.12.2 Shortcomings have also been highlighted in a key pillar of long-term care and carers and workers in the sector, which employs 6.4 million people and is expected to create a further 7 million jobs by 2030. Finally, the contribution of informal long-term carers (and gender bias across the whole sector) and the need to extend certain reconciliation or protection measures for this group have been highlighted, which had not been done previously. The time has come to act.

3.13 The greater focus on demographic challenges and opportunities and, as far as the content of this opinion is concerned, care for older people owing to loss of autonomy or dependence, has helped the European institutions draft important documents on these challenges, as well as on the subject discussed in this opinion.

3.14 These include the European Commission's Green Paper on Ageing, the European Pillar of Social Rights Action Plan, the European Parliament resolution on ageing in an old continent, the European Council Report and Conclusions on Mainstreaming Ageing in Public Policies, the European Commission and Social Protection Committee Report on Trends, challenges and opportunities in an ageing society, the Committee of the Regions Working Document on a Future plan for care workers and care services – local and regional opportunities in the context of a European challenge, and, in particular, the proposal made by the Commission President, Ursula Von der Leyen, during her State of the Union speech in the European Parliament, to draw up a new European Care Strategy.

3.15 The crisis has highlighted the need for greater familiarity with this issue throughout the EU. We note the lack of statistical data on older people, the need for greater public knowledge of social protection and care models, which differ greatly in the Member States, the desirability of collecting and disseminating good practices among the various Member States, and the need to investigate and prevent discrimination and violence against dependent older people. In short, there is a need for detailed, ongoing monitoring of this matter.

3.15.1 In this regard, it should be noted that this opinion's stated aim of analysing and comparing the situation in the various countries is backed up by a number of studies and reports, including that of the European Commission and the Social Protection Committee, published just before this opinion was drawn up.

3.15.2 These studies and reports, as well as demonstrating the diversity of care models and situations in the various Member States, show the corresponding lessons that can be learned. These include the following: i) the preference for care at home or in a home-like environment; ii) the need for better coordination between social and healthcare services; iii) the essential role played by care staff and the need for all aspects of their role to be acknowledged, including the emergence of undeclared work; iv) the fact that the demand for care is not being met; v) the urgent need to address the requirement for sufficient, affordable and sustainable funding; vi) the obligation to counteract partial approaches that disregard the recognition and dignity of older people; vii) the need for informal carers to be more visible and better acknowledged, protected and supported; viii) the inadequacy of statistical and sociological data on older people; ix) the obligation to analyse call-out care and home care; x) the interaction between the various aspects affecting care for older people; xi) the significant gender dimension that exists in this sector; xii) the need to establish action plans, assessment systems and regulatory measures regarding care models.

3.16 The pandemic has helped to highlight shortcomings in care models for older people, whether care is provided by care homes, home care services, family or private carers.

3.17 These shortcomings are reflected in whether or not care is provided to all, in the diversity and fragmented nature of the services on offer, in poorly regulated services, in difficulties in coordinating management levels, in coordination problems between social and healthcare services, in the growing commodification of services and in the need for prevention policies and measures. In structural terms, these shortcomings may depend on the proportion of older people, particularly those who are most dependent, living in care homes rather than in person-centred situations. In functional terms, they are largely revealed in limited funding, a shortage of protective equipment, or insufficient staff, job insecurity, occupational risks (including mental health) or lack of training or professional and occupational recognition for staff.

3.18 COVID-19 has revealed that there is an insufficient supply of long-term care for all older people at prices that are affordable for a large number of Europeans. In fact, in the EU-27, of those aged 65 and over who had severe difficulties in performing personal care tasks, only a third used home care services in 2014. Member States' social protection models should also be adapted to meet these new needs with available, accessible, sustainable, affordable and good-quality public or subsidised services. Member States' social protection models should also be

adapted to meet these new needs with available, accessible, sustainable, affordable and good-quality public or subsidised services.

3.19 The institutionalisation of care for older people in care homes was already widely questioned before the pandemic but, subsequently, this practice has been more broadly rejected, except in the case of some older people who are not autonomous or are severely dependent. Its shortcomings include: increased risk of infection; residents' loss of control over their own lives; the rigidity of daily schedules; overcrowding and a wide variety of profiles among residents; little privacy (normally two people per room); the lack of involvement of residents or their family members in monitoring how homes are run; the weakening of family and social relationships; a feeling of dislocation and being uprooted from their community environments. There is also a great need to strengthen the rights and voice of older people in these homes with forms of safeguarding that respect their dignity and their specific situation, especially when it comes to older people with cognitive and mental problems.

3.20 Attention should also be drawn to the issues affecting older people who are cared for in their own homes, such as a lack of continuity in home-help services, isolation at home and difficulties accessing basic services.

3.21 During the pandemic, in general, older people were stereotyped and even suffered discrimination, even though ageing should be seen as an opportunity rather than a problem. In a number of countries, complaints or lawsuits have been brought before the courts relating to the treatment received in care homes or possible violations of fundamental rights. This has highlighted the need to establish permanent mechanisms to safeguard the well-being and rights of older people, and to combat discrimination against this group.

3.22 Before the pandemic, in many Member States there were major shortcomings when it came to care staff, such as: 1) staff shortage, a high percentage of temporary and part-time contracts, high staff turnover, low wages, little professional recognition, a lack of workers' rights, such as unemployment rights or, in some cases, the recognition of COVID-19 as an occupational disease and even, in some countries, significant percentages of workers without a contract and in many cases without social entitlements or social security rights; 2) lack of training and accreditation for the carers (geriatric assistants, home-help assistants or carers) who provide the vast majority of care home and home care services[2].

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The president of the European Economic and Social Committee

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2 Appendix to Opinion SOC/687 (in English only).