



**EURO
CARERS**

European Association Working for Carers

Eurocarers'
contribution to the Call
for Evidence on the
European Care Strategy

March 2022

THE EU STRATEGY ON CARE

A new paradigm for Carers across Europe?

The Eurocarers network warmly welcomes the EC approach, which perfectly reflects the vision we have been advocating for the last fifteen years:
care should be approached as a comprehensive and multidisciplinary sector, rooted in human rights, choice and dignity for both care recipients and their informal carers.

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On the 15th September 2021, EC President Ursula von der Leyen announced that the European Commission will put forward a new European Care Strategy as part of its Work Programme 2022 in order to “**support men and women in finding the best care and the best life balance for them**”. Ms. Von der Leyen went on to add that “**caring for someone you love is the most precious time of all**”, thereby raising hopes that the EU care sector may finally receive the attention and support it deserves.

The declared ambition of this new – and long-awaited - EU Care Strategy is to address both carers and care recipients, from childcare to long-term care, and to guarantee access to good-quality and sustainable care services for all throughout the life course¹ by setting a framework for policy reforms. **Importantly for our network, it is expected that the Strategy will cover the provision of both formal and informal long-term care** in Europe and be an integral part of the European Pillar of Social Rights’ implementation plan. This very timely EC initiative therefore has the potential to generate very positive developments for an under-resourced and yet overburdened care community.

The Eurocarers network warmly welcomes the EC approach, which perfectly reflects the vision we have been advocating for the last fifteen years: care should be approached as a comprehensive and multidisciplinary sector, rooted in human rights, choice and dignity for both care recipients and their informal carers. Good quality care indeed cannot be achieved without considering care recipients and carers as equal partners in care. As for integrated care, it requires a comprehensive delivery of quality services across the life-course, designed to prevent, manage and overcome risks in accordance with the multidimensional needs of the population/individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care².

Against this backdrop, we believe that **the EU Care Strategy should not only serve to coordinate member states’ efforts to meet the growing care needs of an ageing population, it should also be used to revisit the distribution of caregiving responsibilities between care professionals and informal carers, between the family and the State as well as between women and men.**

¹ [European Commission Work Programme 2022, COM\(2021\) 645 final](#)

² Integrated care models: an overview, WHO, 2016

Why an EU Strategy on Care is badly needed

The impact of Europe's demographic ageing and increased longevity on the prevalence of chronic/age-related diseases and the demand for care is well documented. Yet, over the last decades, the care sector has suffered from underinvestment, mismanagement, poor job quality (i.e. low pay, difficult working conditions, limited career prospects) and – as a result – from low recruitment and retention rates and shortages in both the health and social care workforce. Intra-EU mobile workers as well as non-EU migrant workers (including undocumented migrants) contribute substantially to the provision of care in the European Union, often in precarious conditions. According to a recent study, the EU-27 will need 11 million newly-trained or imported health and long-term care workers by 2030 to satisfy the rising demand in these sectors³. These statistics reveal **serious sustainability and quality challenges for our care systems**. They are also compounded by the impact of the pandemic as well as by the often-inadequate training of personal care workers (who account for 67% of the EU long-term care workforce, are not qualified or certified as nurses and yet often participate in the implementation of care plans and maintenance of health records). **These trends and challenges can be observed across EU member states who must address them as a matter of priority if the principle of universal access to care is to remain at the core of European values.**

As it stands though, the lion's share of all care across the EU is provided by relatives, friends and neighbours (i.e. Informal carers) – and women in particular - outside of a professional context and with extremely limited recognition or support. The provision of this informal care does not come without a cost for carers themselves. **Without proper support, many carers are faced with additional expenditures** as a result of the condition of the person for whom they care, **and their caring responsibilities can be a barrier to entering education and paid employment.** Working carers often have to perform a difficult balancing act and may be forced to reduce their working hours (involuntary part-timers) or drop out of the labour market, thereby reducing their income and pension entitlements. In the case of young carers, involvement in the provision of care to a relative may negatively impact on their (mental) health, educational attainment, employability and social inclusion. The gender dimension of this phenomenon is particularly clear.

The correlation between caregiving and physical and mental health issues is also well established. Research has shown that the pressure associated with informal caregiving presents all the features of a chronic stress experience: it creates a physical and psychological strain over extended periods of time, it is accompanied by high levels of unpredictability and uncontrollability, it frequently requires high levels of vigilance, and it has the capacity to create secondary stress in multiple life domains.

³ Health and long-term care workforce: demographic challenges and the potential contribution of migration and digital technology, EUR 30593 EN, Publications Office of the European Union, Luxembourg, 2021, ISBN 978-92-76-30233-9, doi:10.2760/33427, JRC121

The negative consequences of informal care on carers' living and working conditions can also be observed in all member states and our recent study on the impact of COVID on carers⁴ shows that these pre-existing challenges have been greatly amplified by the pandemic, with carers providing more care, more intense care (high-intensity caregiving being a driver of the above-mentioned penalties) and with a new population of carers emerging from the crisis. The COVID-19 crisis has emphasised the crucial role played by informal carers on the front line. It has also shed light on the shortcomings of institutional care, by reinforcing the pre-existing widespread preferences for home or community-based care among care recipients, which often relies on a combination of both informal and formal care.

It should be added that the prevailing (over)reliance of EU care systems on informal carers generates profound inequalities since many informal carers are forced into caregiving in the absence of alternative options and not everyone can rely on the support of an informal carer.

The results of a recent survey conducted in the framework of the InCARE project (<https://incare.euro.centre.org/>) reveal an increase in the difficulties experienced and/or anticipated by care users in Europe. Access to care services has considerably worsened, especially with respect to home-based care. In addition, users' confidence in the ability of long-term care systems to respond to future care needs is declining across Europe.

Concerning informal care, results show an overwhelming support for the idea of granting an income as well as social rights to informal carers. 9 in 10 respondents indeed fully agree with this or tend to agree that the state should pay an income to those who have to give up work or reduce their working time to care for an older person, and that providing care for a family member should be recognised as work and bring the same benefits as formal employment, including social insurance and a stable income. The same proportion of respondents considers that informal carers should be offered the possibility to take breaks thanks to publicly-funded interventions of care professionals at home. In all three cases, a higher share of women agrees with the idea of strengthening informal carers' rights. Only 5% of respondents totally agree while 12% tend to agree that care should be provided by close relatives of the older person with care needs, even if this means that they have to sacrifice their career to some extent, with slightly higher agreement rates among male respondents. Although the representativeness of the survey sample (2314 responses) is relatively limited in terms of gender, age, education level and experience with care, these results reflect very high expectations for reforms in long-term care services and systems⁵.

⁴ <https://eurocarers.org/publications/impact-of-the-covid-19-outbreak-on-informal-carers-across-europe/>

⁵ This publication uses data from the InCARE survey on attitudes, experiences and expectations on long-term care in Europe, collected in 2021-2022. The InCARE data collection has been supported by funding from the European Commission's EaSI Programme (VS/2020/0258). See also the InCARE project's response to the Call for Evidence.

In light of the above, **it is very clear that professional and informal care are two sides of the same coin that should be addressed in a coordinated manner in future EU policy initiatives.**

From our standpoint, the aims to be achieved by the Strategy are clear. Governments' overreliance on informal care and the social inequalities it produces must be addressed as a matter of urgency. But caregiving cannot only be considered as a hurdle to a productive life, professionally and economically speaking. It should also be approached as an intrinsic part of the human experience and an expression of (intergenerational) solidarity and social cohesion that should be valued and nurtured. In President von der Leyen's own words, "caring [...] is the most precious time of all".

It is therefore imperative for EU member states to alleviate their reliance on informal carers while recognising and supporting the central role they play, provided that the latter is based on choice and free will (i.e. not dictated by necessity). People should have the right to choose whether they want to be – and remain - a carer, and to what extent they want to be involved in caregiving. In contrast, people who do NOT want – or are not able - to be involved in the provision of care to their relatives or who simply want to play a limited role in these activities should be able to access affordable professional care alternatives of good quality, and in particular home-care and community-based services. **In other words, informal care should supplement professional care, not the other way round!**

What we expect from the EU Care Strategy

Unpaid care activities have been left out of policy agendas for too long and our "new normal" shows how this omission has limited policy effectiveness across a range of socio-economic areas. Care should be recognised for what it is, a key driver of society's wellbeing, and the distribution of caregiving responsibilities between the family and the State as well as between men and women should be revisited in order to foster equality and equity, to protect carers and care users' freedom of choice and to prevent discrimination for all.

While competence regarding the design and implementation of policies with an impact on the daily life of informal carers largely lies at (sub-)national level, **a wide-ranging EU coordination process can serve to develop common approaches, define common targets, monitor progress, foster an exchange of information and good practices and complement national efforts. The idea is not to put the exact same support measures in place across the EU but to encourage all member states to define and implement a policy-mix that satisfactorily meets the needs, expectations and resources of the population,** thereby contributing to common EU objectives on both formal and informal care.

If well designed and resourced, the EU Care Strategy can prove instrumental to a more balanced allocation of caregiving responsibilities between the private and public spheres as well as to achieving EU objectives as regards universal access to (long-term) care, among

others. These two aspects are not only closely intertwined, they are crucial to define a comprehensive answer to the European care challenge.

In practical terms, we expect the EU Care Strategy to:

- **Introduce EU-wide indicators as well as ambitious targets regarding access to long-term care**, along the lines of the Barcelona targets⁶ set in 2002 by the European Council in the field of childcare. Ideally, these should be disaggregated by care setting in order to monitor progress – home, community-based and institutional care. The ongoing efforts by the European Commission and Social Protection Committee to develop EU indicators regarding the quality, accessibility and sustainability of long-term care services can be a good starting point for a reflection process on targets.
- **Define a quality framework for care services** rooted in human rights and focused on people's wishes, dignity and quality of life. **Quality care can be defined in many ways but it should at the very least be Effective** (providing evidence-based care services to those who need them), **Safe** (avoiding harm to people for whom the care is intended); **and People-centred** (providing care that responds to individual preferences, needs and values). The involvement of users and informal carers in the co-production of care is crucial. The conclusions of the WeDo European project regarding the establishment of a quality framework for long-term care services could be used as a starting point⁷.
- **Enhance the development and implementation of integrated community-based and home care services.** The lack of such services is indeed often a root cause of many of the challenges facing member states as regards quality, sustainability and unmet care needs. It is also one of the main predictors of the prevalence of informal care, which – as a result - is too often seen as the default option for the provision of care in Europe. It is therefore essential to boost investment and developments in the community-based care sector, so as to reinforce care options while making care professions more attractive. EU-funded projects on social innovation in long-term care should help to inform the process. The WHO and other stakeholders have also developed guidelines on integrated care which should prevent us from reinventing the wheel⁸.

The development of a more care(r)-friendly policy environment requires a mix of measures in various areas. While access to good-quality professional care services is - and should remain - the foundation of universal access to care in Europe, informal carers should be recognised and treated as partners in care.

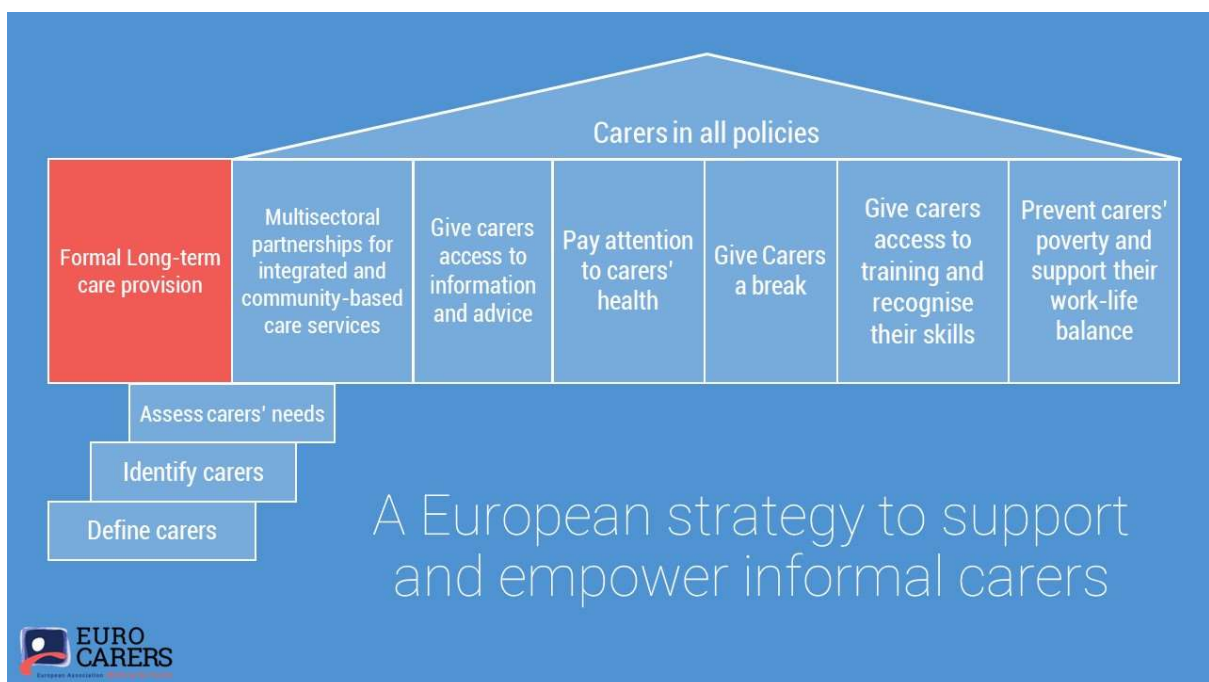
⁶ <https://ec.europa.eu/newsroom/just/items/625317>

⁷ <https://www.age-platform.eu/publications/european-quality-framework-long-term-care-services>

⁸ <https://www.who.int/publications/i/item/9789241550109>

When it comes to informal carers, it is therefore important for the Strategy to:

- Encourage EU member states to **define a legal status for all informal carers**, based on an inclusive definition of informal care (see below), in order to strengthen their ability to promote their best interest as a group. This is not only essential to acknowledge carers' vital role but also to protect them from discrimination. Eurocarers' proposal for an EU Strategy on Carers⁹, re-introduced in 2018, via the European Parliament's interest group on carers, provides ample details on the various dimensions that should be explored through policy and practice in order to support carers effectively and holistically.



- **This legal recognition of informal carers should give them access to a set of rights** (e.g. access to social protection, financial support, pension, respite care, information and training), which have also been described at length in our proposal for an EU Strategy on informal carers¹⁰. In addition, Eurocarers' contribution to the consultation on the Social Pillar Action Plan presents various practical and positive examples of how the social rights of informal carers can be enhanced¹¹. Finally, the legal recognition of informal carers should **be accompanied by a series of obligations** to be co-defined with informal carers themselves or organisations representing them (as regards training and minimal care skills to be acquired or care quality criteria, for instance).

⁹ <https://eurocarers.org/publications/enabling-carers-to-care-explained/>

¹⁰ <https://eurocarers.org/publications/enabling-carers-to-care-explained/>

¹¹ <https://eurocarers.org/publications/enhancing-the-rights-of-informal-carers/>

STEP 1 - DEFINE INFORMAL CARE(RS)

Our annual review of member states' legislation shows that the concept of informal care(r) is rarely explicitly defined in the law. When a definition exists, it often fails to overcome traditional boundaries by focusing exclusively on next of kins or cohabitants, thereby ignoring the contribution of the broader community (e.g. friends and neighbours). As a result, informal carers still constitute an invisible and unprotected long-term care workforce with no – or limited - rights (and obligations).

We therefore call on the EC and member states to take the opportunity of the EU Care Strategy to introduce a broad and inclusive definition of informal care and carers for transposition at national level. The definition used in the Belgian¹², French¹³ or German¹⁴ legislations could serve as an inspiration for this. To some extent, it could be argued that the transposition of the EU Directive on Work-Life Balance for parents and carers, which introduced the legal concept of 'informal care'¹⁵, nicely paves the way for the development of a legal framework across member states (see STEP 9). It should nevertheless be mentioned that the definition used in the Directive is still far from perfect since it overlooks carers who are not in employment, are self-employed or have atypical working conditions.

STEP 2 - IDENTIFY CARERS

Most carers do not immediately perceive themselves as such and often prefer to consider their caregiving tasks in relation to the care recipient. There is also a widespread view that caring for someone, particularly a family member, is just 'a natural thing to do' - that is until it has detrimental effects on the people involved in the caregiving relationship and society as a whole.

Collecting comparable data about the prevalence of informal care and the situation of carers (in terms of gender equality, negative health impact, loss of income, etc.) **is therefore essential.** The available EU data on care and caring is too limited and does not allow to draw a full picture of the situation. It also affects the ability to devise effective policy initiatives and support measures.

For instance, only a (limited) number of national/regional public authorities have introduced questions about care and caring in their population surveys. When these questions do exist, they tend to capture only partially carers' experience. In this regard, the question that concerns the number of hours of informal care or assistance provided per week in the European Health

¹² https://etaamb.openjustice.be/fr/arrete-royal-du-16-juin-2020_n2020202727.html

¹³ [LOI n° 2015-1776 du 28 décembre 2015 relative à l'adaptation de la société au vieillissement](#)

¹⁴ See social law XI §19 - https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=41168&p_lang=en

¹⁵ According to the Directive, "Carers' leave means leave from work in order to provide personal care or support to a relative or a person living in the same household in need of significant care or support due to a serious medical reason, as defined by Member States. Carer means a worker providing personal care or support to the persons referred to in point above."

Interview survey (EHIS) is a good example. It is indeed based on multiple choices, with banded hours – less than 10 hours / 10 – 20 hours / 20+ hours per week – which is problematic for

various reasons. First of all, the upper limit of 20+ years does not reflect the reality of full-time intensive caregiving which is often considered 24/7 and therefore greatly undermines the value of this question. Secondly, these bands of hours also mean that it is much more difficult to calculate the replacement value of care based on the average weekly hours of care.

STEP 3 - ASSESSING THE NEEDS OF CARERS

Steps should be taken to put in place and – when in existence – enhance the uptake and quality of needs assessments targeted at carers. These allow to define the tasks that carers are prepared to take upon themselves as well as the support required to do this in good conditions for themselves and the care user. The assessment looks at how caring affects the carer's life, including for example, physical, mental and emotional needs, and whether the carer is able or willing to carry on caring.

Here, (primary) care professionals could be better equipped to identify, identify the needs and cooperate with carers. 'Carer-aware' care professionals indeed play an important signposting role in the implementation of carer support measures. In this area, quite a few promising practices exist across Europe or elsewhere, which should be documented and transferred. These include care services where a carer champion (i.e. a professional equipped to interact with informal carers and understand their needs) is clearly identified or where carer registers exist; fast referral systems to social care (also known as social prescribing - i.e. means of enabling health professionals to refer people to a range of local, non-clinical services); the inclusion of informal carers in the hospital discharge of persons they are caring for, etc. Institutions beyond health and social care such as the police, fire departments, Parish Councils or faith groups could also be involved in this integrated approach.

See NHS Social Prescribing model here:

<https://www.england.nhs.uk/personalisedcare/social-prescribing/#:~:text=Social%20prescribing%20is%20a%20way,for%20practical%20and%20emotional%20support.>

See also the Carers Act (2016) in Scotland which gives all carers rights to an adult carer support plan or young carer statement to identify each carer's personal outcomes and needs for support. This reflects a general **preventative** approach, which also underpins the duty on local authorities to provide information and advice services to carers.

<https://www.gov.scot/publications/carers-scotland-act-2016-implementation-plan-2021-2023-march-2021/pages/2/#:~:text=The%20Act%20gives%20all%20carers,and%20advice%20services%20to%20carers.>

STEP 4 - MULTISECTORAL PARTNERSHIPS FOR INTEGRATED COMMUNITY-BASED CARE SERVICES

As mentioned above, care integration helps to improve outcomes by overcoming fragmentation along the continuum of care. The establishment of **multidisciplinary care teams should be fostered across Europe in order to overcome silos and improve coordination between actors of the care pathway**. Given their central role in the provision of care in Europe, **informal carers (or organisations representing them) should form part of these teams**. For example, Health and Social Care Partnerships in Scotland (which manage community health services and aim to create closer partnerships between health, social care and hospital-based services) also include representatives of local informal carers' organisations.

See Scottish Health and Social Care partnership model, here: <https://hscscotland.scot/>

See also the multi-sectoral theory of change (ToC) workshops piloted as part of the InCARE project (funded under the EaSI programme), which involve a wide range of stakeholders in dialogues on the identification and resolution of the challenges facing LTC services in each project country. By creating a space for conversation and cooperation, these workshops allow to develop a cohesive vision for national policy and LTC service development¹⁶.

STEP 5 - ACCESS TO INFORMATION AND ADVICE

Carers' access to reliable information and advice about care, caring and care-life balance should be ensured. Carers often struggle to access - sometimes basic - information about the condition of the person they care for, the services and support measures available to them and ways of maintaining their own health and wellbeing. Here again, the role of care professionals (and, in particular, the primary care sector) as well as of civil society organisations is important and should be supported. ICT-based solutions offer great potential to give carers access to the information they need.

See examples of support provided by the Carers Finland:

<https://omaishoitajat.fi/omaishoidon-tietopaketti/omaishoidon-neuvonta/>

and by Family carers Ireland: <https://familycarers.ie/carer-supports/help-guidance>.

STEP 6 - CARERS' HEALTH AND PREVENTION OF NEGATIVE HEALTH OUTCOMES

More attention should be paid to carers' health in order to break vicious circles where carers themselves become unwell and in need of care. Caring can impact heavily on a carer's health and wellbeing, when not adequately supported. Access to emotional support (via an NGO or care professional), counselling and training can help to prevent negative health outcomes

¹⁶ See InCARE project's response to the Call for Evidence, and the policy brief on lessons from the comparative analysis of participatory decision-making approaches in LTC system development to be available in June 2022 at:

<https://incare.euro.centre.org/formative-research/#1618318970119-803c362b-ec7d>

among carers. Peer support – including through ICT-based platforms - has also proven very useful for informal carers.

For example, the EU-funded ‘Care4Dem’ project (<https://eurocarers.org/care4dem/>) demonstrated the added value of giving informal carers access to online peer support groups facilitated by trained professionals or experienced carers, with improved carers’ satisfaction with care and a reduced risk of burn-out.

STEP 7 - GIVE CARERS A BREAK

Investments should be made to provide innovative breaks, which are adapted to both the care recipient and their carer(s) and which can be delivered in partnership with the third sector. The provision of short breaks or respite is hugely important to alleviate the care burden and stress.

In this regard, the Scottish Respite model¹⁷ - which connects carers’ organisations with hospitality, tourism and leisure businesses who are willing to donate a break free of charge as well as the French models of home care provision in foster care settings¹⁸ and ‘baluchonnage’¹⁹ (whereby informal carers are able to take a few days off, outside of their home, while being replaced by a care professional available around the clock) should be supported and promoted. Yet, it should be pointed out that carers are often reluctant to take such breaks because of uncertainties about the quality of respite care and financial difficulties.

STEP 8 - TRAINING AND RECOGNITION OF SKILLS

Investment in carer training is important to improve carers’ confidence and enable them to provide better quality care for longer and in better conditions for themselves and the person for whom they care. Yet, training opportunities remain insufficient, inaccessible or irrelevant. Training, especially in core caring skills e.g. manual handling, coping with caring, knowledge of conditions, management and monitoring of complex prescriptions is often seen as essential by carers themselves and yet it is lacking. Training in stress-management techniques is also useful to prevent informal carers’ burn-out. Adequate training and support have a preventative aspect in avoiding or delaying hospital admission and long-term institutional care.

Moreover, **training may also be useful to validate the sometimes very technical skills acquired by carers on the job to prevent their social exclusion and improve their chances of remaining on/re-entering the labour market.** Informal carers indeed tend to gain skills in the

¹⁷ <https://www.sharedcarescotland.org.uk/respitality/>

¹⁸ <https://fnaaf.org/>

¹⁹ <https://baluchonfrance.com/>

areas of personal²⁰ and medical care²¹. They often have to deal with challenging behaviours in the context of demanding care needs (e.g. dementia or other mental illnesses) and therefore acquire important transversal management and communication skills which could be certified.

Our work on the topic so far has allowed to identify four types of training available to carers:

- Professional vocational training that is also open to informal carers who are willing to obtain a formal qualification;
- Training developed by the health sector with the aim of equipping carers with the necessary skills to maintain the health status of a patient discharged at home, as well as their own health (This rarely takes into consideration the actual needs and preferences of carers themselves);
- Training developed by Civil Society Organisations (CSOs) in the continuation of their role as information providers, generally free and open to all carers but on the basis of extremely limited resources (see trainings provided by Family Carers Ireland - <https://familycarers.ie/carer-supports/learning-education> or the Swedish Family Care Competence Centre - <https://www.anhoriga.se/stod-och-kunskap/webbutbildningar/>) ; and
- Training developed by CSOs, specifically targeted at female carers at a disadvantage on the labour market, with the view of improving their situation through certification. Once again, these training programmes are provided with extremely limited resources and are not available in every EU country or region.

It is important to note that existing training pathways, both developed by the health sector and CSOs, rarely include a formal validation process. So, a lot remains to be done to develop training pathways for carers accompanied by certification and formal validation schemes, providing opportunities for carers to engage in recognised training curricula and employment.

STEP 9 – CARERS’ POVERTY AND ACCESS TO AN ACTIVE SOCIAL, PRO AND EDUCATIONAL LIFE

Policies aiming to successfully assist informal carers should include financial support. As the EU seeks to reduce poverty and material deprivation via the introduction of minimum income schemes, the specific situation and needs of informal carers, who often face poverty as a result of their contribution, cannot be overlooked. A range of financial support options should therefore be made available to them - such as minimum incomes schemes, personal care budgets or care allowances, compensation for care-related costs, in addition to better coordinated social benefits, enabling social services and personalised pathways to employment when possible.

²⁰ e.g. bathing, washing, feeding, dressing, continence care, etc.

²¹ e.g. dialyses, management of oxygen/nebulisers, monitoring of blood and insulin levels in the case of diabetes, tracheotomy patient care, blood pressure monitoring, colostomy bag management, administration of medication, diet monitoring, etc.

It is also important to mention that, from a gender equality dimension, the four social policy arrangements identified by the ILO to ensure that women can participate on equal terms with men within an inclusive labour market system include²²:

- (i) **paid leave, which must be paid at a high level to enable continuity of careers and enable the higher earner in the household to take leave**, not just the lower earner;
- (ii) access to affordable professional care provision;
- (iii) flexible work options to allow for two earner households e.g. teleworking, part-time, flexible working time, etc.; and
- (iv) care credits for social protection to reduce the penalties of undertaking unpaid care work.

The Work-Life Balance Directive does partly address the first and third points in this list but as our analysis of the Directive's transposition²³ shows, while the legislation in place in a huge majority of member states already complies with the Directive, existing benefits and entitlements are often provided at a minimal level. It is indeed common for these rights to be defined on the basis of a narrow-focused notion of 'informal care', strict eligibility criteria or the benevolence of employers. Moreover, existing rights continue to favour those carers who have a first-degree relationship with the person in-need of care, who live in the same household or who are employees in the public or private sector (thereby excluding self-employed workers and atypical forms of employment). Finally, access to the carer's leave and flexible working conditions tend to remain problematic for those who provide care to dependent elderly persons, despite the fact that demographic ageing was one of the justifications for the Directive.

On a positive note, some governments have taken measures to extend access to paid carer's leaves (e.g. in Belgium, where a new carer's leave was added to the existing package of support measures already available in September 2020) or to improve the financial compensation of the leave (e.g. in France where, since October 2020, the pre-existing carer leave is now financially compensated, for a maximum of 66 days²⁴).

As listed by the ILO, it is also essential to introduce pension credits for care-related career breaks in occupational pension schemes. As described in the 2021 Pension Adequacy Report, reduced earnings, higher concentration in part-time work and career gaps related to women's caring responsibilities substantially contribute to the gender pension gap. **While it is true that many EU member states provide pension credits to carers (as stated in the SPC report), these rights are often accessible only by working carers benefitting from a carer's leave – which itself is usually available to specific types of informal carers (due to narrow definitions of informal care).** These pension credits should be made accessible to all informal carers, based on an all-inclusive definition, including those who have left the labour market because

²² Closing the gender pay gap: A review of the issues, policy mechanisms and international evidence - ILO, 2015

²³ [Implementation of Work-Life Balance Directive and new Carers' Rights – Where do we stand?](#) October 2020

²⁴ See: <https://solidarites-sante.gouv.fr/affaires-sociales/personnes-agees/droits-et-aides/article/allocation-journaliere-du-proche-aidant>

of their caregiving responsibilities. Generally speaking, benefits that are targeted at informal carers should not only concern people of working age but also address the needs of older and young carers (who are listed as a group at risk in the Child guarantee).

Finally, when it comes to young carers and young adult carers, it is important to ensure that their caring role does not prevent them from enjoying their rights as children or to access education, training or employment. **A key focus should therefore be in promoting a whole-family approach – i.e. a family-led strategy that provides adults and children with the tools they need to set goals together, create plans, and achieve those goals.**

STEP 10 - ADOPT THE CARERS' PERSPECTIVE IN ALL RELEVANT POLICIES

As a rule of thumb, the perspective of carers should be systematically considered in all policies that may affect them at international, national and regional level. Besides, no policy or practice relevant to the daily life of informal carers should be developed without them. Organisations voicing their interests and needs at local and national should therefore be supported, and invited to participate in the design of long-term care policies and services.

The way forward

To ensure that the EU Care Strategy delivers concrete results, it should be treated as a prominent priority at all levels and appropriate means should be mobilised.

In particular, the European Commission should ensure that:

- The Care Strategy is mainstreamed in all relevant policy areas beyond Employment, Social Affairs and Inclusion, including Health, Gender Equality, Disability, Research, Anti-discrimination, Digitalisation, Economic Recovery, Sustainable Urban Development, Rural Areas, Migration, Demographic Ageing;
- An ad-hoc transversal coordination mechanism is put in place across EC services in order to ensure that the various initiatives that are being developed and that have a bearing on care and caring are underpinned by a consistent vision;
- A regular review of progress is organised, for example through an annual event centred on a dialogue with all stakeholders;
- Meaningful participation of all stakeholders, including informal carers, is ensured at all stages of the design, implementation and evaluation of the Strategy.
- Adequate EU funding is geared towards the objectives of the Strategy, including through the Recovery and Resilience Funds, Cohesion policy and Research programmes (Horizon Europe, EaSI, Erasmus+, etc.);
- Awareness raising activities are foreseen, including among others a European Year of Care.



Moreover, the European Parliament should keep an active role in the development and implementation of the Strategy, ensuring that citizen's needs are echoed and that momentum is maintained, building on an ambitious approach.

As mentioned already, **no decisive progress will be achieved without the active mobilisation of member states, who should be encouraged to develop their own strategic plan for Care, in line with the vision agreed upon at EU level.** This roadmap should be defined in collaboration with all relevant stakeholders and should include objectives, funding resources and participatory annual reviews.

It goes without saying that the Eurocarers network will continue to contribute to this debate through evidence-based recommendations for the benefit of all informal carers in Europe in the coming months and years.

For additional information, please contact Stecy Yghemonos, Executive Director at sy@eurocarers.org or Claire Champeix, Policy Officer at cc@eurocarers.org.



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