United Nations Department of Economic and Social Affairs
Division for Social Policy and Development

Expert Group Meeting on Care and Older Persons:
Links to Decent Work, Migration and Gender

Secretariat Building, UNHQ, New York
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Introduction

The United Nations Expert Group Meeting on Care and Older Persons: Links to Decent Work, Migration and Gender was held from 5 to 7 December 2017 at UN Headquarters in New York. The meeting brought together 12 experts from across regions and from a cross disciplinary selection of universities and civil society and intergovernmental organizations over two and a half days.

The issue of care for older persons is garnering growing visibility and attention amidst rapid population ageing. The population of older persons has been on the rise and is further projected to double between now and 2050. This trend is shedding light on the absent or inadequate care systems currently in place in many countries, and the need for swift policy action to not only meet existing care gaps but to also expand the supply and quality of care in line with growing demand. Notably, the General Assembly's Open-ended Working Group on Ageing selected long-term care – as well as palliative care – as one of two areas of concentration for its next session in 2018. One session of the expert group meeting examined this broad issue, focusing on care models and trends and the promotion of high-quality care.

Yet the issue of care for older persons is clearly not a singular one. Rather, it has multiple dimensions, some of which have been examined more than others. Accordingly, the meeting homed in on the specific, intersecting social dimensions of gender, migration and decent work during three of its sessions. It examined unpaid care work, which is usually – and stereotypically – carried out by women family members, the volume of which is intensified where public spending is cut. It also explored paid care work, which is also often performed by women and frequently characterized by low wages and sometimes exploitative conditions. In particular, it addressed the growing relevance of migration to the global supply of care work, which has repercussions for both sending and receiving countries. It also calls attention to the increased vulnerabilities of migrant care workers, who are disproportionately female, regarding decent work and other rights.

Throughout the first four sessions, experts shared their respective research and analysis and discussed one another's findings and experiences, asking key questions and developing conclusions for specific policy action. In analysing these inter-related issues, they focused on the end users of care, who are older persons, while recognizing that the goal of quality care for older persons is intricately connected to decent and fair employment and migration, as well as respect for rights and the principle of non-discrimination. They also stressed that many older persons are in fact caregivers themselves, and additionally, that unpaid care and paid care are inter-related and need to be balanced. For instance, easing an

individual's unpaid care burden may enable their access to a decent job. At the same time, measures can be taken to recognize, value, and create decent conditions for unpaid care.

Overall, the meeting was premised on the following overarching question: how can all older persons have access to affordable and high-quality care if and when needed, while ensuring that all care workers have decent jobs and are valued and supported.

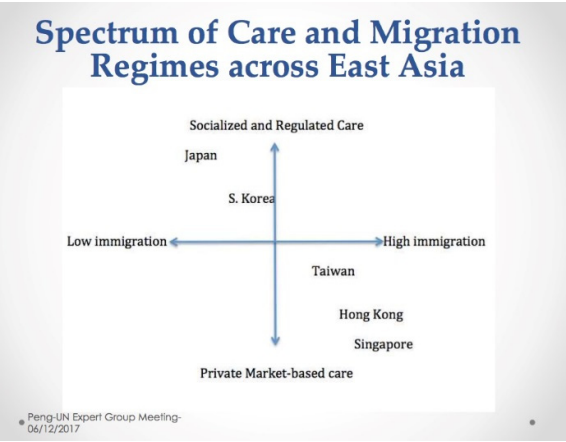
Based on the discussions throughout the first four sessions, the final session was devoted to jointly formulating an agreed set of policy recommendations, which will inform the work of UNDESA's Division for Social Policy and Development.

Session I: Care work and migration

Ms. Ito Peng, professor at the University of Toronto, delivered a presentation entitled "Elderly Care Work and Migration: East and Southeast Asian Contexts". While population ageing is a global phenomenon, nowhere is it more dramatic than in East Asia, where 292 million older persons live today, a number that is expected to increase at a much faster rate than in any other region in the world, to reach an estimated 439 million by 2030. This dramatic increase, coupled with increasing longevity means that many East Asian countries are experiencing dramatic growth in demand for care for older persons, shrinking labour forces, and shortages of care workers. Population ageing and care deficits have become emerging issues on the policy agenda of the East Asia sub-region.

Unlike in the West, where the notion of "independent living" for older persons constitutes an important part of a continuum of care and is considered an affirmation of older people's self-determination, there remains a prevailing familial welfare approach to care for older persons in East Asia, which translates into policies that put a high priority on elder care but also relegates much of it to the family. However, due to socioeconomic changes in recent decades, most East Asian families are no longer able to fully provide elder care on their own, and the outsourcing of elder care to paid caregivers has become an increasingly common practice. Nevertheless, and despite similar shared cultural orientation, East Asia countries have adopted diverse approaches to care and related policies, which in turn have influenced (a) the use of migrant care workers; (b) policies towards foreign workers and their migration patterns; (c) foreign care workers' working conditions and labour protection; and (d) the quality of care provision for older persons. **Figure 1** (below), shows how national and regional policies towards care and migration vary greatly across East Asia, and in turn, directly influence the uses of domestic/care workers and the patterns of migration.

Figure 1



In some high-income Eastern Asia countries, there is growing pressure to use foreign migrant workers. Governments have created special immigration channels for foreign domestic and care workers, as well as subsidies for families to hire them. However, in Japan and South Korea, Long-Term Care Insurance (LTCI) ensures the public provision of a range of care services for older persons, from home care to visiting nurses to institutional care. This has shaped public preferences for long-term care, with the majority of Japanese and Koreans preferring to receive care from their family members first, and then from home-helpers employed through the State (LTCI), and has also deterred the use of live-in domestic care workers in private homes[1]. The formalization of LTCI has also resulted in a highly regulated care work in both countries and discouraged the expansion of private markets for the care for older persons. For example, Japan accepts nurses and care workers from the Philippines, Indonesia and Viet Nam through the Economic Partnership Agreement, which allows them to work up to four years in institutions within the LTCI system. However, these care workers must pass the national license examination to qualify for a longer stay. Passing the license examination grants them long-term residency and employment, and accords them the receipt of similar wages and employment conditions to their Japanese counterparts. On the other hand, with the reform of the Working Visit System (or H-2 visa) in South Korea, ethnic Koreans from China (Chosunjok) are granted free entry and exit, long-term stay and access to a broader range of low-skilled work, including care work.

In contrast, the Governments of Singapore, Hong Kong and Taiwan, Province of China, have created special immigration channels for foreign domestic workers and caregivers. The strong preferences for the use of foreign live-in domestic/care workers and a private market solution to elder care are attributed to several factors including societal norms about families caring for older persons in their homes. This is further reinforced by laws mandating children to look after their ageing parents, as well as tax relief and subsidies for families to hire foreign /care workers. In these countries, foreign live-in domestic workers often engage in a wide range of domestic work, including housework. While foreign domestic workers in Singapore are covered under the Employment of Foreign Manpower Act,

[1] While the term "care workers" is used, we acknowledge that in many cases, domestic workers in the home are also required to work in a care giving capacity.

which grants them a weekly rest day, or compensation in lieu of it, adequate accommodation and meals in the employer's house, and employer-sponsored medical insurance, the lack of Government oversight in employment practices in private markets, and Governments' inability to inspect working conditions of domestic/caregivers in private homes have led to employment legislation violations and human rights abuse concerns.

Different care and migration regimes have implications for the quality of care of older persons, as this quality is greatly dependent on who gives care and how it is given. The implicit quantity-quality trade-off that often exists in care work, which attempts to raise productivity or decrease cost by increasing the caseload of care workers, including within institutional settings, will likely result in lower quality care as well as worker fatigue. Similarly, in the case of foreign live-in domestic workers or caregivers, the isolation and enormous workloads associated with domestic work in addition to care work can also result in a lower quality of care. It is also important to note that the relational aspect of care means that care work is not limited to technical skills in caring but also extends to cultural-linguistic knowledge that would enable care workers to develop trusting relationships with the older persons for whom they care. Foreign migrant care workers may face cultural-linguistic challenges that reduce the quality of care. Moreover, Government regulations have an important impact on the quality of care. In countries where care is regulated, Government regulations on training and certification of care workers, employment conditions, and the system of elder care provision helps set a standard for a basic level of quality of care. In contrast, quality of care work cannot be guaranteed in countries where there is little or no Government regulations on care work, or where care is left to the private market.

In conclusion, Ms. Peng addressed future policy and research implications on care work in East Asia. While many East Asian countries may benefit from the inflow of foreign domestic/care workers from Southeast Asia, this inflow is unlikely to reduce the future demand for elder care, and will intensify the East Asian care dependency on Southeast Asia (China, Korea, Japan and Taiwan, Province of China). This raises concerns about the care drain faced by sending countries as young working-age women out-migrate to work as domestic and care workers in receiving countries, at the same time that these Southeast Asian countries face progressive ageing of their populations, an issue that has not yet been adequately addressed by both the research and policy communities.

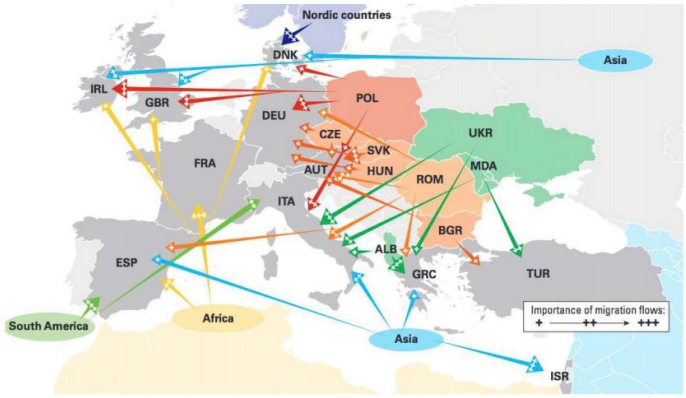
Ms. Agnieszka Sowa-Kofta, Researcher and Expert at the Centre for Social and Economic Research (CASE) delivered a presentation entitled "Central and Eastern European Countries in the Migrant Care Chain". While migration related to care is a phenomenon that has not been fully recognized in the context of public policy in Europe, and especially in Central and Eastern European Countries (CEEC), in recent years, some CEEC European Union (EU) members have become an attractive destination for migrant care workers from other poorer regions. In this context, migrant care work is predominantly a woman's activity, often undeclared, poorly or moderately paid, with migrant care workers having lower economic and social status and typically not enjoying the social protection rights that domestic workers have.

Care migration in Europe is driven by several demand and supply factors. The most important demand factor is the growing need for care work for older persons in high income countries with rising numbers of older persons, where the shortages in nursing and care employment cannot be filled by domestic workers - even if unemployment is present. With inadequate policies and measures aimed at increasing the desirability of care employment and at re-training or increasing the labour participation of women to fulfil the demand for care work, recruitment of care personnel from countries within the EU becomes a practical option. In countries such as Austria, Germany and Italy, generous and unconditional cash benefits granted to older persons with care needs stimulated the employment of low-salaried, family and other non-professional caregivers, and created a politically and socially accepted semi-regulated migrant care sector. While some countries such as Austria, Italy and Spain, have introduced regulations and minimum standards of care in this sector, there has been no clear evidence of improvement in the standards and quality of work. On the other hand, in countries that rely on earmarked cash transfers, such as France and Sweden, paid services are more developed and provided either by domestic workers, or by migrant care workers formally employed in the health and social services sector such as in the United Kingdom.

On the supply side, the main factors contributing to migration are unsatisfactory working conditions and low earnings in health and care professions, high poverty levels, unemployment and inability to find a job in the home country. **Figure 2** below illustrates the origin and destination of care work migration in Europe.

Figure 2

Origin and destination countries in Europe



Source: Rodrigues et al. 2012

The employment of migrants from CEEC in the care sector remains un or under-reported in public statistics within both sending and receiving countries, due to their frequently being non-registered and often in circular and temporary employment in care services in the countries of Northern, Western and Southern Europe. While CEEC are predominantly source countries, those that enjoy higher living standards and incomes per capita – such as the Czech Republic, Hungary, Poland and Slovenia – become a destination

for caregivers from other, mostly non-EU countries such as Belarus, Ukraine or other former Soviet Union countries.

Care migration creates many economic and social problems in sending countries. For example, there is an inability to meet the growing demand for care of older persons in these countries, especially considering the demographic transition in Central and Eastern Europe. This is exacerbated by the inadequate recognition of the care needs of older people within national social policies. Although long-term care is provided at home and in residential care facilities within the health and social sectors, paid services only reach a small proportion of the dependent population, including older people. Challenges also arise from the lack of a comprehensive or even coordinated care system, including adequate funding of care in two-tier health and social care systems, accessibility of care that responds to actual needs, and the standardization of care provided to ensure quality. Assuring adequate employment in the health and social work sector is also a challenge, especially given that the region has a high and increasing share of older workers in that sector. The ageing of care workers is related to the limited attractiveness of the profession, where job earnings and prestige are low, accompanied by a high level of responsibility and numerous obligations.

The care profession is strongly gender biased. Migrant care workers are typically women who often decide to migrate between the ages of 40 and 50 years - when their children are grown-up and before their parents become physically dependent. If a younger mother decides to migrate, often it is the grandparent who undertakes her family responsibilities. With the outflow of caregivers being mostly women, the migrants' families are often better-off financially as higher earnings allow them to contribute to loan payments or building houses, but on the other hand, they are left socially deprived and challenged by limited assistance with older and younger family members in need of care.

In receiving countries, migrant caregivers function in different working conditions. Those employed in the regulated and paid care setting, such as in Sweden and the United Kingdom, are covered by social protection. In countries such as Austria and Germany, where most migrant care work is offered through semi-formal arrangements, such as self-employment or cross-border temporary contracts, employment in care is often without any labour protection, and contracts are typically temporary with earnings below local minimum wage and minimal, if any, coverage by social protection schemes

Ms. Sowa-Kofta concluded by highlighting the main policy issues to be addressed, namely: (a) drawing attention to the challenges of migrant care work in CEEC; (b) the need to discuss the gradually changing role of CEEC (in the migration chain) and the impact of migration care work on the supply of care domestically – both paid and unpaid – as well as on family relations and female roles; (c) formally recognizing migrant care work in most of the European countries including CEEC; and (d) improving the working conditions of migrant caregivers, assuring equal rights with domestic care workers as well as access to social protection.

Ms. Sawsan Abdulrahim, Chair and Associate Professor at the American University of Beirut delivered a presentation entitled "Gender, Migration, and Elder Care in Lebanon". The Arab region is undergoing a youth bulge, and long-term care is not yet seen as a pressing policy issue given the prevailing perception that a vast supply of youth will be the primary source of care for older persons, who are relatively low in numbers. However, this demographic pattern does not apply to all countries in the region, such as Lebanon, Tunisia and Qatar, which are currently experiencing rapid population ageing. In Lebanon, decreased fertility rates, longer life expectancy and high rates of out-migration are key factors in population ageing.

In her presentation, Ms. Abdulrahim drew on two studies. The first is a 2015 quantitative survey that was commissioned by the International Labour Organization (ILO) focusing on providing an evidence base on the practices and perceptions of employers of migrant domestic workers in Lebanon. The study addressed the critical role of employers in recruiting and managing the employment relationship within the current normative framework of Lebanon. The second is a qualitative study that is currently ongoing, in which 17 out of 29 in-depth interviews were completed to date, specifically focusing on caregiving for older persons by family and immigrant women, and addressing the responsibilities of caregivers, the caregiving burden, as well as expectations and views of care recipients.

In contrast to countries like Egypt and Jordan, the proportion of those aged over 65 years in Lebanon is currently estimated at approximately 10 per cent of the population. The most recent research shows that more women live alone in old age compared to men; 18 per cent and 7 per cent respectively. The 2016 ILO publication "Intertwined – A Study of Employers of Migrant Domestic Workers in Lebanon"[2] highlighted the culturally gendered responsibilities of caring for older persons. Despite the increasing number of nursing homes, the family continues to be seen as the main source of caregiving in later life and is romanticized as a deeply rooted religious and cultural obligation. The notion of placing an older person in a nursing home remains a stigma in the Arab culture, to the extent that referring to nursing homes as "hospitals" has served as a cover for families to consider placing an older person there for "medical" reasons. Moreover, the out-migration of youth for economic reasons and the consequent unsustainable model of family caregiving in the context of extremely weak policies to protect older persons are additional determinants of the use of migrant care for older persons in Lebanon. Against this backdrop, 1 in 5 Lebanese households hires a live-in migrant domestic worker, from countries such as Ethiopia, the Philippines and Sri Lanka, to provide various services including cleaning, cooking, caring for children, caring for a sick or family member with a disability, or caring for an older person. This arrangement presents a more cost-effective alternative to nursing homes and enables older persons to age in place.

Ms. Abdulrahim concluded by noting that there are two legal frameworks that cover care work in Lebanon. The first is a sponsorship system called "kafalah" that governs care work, under which a migrant care worker's legal status is linked to one employer and may not be terminated unilaterally, even in situations of abuse or non-payment. This sponsorship

[2] *Intertwined - A study of employers of migrant domestic workers in Lebanon*/International Labour Office, Fundamental Principles and Rights at Work (FUNDAMENTALS); Labour Migration Branch (MIGRANT) - Geneva: ILO, 2016

scheme constitutes a violation of the ILO Domestic Workers Convention of 2011 (No. 189) and other relevant labour standards. Moreover, migrant domestic workers are excluded from local labour legislation as well as social protection in Lebanon. The second is a standard legally-binding contract of employment, developed by the Ministry of Labour in collaboration with human rights organizations, that sets out the rights and obligations of migrant domestic workers. While the contract has provisions outlining rights such as payments and restrictions on work hours per day, it does not, however, address issues of fair compensation (there is no explicit use of the word "salary"), the right to free movement, the right to a private bedroom, the right to a full day of rest, and the right for migrant domestic workers to hold onto their identification documents, including passports. The latter continues to be a social norm perpetuated among families and reinforced by recruitment agencies, although it is not part of any legal contract. More than 90 per cent of families retain the passports of migrant domestic workers in Lebanon. Furthermore, domestic care workers are not covered by the national minimal wage, with the majority earning less than USD300 per month. Migrant domestic workers providing care for older persons tend to earn even less.

In the discussions that followed the presentations, the participants highlighted the following key points:

- In all regions, migration and care work have moved beyond simply meeting care deficits, to creating a global system of deepening interdependencies between sending and receiving countries.

- There is a need for policymakers to discuss the responsibilities of both host and sending countries regarding the well-being of migrant caregivers as they age, including the provision of and access to adequate social protection and healthcare services.

- There is a need for policymakers to identify the challenges that restrict the portability of social security rights, for example between EU law and national law, including the transferability of occupational pensions, housing benefits, and children's allowances to ensure that migrant care workers can preserve benefits and build up sufficient pensions by the end of their careers.

- International dialogue on migrant care workers should not neglect internal migrants, who constitute a significant number of domestic care workers for older persons in countries such as China, Iran and Turkey. Trade unions are key stakeholders and should play a role in promoting decent working conditions and protecting the rights of internal migrant care workers.

- A key prerequisite to protecting the rights of migrant care workers is the recognition of migrant care work as legitimate standard employment.

- Without intervention, the demand for migrant care workers is likely to be a dive to the bottom regarding migrants' rights. Informality means cheaper labour, and migrant care workers may be willing to accept wages and working conditions significantly lower/worse than those mandated by local laws and international norms.

- Circular migration is increasingly dominating policy discussions, especially as returning migrant care workers set up care services based on models of receiving countries, which may not be applicable or suitable to the local context.

- Policymakers must better manage labour migration to protect migrant care workers from human trafficking. For example, in the Caribbean, there is no certification in place that permits domestic workers or their family members free movement within the CARICOM Single Market Economy, as opposed to other workers such as nurses who may have academic certificates. Many migrant care workers are subjected to forced labour.

- Sex/gender, race/ethnicity and culture contribute to the construction of the perception of an ideal care worker for older persons. However, it is also important to explore the role of intermediary operators in this process in shaping the perception and flow of migrant care workers.

- Long-term care work is a skill that requires training. However, it is important to strike a fair balance between training and certification requirements on the one hand, and the unintentional exclusion of migrant care workers who may not have been able to afford the training on the other hand.

- Addressing sexual harassment is essential when discussing care work. There is a need to better understand and protect both the care recipients as well as the migrant domestic care workers from inappropriate sexual behavior and other types of elder abuse, which continue to be a challenge in regulated and unregulated settings.

- Older persons in receipt of care continue to face a variety of serious violations to their human dignity, including rough physical treatment, neglect, sexual exploitation and financial abuse. On the other hand, migrant care workers themselves are subject to expressions of prejudice, ill-treatment and violence, or even hostility from older persons in their care. There is therefore a need for policymakers to reconcile the rights of both caregivers and older persons in receipt of care to ensure that their human rights are equally protected and upheld.

- Education initiatives are important to address and alleviate the cultural disconnect exhibited in the day-to-day personal care between migrant care workers and older persons.

Session II: Unpaid care work

Ms. Shahra Razavi from UN Women presented on "Long-term care for older people: the role of unpaid care work". She opened her presentation by noting that life expectancy has increased significantly, rising by 3.6 years just between 2000-2005 and 2010-2015. In 2015, more than half of persons aged 75 years and older lived in developing regions, where the relative weight of older persons is lower than in developed regions. She presented a "care dependency ratio" for this age group (75+) over potential caregivers aged 15 to 64 years across major world regions. The ratios in East Asia and the Pacific, the Middle East and North Africa, South Asia, and sub-Saharan Africa are similar and lower than those in Latin America and the Caribbean, Central and Eastern Europe and Central Asia, and developed countries, which also have higher ranges. In contrast, care dependency ratios for the 0-6 age group across regions have an inverse pattern, (being higher for most developing regions than in CEECA and 'Developed' countries). These ratios may help shed light on the reasons for which the challenge of long-term care in lower- and middle-income countries may not be high on the agendas of policymakers. However, by 2050, older persons aged 60 and over are projected to comprise around one quarter of the population of all global regions except Africa.

Against this backdrop, Ms. Razavi called attention to the current social arrangements for long-term care and related policy challenges. She noted particularly that women are both the main stakeholders in the provision of long-term care, as well as most of its beneficiaries. She focused on four main points regarding: conceptual issues; the role of unpaid care work in the "care diamond"; methodological challenges; and what we know about unpaid care work.

The "care diamond" is a term that depicts the institutional framework of care, comprised of the market (for-profit service providers along a spectrum), the State (e.g. care homes for older persons run by municipalities), the non-for-profit sector (e.g. community hospices) and families. The term conveys the interdependent relationships among these institutions and the tensions therein. Where one is constrained, for example by State austerity measures, the pressure on the others is intensified and, in some cases, care needs may go unattended.

"Unpaid care" entails the provision of both direct – or person-to-person – care (e.g. helping with bathing) and indirect care (e.g. preparing food or cleaning). There is some confusion around the terms "informal" and "unpaid", which are sometimes used interchangeably.

In families, the provision of care is not random; it is universally agreed that carers are women, reflecting a deeply adhered-to social construct. Women devote around three times as much time as do men on unpaid care, though gender inequalities vary across countries. In many developing countries, inequalities are greater. Within countries, care work is particularly influenced by family structure and composition, infrastructure availability (e.g. clean water and health services) and income level and social class. In addition to these factors, the presence of young children in a household also creates more unpaid care need, and women of lower income groups provide more unpaid care.

The important role of families in the provision of care for older persons is reinforced both by social norms and, in some cases, legislation. Several countries have laws that mandate families to provide unpaid care to older persons.

Everywhere, families are still the backbone of unpaid care systems. However, neighbours and friends may contribute to care that is generally provided by spouses, daughters and grandchildren. In Japan and the Republic of Korea, most care for older persons who still live at home is provided by female spouses, children and children's spouses. In the Republic of Korea, care for older men is mostly provided by spouses, while carers of older women are mostly female relatives. Limited time-use data on care for older persons is available for developing countries, but information that does exist largely indicates significant gender inequalities in care provision.

Although time-use surveys have been useful for broadly measuring time spent on unpaid care work, it is difficult to measure care for older persons specifically with them, in part due to coding issues, as well as the lower frequency of such cases, especially compared to care for children. It is easier to measure time spent on child care. Specialists who work on long-term care should engage with those who work on time-use surveys to explore ways to include questions about care for older persons.

However, the living arrangements of older persons can also provide some indirect information about the provision of care. Across countries, older women are more likely than older men to live alone. Although those living alone may receive care and other assistance from persons living in other households (e.g. adult children), living with others does make the exchange of care and other resources more likely (both directed to older persons and from them). Census data harmonized by Integrated Public Use Microdata Series (IPUMS) suggests that among persons aged 80 years and older, 14 per cent of men and 30 per cent of women live alone. Residential patterns in this age group suggest that women across age groups are more likely than men to be providing care, and that women are less likely than men to have someone to care for them in old age.

In high-income European countries, evidence shows that gender inequalities in the provision of unpaid care for older persons are smaller, particularly compared to gender inequalities in the provision of unpaid child care.

Given the importance of families and women in particular, for long-term care, it is critical to have policies that support unpaid caregivers and reduce their care burdens. An interesting study of the Republic of Korea shows that the country's 2008 policy on long-term care insurance has been effective in reducing out-of-pocket payments on long-term care as well as lowering the time burden of unpaid caregivers through improved availability and affordability of home-based care services.

It must be stressed that investment in long-term care services can also be a significant engine of employment growth in the social care sector. However, the key is to achieve quality standards of service for care recipients as well as decent care jobs.

Ms. Razavi concluded her presentation by highlighting the synergies between investments in affordable, accessible and quality long-term care systems and the 2030 Agenda's Sustainable Development Goals. Such investments can contribute to gender-equitable sustainable development by:

- enabling the autonomy and well-being of older persons, among whom women are overrepresented (Target 3.4);
- providing respite for unpaid caregivers, also predominantly women, by shifting some of the responsibility to care workers (Target 5.4)
- giving unpaid caregivers the capacity to maintain their connection to the labour market (Target 8.5)
- creating decent jobs (Target 8.3) in the social care sector by promoting adequate wages, working conditions and training opportunities for a predominantly female workforce that is often also disadvantaged in terms of ethnic, racial and migrant status.

Mr. Peter Lloyd-Sherlock from the University of East Anglia and the Bronfenbrenner Centre for Translational Research at Cornell University presented on "Unpaid family care for older people in low- and middle-income countries". His presentation was premised on the fact that we do not really know the questions that need to be answered. He therefore proposed several key issues. Firstly, was that when family care is unpaid is this the only issue we should be concerned about. Research with unpaid carers shows that other important issues can include limited external support or recognition for this activity.

Alternatives to unpaid care were examined, including the employment of carers by families, which sometimes risks exploitation of care workers, in particular workers who belong to vulnerable groups. There is also the provision of cash benefits for older people/carers, which occurs, for example, in Argentina, Chile and South Africa. However, the Republic of Korea decided against cash benefits in favour of in-kind benefits, in part to try to avoid financial exploitation of older persons. There is also "non-family" care, which includes care in hospitals and residential care homes.

Another key issue proposed was that some women are coerced into taking the role of unpaid carer. Given the current demographic scenario, most women in low- and middle-income countries are not primarily caregivers for older persons. This begs the question of which women have the primary caregiving roles – in other words, how is care allocated among women? Mr. Lloyd-Sherlock shared examples from Mexico and Peru, where less powerful younger female family members were coerced or tricked into unpaid caregiving – often by older women. As another key issue, he noted that the role of unpaid caregiver can exact a heavy toll, as women may not realize at the outset the extent and/or degree of work involved, which is often unsupported and unrecognized, especially in developing countries. He stressed that actions to rectify this can indeed go a long way.

In addition, it was proposed as a key issue that unpaid family carers are not always able to provide good care.

Mr. Lloyd-Sherlock shared promising examples of interventions to support family care. For instance, the 10/66 caregiver intervention initiative of the 1066 Dementia Research Group is aimed at improving dementia care in low- and middle-income countries, applying the principle of "use what there is"; namely family members and community healthcare

workers[3]. The project focuses on caregiver education combined with training, which have been shown to be able to improve caregiver outcomes and to possibly also delay institutionalization and reduce mortality for people living with dementia, and is currently being formally tested in randomized controlled trials in nine countries. He also referred to the EASYCare Project, which aims to extend healthy active life and independence in old age through a targeted approach to the early identification of needs and responses that align with an individual's own priorities. The approach entails a set of tools, including for a multidimensional health assessment and to mobilize information and support, that can be used by practitioners, volunteers and family members, as well as older persons[4].

It is important to stress, however, that we must go beyond piecemeal pilots – and most are just that. What is needed is major, integrated investment in family care, which is also most cost-effective. There must be integrated community-level primary health and social care.

Often, there is little care literacy -- understanding ageing, frailty, etc., what caregiving involves, and how care needs evolve, and knowing how to access appropriate forms of external assistance and how to evaluate the quality of care - as well as what to do if that quality is poor. There is a need for "proactive care literacy".

Supporting family care should be the priority of any long-term care system. It reduces the non-monetary costs that carers face, such as time and freedom. It also empowers carers, reduces the care burden, and improves care outcomes. It does not entail a trade-off between caregivers and recipients.

Mr. Mahmoud Meskoub from Erasmus University Rotterdam presented on "Why unpaid female labour matters: how to use time-use studies to evaluate it". Unpaid care is not accounted for in systems of national accounts. Within households, care goes unnoticed – largely it is women's work. Care is thus invisible, non-monetized and considered to be without value. Valuation – or market valuation of income or expenditure (i.e. value added) – is important, as the domestic sphere (care, production and reproduction of labour) is essential for the market and needs to be valued and visible. The repercussions of the invisibility of unpaid care is seen, for instance, in pension and healthcare coverage, so that unless based on citizenship, access to health and old-age support is provided through the market – e.g. employment, so that women who have not been in formal employment must rely on their husbands for coverage.

Data on OECD and selected developing countries show that time spent on unpaid work is nearly equal to that spent on paid work in most countries. There is a trade-off between paid and unpaid work. The data also show that women do more unpaid work than do men, ranging from around 50 minutes more per day in Denmark to around 300 minutes more in India. In Iran, unpaid work is dominated by women.

How is unpaid work valued? There is the output of the unpaid work, being goods with market value, but detailed information is needed and costly to obtain and assess. There is also the input – mainly time needed to carry out the unpaid work. Time-use studies determine how

[3] https://www.alz.co.uk/1066/resources_caregiver_intervention_rct.php
[4] https://www.easycareacademy.com/en/

much time is spent on unpaid work. Time is valued with a market income or wage, and includes the opportunity costs of unpaid work or the replacement costs (market wage rate) for general workers (all unpaid work) or specialist workers (in cooking, education, care, etc.).

Mr. Meskoub introduced a study in which he looked at the average daily time allocated to core unpaid household activities by housewives in urban areas of Iran (2008-9), and explained his valuation methodology (using the replacement method). He found that the estimated annual monetary value of the activities in 2008 was 26 million United States Dollars, though this is underestimated (as it is limited to married women in urban areas). It represents 7.6 per cent of total gross domestic product (GDP); if all urban and rural women are included, that figure rises to at least 15 per cent. These numbers are in line with studies from other countries. The female to male household work ratio was 4.5, and for persons aged 60 and above, it was 2.8. Women continue to do a significant amount of unpaid work into old age.

In OECD countries (1998-2009), the estimated value of unpaid work (male and female, 15-64 years of age) – using the replacement method – ranged from about 20 per cent of GDP in the Republic of Korea to over 50 per cent in Portugal.

Turning to conclusions and policy implications, Mr. Meskoub urged that unpaid work be made visible in national accounting systems. He noted that the value of unpaid work justifies Islamic tenets of family upkeep and compensation for wives' labour, while stressing the need to support women's rights to income and wealth without discrimination (especially regarding Islamic inheritance laws).

While it is necessary to increase female labour participation rates, this alone may not decrease women's unpaid work; the care burden at home has implications for economies and labour force participation. This highlights the need for social support for care and domestic work, particularly for women, as well as cultural change regarding gender roles. Moreover, women carers get old like everybody else, needing support themselves. Mr. Meskoub concluded his presentation by stating that women have earned their share of GDP – and urged them to claim it.

Ms. Claudia Vinay from UNDP presented on "Women's empowerment, ageing and unpaid care work". Her presentation opened with a range of facts about older women world-wide. Women continue to work and provide unpaid care into old age, yet – compared to older men – they are less likely to receive a pension, receive lower pension benefits, live longer, re-marry less often, are more likely to experience poverty and to live alone, and are thus less economically protected. Often, older women continue to work out of economic necessity. Around 65 per cent of people above retirement age who lack any regular pension are women. Moreover, many pension systems disadvantage women despite their longer life expectancy. Although poverty statistics that are both age- and sex-disaggregated are hard to come by in some regions and to compare, in Europe, for example, 12 per cent of older women live in poverty compared to 16 per cent of older men.

A key message of the presentation was that a life-cycle approach to policy has great value, since social exclusion is compounded over time. Gender-based and intersecting disadvantage accumulates over the life course. A woman's care burden early in life can

influence her educational opportunities and outcomes, which in turn influence her job options and wage potential, all of which can lead to economic insecurity in old age. Other areas of disadvantage, such as discrimination in laws or in hiring practices, are also factors in this process.

Further exploring the links between unpaid care, gender, age and poverty, according to UNDP research (2016 Human Development Report for Latin America and the Caribbean; 18 countries and 6 other case studies), the absence of care services and/or systems and the presence of an older adult in a household can make that household vulnerable to poverty.

The determinants of escaping poverty may differ from those of falling into poverty. In the case of Jamaica in 2009-2010, the probability of an average household transitioning from vulnerability to poverty would decline 14 percentage points (from 31.7 per cent to 18 per cent) if that household had health insurance, all else remaining constant. However, the likelihood of falling back into poverty would rise 10 percentage points with the addition of one person to the household, particularly an older person – who would increase the probability by 14 percentage points. Nonetheless, in some countries, the presence of an older persons in the household does not have a negative effect, perhaps due to the benefit of old age pensions. Family care has many positive dimensions, yet it is not always engaged in by choice and can create or worsen financial pressure and resentment.

Policy responses should take a life-course approach. They should aim to achieve gender equality in education, skills development, employment (recruitment, wages) and retirement regulations. They should also promote financial literacy and inclusion.

There is a need to recognize, redistribute and reduce unpaid care. Greater investment is necessary in social care services to address the care deficit, which would also create employment opportunities for women of all ages. Care must also be recognized as a right – both in terms of provision and receipt. This right calls for a reorganization of care responsibilities and jobs away from the mainly private, family and female spheres. Care should be a collective, public and universal issue involving both men and women. Care responsibilities can be recognized with, for instance, caregiver credits or transfers, which also tend to benefit older women.

Most countries do not provide long-term care protection to the entire population. In many, means-tested programmes providing financial support towards the cost of care services require that one become poor to be eligible. Moreover, there is a shortage of long-term care workers, with informal workers – mostly unpaid female family members – far outnumbering formal paid workers.

Greater participation of other household members in care work can be promoted through measures such as mandatory maternity and paternity leave and the expansion of family leave to include care of those other than children. At the same time, more investment is needed in care infrastructure and in time-use surveys and data. Furthermore, social protection systems should encompass universal pensions, health care/social health insurance, caregiver credits or cash transfers, and maternity benefits for all.

During the discussion that followed the presentations, the experts made the following points:

- Care is a very particular kind of labour for which there is no ideal way of assigning value. The experts debated the importance of including finance ministries in discussions about time-use surveys. On the one hand, finance ministries would be satisfied to see that women are providing free labour. On the other hand, a strong case may be made by stressing that a lack of support to unpaid carers is in fact more expensive than the provision of support (for example, leading to higher rates of hospitalization among people who live alone and either do not receive any care or sub-standard care). In this way, time-use data can be an important advocacy tool. In fact, advocacy based on such surveys was successfully used in Trinidad & Tobago to push the passage of the Counting Unremunerated Work Act, which aimed to count unpaid work as productive work.

- In addition to valuation and advocacy, time-use surveys are also useful for informing policy by revealing who is undertaking unpaid care. It is important to generate more ethnographic work along with time-use work (i.e. qualitative and quantitative research), and to have data disaggregated by age and gender, to guide policies. It is essential to know and understand that it has been invisible and yet has been sustaining our productivity and economies.

- We know that care is valuable, but what should be done about it? Do we pay unpaid carers, provide support to families, monetize care, etc.? Experts' held more positive views about the provision of supportive services than of cash allowances.

- Governments need to see the financial benefit of giving back to those who contribute to society without recognition. For instance, Singapore's Pioneer Generation Package was conceived of as repaying a debt to the older generation; it was well accepted and even eased potential intergenerational conflict. What was needed was to make the case.

- Many assumptions are made regarding unpaid care: that all families are strong and have children; and that all unpaid carers choose to engage in unpaid care. It is assumed that caregiving arises naturally out of affective ties. Yet these scenarios do not always exist. For instance, in some cases there is no family member available to provide care or a family member chooses to work in a remunerated job instead of providing unpaid care. The right not to care must also be respected. Families should have the right to opt out. However, it was argued that if they are supported, they would feel less inclined to do so.

- Experts referred to the importance of intergenerational ties and questioned how to support them through policy action.

- However, some family members undertake care only with the aim of benefitting from pensions or inheritance, which is a major impediment to quality care.

- Experts referred to the increasing role of technology in providing care and reducing unpaid care burdens.

- Experts noted that there is more gender equality in the provision of elder care than of child care, though mainly by spouses. Men tend to give care in the form of assistance with finances and paperwork, while women are more involved in bodily care. No policies were identified that promote men's involvement in elder care apart from the general expansion of family care to include family members other than children. It was noted, however, that some older men do not want women caring for them and so there is some male presence in paid elder care work. Experts agreed on the need to support men as caregivers, and to also avoid reinforcing gender stereotypes in support to caregivers generally.

- Experts addressed multiple burdens experienced by caregivers. For instance, caregivers are often particularly vulnerable when the person for whom they care dies, an issue that is largely unrecognized. In addition, respite from care is often the greatest need experienced by caregivers, yet frequently goes unmet. Overworked carers are at risk of providing poor-quality care.

Session III: Care and decent work

Mr. Borja Arrue Astrain from AGE Platform Europe presented on "Growing demand, precariousness and austerity: the long way to universal and quality long-term care in Europe". Mr. Arrue Astrain began his presentation by highlighting the low levels of public spending on long-term care in the region, which averages just 1.7 per cent of gross domestic product (GDP) and is a barrier for many older persons in need of care from affordable and quality services. At the same time, due to population ageing there is growing demand for long-term care, which projections indicate could lead to a 65 per cent increase in public spending on long-term care, an average of 2.7 per cent GDP by 2060.

Based on available data and widely-shared user experiences, long-term care services are generally insufficient and sometimes of poor quality. Residential care expenses are covered by Governments more extensively than are expenses for care at home, which may give rise to the need for more unpaid care. There is a dearth of comprehensive and comparable data on the quality of long-term care (as opposed to the quality of health care), with just a few countries monitoring quality on a systematic basis.

Care work in the region is characterized by precarious work, which is linked to weak public spending and inadequate social protection that put pressure on services. The field is under-professionalized, with inadequate training for care workers, particularly on the rights and dignity of care recipients. Moreover, there is little recognition by society of the importance of long-term care professionals and services in general, likely due in part to ageist views. All these factors also negatively impact the quality of services.

Long-term care is widely considered to be an unattractive field of employment. Many are deterred by long and undesirable work hours, low pay, lack of recognition, and few opportunities to advance skills, which also result in low retention rates. In countries of the Organization for Economic Cooperation and Development (OECD), around 70 per cent of the formal care labour force are personal care workers, for whom, in some countries, no standard or minimum qualifications are required. Accordingly, long-term care jobs tend to be filled by members of those social groups which experience the greatest vulnerability and discrimination, particularly migrants and middle-aged and older women. Low investment in care workers contributes to the perpetuation of inadequate care practices that overlook the dignity of care recipients and can lead to neglect and abuse.

A research project on residential care homes for older persons in six countries found that the enjoyment of most human rights related to care by residents was at risk because of both a lack of awareness of human rights obligations and poor working conditions – that is, issues regarding qualifications, motivation and overburdening. "Discontent among care workers" was identified as a contributing factor in some cases[5].

There have been efforts to try to shift the culture of care to respect the rights of care users and improve care quality, including to prevent neglect and abuse and address ageism. The European Charter of the rights and responsibilities of older persons in need of care and assistance (2010) and the European Quality Framework for long-term care services: principles and guidelines for the well-being and dignity of older people in need of care and assistance (2012), two voluntary frameworks developed by a broad range of stakeholders, have resulted in some progress and served to build awareness.

Austerity measures related to the economic and financial crisis of 2007 have exacerbated the precarity of care work and gaps in quality care. Following a period of counter-cyclical policies in 2008-2009, total spending on social protection fell in most countries. For instance, cuts to public spending in Hungary, Portugal, Spain and the United Kingdom amounted to 7-8 per cent of GDP. These extended to long-term care, with Ireland, for instance, implementing a 5 to 8 per cent reduction in disability and long-term care benefits. Users experienced longer waiting lists and a freeze on – or elimination of – entitlements. Many workers saw wage cuts, staff reductions and greater use of short-term contracts, as well as reduced working hours. This came in addition to growing instability in the region's labour market generally due to reforms. In this context, the United Nations Independent Expert on the Effects of Foreign Debt conveyed concern about the impacts of austerity on the health and social welfare entitlements of persons with disabilities, stressing that States "have limited capacity to make 'efficiency gains'" without adversely "affecting the quality, accessibility and affordability of public services".

Evidence shows that inadequate staffing in residential care facilities is a factor in how residents are treated and their enjoyment of autonomy, privacy and freedom of movement. For example, workers at a residential care home who engaged in a historic strike in France in 2017 reported that their poor working conditions led to their treating residents in an undignified manner.

[5] Belgium, Croatia, Germany, Hungary, Lithuania and Romania.

The gradual reduction of long-term care coverage and other effects of austerity measures have forced greater reliance on unpaid carers, mainly female family members who often lack adequate support, and sometimes increases the risk of elder abuse.

In 2013, the European Commission published a Communication on "Social Investment for Growth and Cohesion", creating a regional narrative for formal care services and dignified working conditions. It called on European Union countries to consider long-term care services a social investment and to address the care worker shortage through the provision of incentives and improved working conditions. The Commission also encouraged countries to boost the number of "white jobs" (or "white coat" jobs, related to health and social services) in the care sector, where there is expected to be the greatest potential for job creation, stressing that good working conditions and appropriate skills are essential for high-quality services. In this regard, European trade unions are calling for guaranteed access to training and qualifications and action to boost low wages; recruitment and retention strategies; consideration of employment conditions and care quality standards in public procurement of services; and access to unions (collective bargaining) by all care workers.

Mr. Arrue Astrain concluded his presentation with the following key recommendations: invest in the skills of care professionals; integrate human rights and respect for dignity in training for caregivers; promote societal recognition of the importance of care; improve public procurement processes for care services; enforce a right to quality long-term care; and better monitor the multiple impacts of austerity.

Ms. Thelma Kay, independent expert, presented on "Towards caregiving as decent work". She opened her presentation with an overview of ageing in the Asia-Pacific region. Population ageing is occurring throughout the region, but in waves. In Japan, the Republic of Korea, Singapore, and Hong Kong, Province of China, over 40 per cent of the population will be over aged 60 years and over by 2060. Another group of countries, such as China and Thailand, are rapidly ageing, while a third group are ageing at a slower place. Only in Afghanistan and Timor Leste will less than 10 per cent of the population be comprised of older persons by 2050. As many countries are ageing at a pace that exceeds their economic development, adapting societies to older populations poses a challenge. Other changes are also well underway in the region, including rising numbers of people aged 80 years and older, declining household sizes, family members becoming increasingly mobile and scattered, women increasingly participating in the labour market, older persons living alone in greater numbers, and a rise in chronic non-communicable diseases. These factors, and their interaction, have implications for models of care.

Countries across different levels of development have diverse patterns of care. Care exists on a continuum: primary prevention, primary care, acute care, step-down care/rehabilitation, community/home care, palliative care (with the latter two steps comprising long-term care). There is also a spectrum of health/care workers: formal (such as medical practitioners and paid caregivers), informal (such as family caregivers), multitasking untrained or undertrained domestic workers (some foreign), and volunteers (older persons' associations, self-help groups). Each step along the care continuum corresponds to one or more types of care worker, specialization or setting.

Ms. Kay turned to reviewing the human resources for care work within the context of the Decent Work Agenda. According to the ILO, decent work has four strategic pillars:

employment; standards and fundamental principles and rights at work; social protection; and social dialogue. A framework to measure decent work contains 11 indicators: employment opportunities; adequate earnings and productive work; decent hours; combining work, family and personal life; stability and security of work; equal opportunity and treatment in employment; safe work environment; social security; social dialogue, employers and workers' representation; work that should be abolished (for instance, child and forced labour); economic and social context for decent work.

The ILO has estimated that there is significant health workforce shortages--including more than 18 million health workers in health occupations and more than 31 million workers in non-health occupations--of which the Asia-Pacific region accounts for around 56 to 59 per cent. In particular, there is a shortage in the supply of nurses. Working conditions are also problematic for health workers given the often long working hours, sometimes unsafe conditions, low wages, lack of recognition and respect, and a risk of being replaced by lower-skilled assistive personnel. In turning to responses to these challenges, Ms. Kay illustrated the long-term care human resource development strategy of Singapore's Ministry of Health, which has largely been implemented. It focuses on ensuring adequate staffing through enhanced planning and funding; ensuring competitive pay; increasing capability and skills, including through different types of training opportunities; and increasing efficiency and effectiveness through, inter alia, job redesign and use of technology/innovation.

As a starting point for increasing the supply of care workers, countries should prepare a health human resources landscape study and an overarching plan. Measures undertaken have included increasing the intake of students, which requires adequate training facilities and staff; establishing initiatives to promote career progression and professional development; setting up professional certification conversion programmes; and facilitating returns to nursing. There is also a new trend of seconding staff from acute hospitals to community setting. Basic care assistants are additionally being recruited to free up nurses for clinical work.

Ms. Kay referred to training in the region as a "a big can of worms". Classifications of long-term care work differ across countries, with training programmes varying in content and levels of skills and competencies. Experts have been advocating for national training standards to address fundamental skills and core competencies, including the engagement of occupational certification bodies; a tiered approach to training to foster a career ladder; and regulation or registration of training providers such as vocational schools, hospitals and NGOs. The Philippines, for instance, issues certificates in elder care. Though the feasibility is questionable, there is a move now towards harmonization and standardization of skills. Governments are looking at what other countries are doing to enable the cross-border exchange of skills.

International labour standards provide benchmarks for the working conditions of care workers. At the national level, labour laws and standards govern working conditions, though implementation and enforcement are challenging. There are trends aimed at improving care working hours, such as changes to standard shifts and flexi work.

Large wage variations exist which reflect skill levels, qualifications and education. Job evaluations which cover a job's size and scope are one measure to establish wage levels. The expansion of a job's scope, upgrading of skills and advancement up the career ladder

should lead to higher wage levels. Amidst care worker shortages, there should also be room to leverage global competition for care workers to increase wage levels. In addition, it is important to challenge and address the perception of care work as women's work, which has contributed to its being undervalued.

New technology has the promise to be a game changer in care work, with important implications for efficiency and effectiveness. Through job redesign, it can ease physically-demanding tasks. It is overcoming geographic barriers, expanding access to health and care information and services through e-learning, communication channels, telehealth and telemonitoring, and digital healthcare market places, for instance, while also facilitating collaboration across professions that can improve opportunities and outcomes. However, such technological developments will require training of medical personnel and inclusion in health and care curricula.

Although Governments in the region are improving the coverage of social protection, employment in the informal sector predominates and just 30 per cent of people above retirement age receive a pension. While health workers tend to be covered by social security in the formal sector in Government service, informal workers are rarely covered by schemes. Social protection can be strengthened through guaranteeing the right to coverage in national legislation and exploring innovative financing measures such as sovereign wealth funds or sin taxes.

Caregivers organize in various forms. There are professional bodies and councils, such as for doctors and nurses, which serve as accreditation bodies and negotiate on working conditions. There are also organizations of other healthcare service personnel. Organizations, collectives or networks also exist for domestic workers and for migrant workers, which may connect members for social, protection, and/or advocacy purposes. Patterns of organization are influenced by context, particularly if there is a tradition of collective action in a country. Sometimes, engagement between workers and employers in social dialogue and consultation can be guarded, discouraged or regulated in some settings.

Ms. Kay emphasized that care workers fall along a wide spectrum of jobs. In many cases, high-skilled jobs in the region--at the top end of the spectrum--can meet the criteria for decent work across the 4 pillars of the Decent Work Agenda. However, most care jobs fall short. This tells us that policy changes and multi stakeholder support are needed to transform care work into decent work.

Ms. Ida Le Blanc of the National Union of Domestic Employees of Trinidad and Tobago presented on "Preparing caregivers for the future of work". She shared that the Union has worked for more than two decades on behalf of domestic workers nationally, regionally and internationally. Its members are men and women who work as caregivers as well as housekeepers and cleaners, cooks, gardeners and other low-income workers in the informal sector. The Union represents members in workplace disputes, and facilitates organizing, negotiation, advocacy as well as training and education programmes for them and their families, with the aim of ensuring that workers in the country and region can secure decent work and an improved quality of life. It seeks recognition for domestic workers as workers

under the Industrial Relations Act; in Trinidad and Tobago, an individual is only classified as a "worker" when s/he works outside a home.

The Union disseminates outreach information to build awareness of domestic workers' rights and their employers' responsibilities and organizes talks by Government officials and representatives of the International Labour Organization (ILO) on issues such as social protection and wages as well as on resources and programmes. It partnered with the trade union movement and a network of non-governmental organizations (NGOs) by hosting International Women's Day to give attention to domestic workers and provided a shadow report to the Committee on the Elimination of Discrimination Against Women (CEDAW). Additionally, it has won court cases for domestic workers whose rights under minimum wage and maternity protection legislation have been violated.

Many members provide care to older persons either in private homes or residential care facilities, either directly or as subsidized employees of a Government-managed assistance programme. They may be referred to as nurses' aides, geriatric workers, companions, or "helpers" (rather than workers). Older persons who require care services are categorized either as bedridden and unable to take care of themselves, or as able to care for themselves physically but requiring care for their social needs, such as meal preparation or assistance with medication. The first category involves more skilled and physical work, requires certain training, and often is conducted through shift work. In Trinidad and Tobago, people over 65 years of age who fall below a certain income threshold can claim a pension and placement in a residential facility; many would otherwise be unable to afford housing and care.

Mobilizing workers is not easy. However, when it comes to unionization, there is no difference among low-income workers – they all have in common a fear of losing their jobs and wages, while also fearing that their employers will know that they have joined a union. When workers are dismissed, they have no recourse. In addition, these workers receive low wages that do not match their skills. Many must work overtime to meet their needs. When workers complain about their employers to Government offices, they risk getting fired.

The Union's members (care workers) report abuse committed by care recipients as well as their relatives, some of whom expect care for themselves and other family members as well. Abuse occurs verbally and physically, including with the intent to demean and with racial undertones. In fact, racism is cited as one of the biggest challenges faced by caregivers. Sexual harassment is another major problem which, when committed by the older person being care for, is often shrugged or laughed off. Discrimination is reported based on race, class and gender. For instance, gardeners tend to be men who are paid more and treated better. Many workers endure abuse and discrimination because they fear that they may be unable to find other work.

Domestic workers also face employers who refuse to adhere to the legal minimum wage requirements, inadequate monitoring of labour laws, and employers who fail to comply with the national insurance system – which provides workers social security benefits.

To address such gaps in decent work, and to the provide the public with high-quality and affordable services, the Union established the Service Workers Centre Cooperative. The ILO provided training and management support to the Cooperative, and facilitated the

finalization of an employment contract model through a tripartite process. The Coop, which is run by workers and operated democratically, secures for its members work contracts (some of which can be tailored) that ensure a living wage as well as ongoing training and continuing education. The Coop has helped workers to assert themselves and to confidently negotiate the terms of their employment. It also enables workers to lodge complaints and ensures that dismissals follow an appropriate investigation and have legitimate grounds.

Ms. Le Blanc stressed that the worker-owned cooperative model has the potential to bring together domestic workers to increase their voice and recognition, strengthen their bargaining power, expand their income-generating opportunities, and improve their managerial and entrepreneurial skills. Cooperatives themselves can also offer access to services, such as in the areas of housing and finance. Research suggests that women who are members of cooperatives practice democratic and participatory decision-making and assume leadership roles both in the organization as well as in their communities.

The Union calls for Governments and international agencies to devote greater attention and support to care, including through tackling sexist views on the provision of care within families, subsidizing the provision of high-quality care, and engaging in partnerships to improve and expand training for caregivers (which should cover the psychological and emotional aspects of the work). There is also a need to engage young people in the field of caregiving and to sensitive youth and the public about the ageing process and geriatric care.

The Union will continue to advocate to have domestic workers qualified as workers under the law. Meanwhile, the Cooperative serves to protect, equip and empower domestic workers.

During the discussion that followed the presentations, the experts made the following points:

- The terms “care” and “long-term care” are sometimes used interchangeably but may encompass different things. As one example, some studies lump together health and non-health services while others do not. Ms. Pot of WHO noted that her presentation refers to what each country calls long-term care – which may differ among countries.

- It is a fallacy that a plethora of care services exist across Europe. However, that is the case mainly in Nordic countries and not all countries in the region.

- Experts discussed the Domestic Workers Convention, 2011 (ILO Convention 189), which has been ratified by 24 countries, and debated its practical value. There is a lot of advocacy to push for more ratifications of the Convention, but some countries that have ratified it are not any better off since doing so. In the case of the United States, which has not ratified or signed the Convention, progress is occurring at the State – rather than the federal – level; several States have approved a Domestic Workers’ Bill of Rights. Experts identified a need to elicit more local action. Experts noted that an intersectoral approach to care has worked well in some cases, with multiple ministries collaborating to reduce costs, improve efficiency, and complement one another’s work. However, there can also be contention between/among ministries, particularly when one or more ministries has a budgetary advantage. As a starting point, a Common African Position on Long-term Care was adopted

by the African Union in April 2017, which emphasizes the importance of forming an intersectoral mechanism. The need to ensure a gender lens in long-term care planning was emphasized.

- A crucial first step towards achieving decent work for care workers is recognition that they are indeed workers. This is not the case in many countries and territories.

- Experts discussed the situations of care workers who go abroad for work, as well as those who then return home. In the Asian region, some countries in fact conduct long-term care training for workers prior to their leaving to take jobs elsewhere. Most workers who return home do so as entrepreneurs, with few continuing to work in the care field. The migration of care workers is an issue that is beginning to garner the attention of Governments, as sending countries must consider who will care for their own ageing populations. Governments should also further examine ways to harmonize care training as well as to capitalize on workers with care qualifications who return to their home countries.

- It is essential to address the shortages of nurses. Nursing is central to bridging health care and social care.

- Community-based care is an emerging area, representing an important shift away from acute care. Voluntary work is an important aspect of community-based care, which can be supported through small payments to volunteers by Government programmes.

- Social security rights and portability are key to decent work, particularly for migrant care workers. Among Caribbean Community (CARICOM) countries, for example, pensions can be transferred to home countries.

- All care workers should receive some training and have access to different levels of training. There must also be training standards.

- Attention should be given to ways to make care work attractive to young workers, both male and female. Decent wages are clearly one key component.

- Gaps in decent work affect not only care workers but also their families. There is a need to highlight the intergenerational impacts of non-decent working arrangements and conditions.

- Care and decent work and their linkages must be connected to the Sustainable Development Goals (SDGs), which are already helping to address such issues in an inter-connected way.

- UNDP noted the "MAPS framework" (Mainstreaming, Acceleration and Policy Support) for the 2030 Agenda, adopted by the UN Development Group (UNDG). Though the framework is difficult to translate into practical actions at the country level, it helps with prioritization in each country context. For instance, social protection would be an accelerator. MAPS missions are undertaken to try to align national processes with the international agenda and to support countries in achieving progress in key areas.

- Care can be an accelerator for economic growth. For instance, the EU is looking at care as a win-win situation – an employment generator and an economic growth accelerator. Long-term care is among the fastest growing sectors. We need to frame the discussion as a rethinking of economies.

Session IV: Care for older persons: models, quality and trends

Ms. Anne Margriet Pot, World Health Organization (WHO), delivered a presentation entitled "Healthy Ageing and the need for long-term care systems accessibility, sustainability, quality and ageism". As one of the authors of the 2015 WHO *World Report on Ageing and Health*, Ms. Pot defined ageism as the stereotyping of and discrimination against individuals or groups based on their age. Some of the most important barriers to care for older persons are lingering pervasive misconceptions, attitudes and assumptions. These include references to care dependency ratios, the assumption that families alone can meet the care needs of older persons, and that caring for older people does not need training. Other factors that influence care for older persons are cultural norms and views on the value of family and paid care, the role of women in care, as well as the value of older people themselves. The absence of consensus on terminology used in care remains problematic, such as using terms like informal versus formal care without clarifying if what is meant is, for example paid or unpaid care, organized or unorganized care, trained or untrained caregivers, or regulated or unregulated care work.

Worldwide, the number of older people requiring care and support is rapidly growing. The recently-adopted Global Strategy and Plan of Action on Ageing and Health (2016-2020) renews the commitment to align health systems to the needs and rights of older persons and includes strategic objective 4 on "developing sustainable and equitable systems for providing long-term care (home, communities and institutions)". The objective states that "In the 21st century, every country needs to have a comprehensive system for long-term care". In framing how this could be achieved, the Strategy adopts the definition of long-term care (LTC) used in the *World Report on Ageing and Health*[6] as "The activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity". The Strategy also calls for establishing and continually improving the foundations for a sustainable and equitable LTC system; building workforce capacity and supporting caregivers; as well as ensuring the quality of person-centred and integrated LTC.

LTC focuses on health from the perspective of older people's trajectory of functional ability rather than on a disease they may experience at a single point in time. Among the most common misconceptions about LTC is that older persons lack independence while LTC attempts to stimulate them to do as much as possible themselves. LTC not only focuses on meeting older persons' basic needs for survival, but also on their ability to move around, build and maintain relationships, learn and make decisions as well as contribute to their

[6] WHO, *World Report on Ageing and Health 2015.* Available from http://www.who.int/ageing/events/world-report-2015-launch/en/

communities. Ms. Pot reiterated that older persons have the right and deserve the freedom to realize their continuing aspirations to well-being, meaning and dignity, and a good life, even in the event of significant loss in intrinsic capacity.

The form that LTC takes varies significantly among and within countries. It could be provided in settings that range from an older person's home to community centres, hospitals and care homes. The LTC workforce is comprised of a diverse spectrum of caregivers, ranging from untrained and unpaid family members, friends and volunteers, to paid home-care workers and highly trained professional caregivers. In this context, Ms. Pot provided an overview of the current global situation regarding LTC systems, noting that in many countries, the responsibility often falls on family members, who tend to bear the resulting social and economic costs of care for their older relatives. Other countries, such as Japan and the Netherlands, have adopted new care concepts with a comprehensive set of services and funding sources, including mandatory insurance schemes. However, challenges linger, including accessibility of care, financial sustainability and quality of care. LTC should be a part of universal health coverage for older persons, which is defined by WHO as ensuring that all people have access to needed health services without the risk of financial hardship associated with accessing those services.

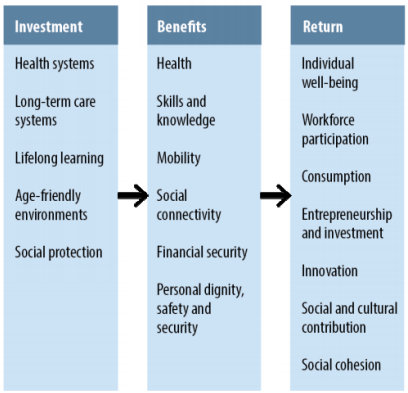
Shrinking family sizes, growing out-migration among younger generations and increased aspirations of women to undertake other economic and social roles leave many older persons without the family members they would have relied on for care. There is a need to further engage a wider range of family members and the wider community able to contribute to the care of older persons, including males, non-family members, volunteers, young retirees and peers. While there is scope for low- and middle-income countries to develop large-scale networks of community-based LTC volunteers, as in Thailand and Costa Rica,[7] these countries still need to establish LTC systems that are sustainable and equitable.

In most countries, financial sustainability is the focus of discussions on LTC. The European Union projects that current health expenditure levels will double by 2060. There is a need to reset current mindsets about LTC and to highlight its key benefits. The real costs to society are the missed opportunities to foster the functional ability of older persons, and not the expenditures made to foster this ability. Further, there is a need to move away from disease-based curative models towards the provision of integrated care that is oriented around the needs of older people. **Figure 1** (below), shows how healthy ageing is an investment, not a cost.

[7] Bulletin of the World Health Organization (November 2017). *Volunteer provision of long-term care for older people in Thailand and Costa Rica*. Available from http://www.who.int/bulletin/volumes/95/11/16-187526.pdf.

Figure 1

***Healthy Ageing* is an investment, not a cost**



Ensuring quality care for older persons could be achieved through supporting unpaid caregivers by providing education, training and respite care, as well as offering cash payments or vouchers. It is important to complement unpaid caregivers' work with additional home-based services for older persons as well as access to a range of services including day-care or even institutional care settings such as nursing homes. Building a paid care workforce also contributes to the quality of care. This could be achieved through increasing pay and benefits, improving working conditions, providing training and career opportunities, appropriate workloads, and flexible work hours, as well as giving care workers the authority to make decisions. Ensuring that the paid care workforce has the skills and knowledge needed is also crucial to enable care workers to practice older person-centred care. This includes ongoing supervision, licensing and accreditation of caregivers and facilities, as well as adhering to national standards of care and care guidelines. There is also a need to invest in improving the image and status of caregiving. This could be realized by reducing negative stereotypes about the role of caregivers and shifting perceptions and values placed on caregiving for older persons.

Ms. Pot noted that WHO recently produced an analytical report on care workers who are largely migrant women and who often work in informal settings in homes. The report is entitled "Women on the Move: Migration, care work and health."[8] It recognizes the growing contributions that migrant women care workers make to public healthcare systems while also underscoring the legal and ethical challenges of relying on that contribution. The report further raises concerns about the health status of the migrant care workers themselves and the care implications for the families they leave behind.

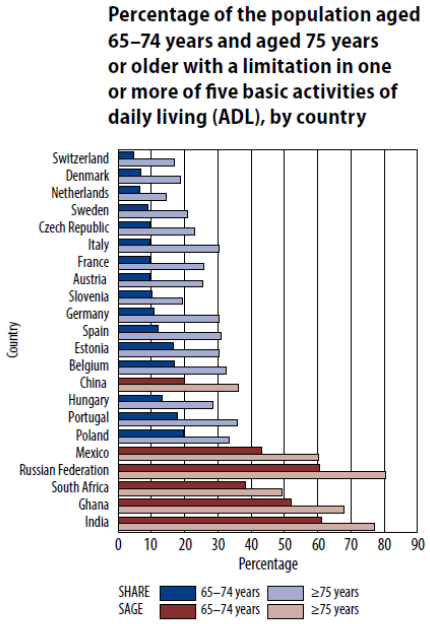
One of the ten priorities for a Decade of Action on Healthy Ageing is laying the foundation for a long-term care system in every country. WHO has carried out a series of

[8] Women on the move: migration, care work and health. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO. Available from http://apps.who.int/iris/bitstream/10665/259463/1/9789241513142-eng.pdf?ua=1.

regional discussions, including in Nairobi and Manila. These discussions have triggered a WHO long-term care series that aims to encourage the development of sustainable and equitable long-term care systems worldwide by sharing regional experiences, including gaps as well as good examples of models of care. The series also provides guidance on key LTC issues including financing, human resourcing, monitoring and research. In 2017, the series launched its first report entitled "Towards Long-Term-Care Systems in sub-Saharan Africa".[9] Despite progress in the region, there remains a lack of focused work on LTC, reflecting low policy and political priority given to the issue in the region.

In conclusion, Ms. Pot noted the importance of developing indicators and mapping LTC as an essential prerequisite for policymakers to frame policy around the issue and inform action on it. Mapping will also offer a baseline reference for comparison and evaluation. **Figure 2** (below) shows the percentage of the population aged 65–74 years and 75+ years with a limitation in one or more of five basic activities of daily living (ADL), by country.[10]

Figure 2



Note: The five basic ADL items included in the analysis were eating, bathing, dressing, getting in and out of bed, and using the toilet.
Sources: (*16*, *34*).

The Figure summarizes information from the Survey of Health, Ageing and Retirement in Europe (SHARE) and the WHO Study on global Ageing and adult health (SAGE) on the prevalence among older people of needing assistance with at least one of five ADLs, namely: eating, bathing, dressing, getting in and out of bed, using the toilet. It shows marked differences among countries and demonstrates the impact of increased age on

[9] Towards long-term care systems in sub-Saharan Africa: WHO series on long-term care. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO. Available from http://www.who.int/ageing/long-term-care/WHO-LTC-series-subsaharan-africa.pdf

[10] Source: Fig 3.20 page 68. WHO, *World Report on Ageing and Health 2015.* Available from http://www.who.int/ageing/events/world-report-2015-launch/en/

undertaking basic activities of daily living. Understanding the situation of older persons will assist policymakers in developing more informed public health responses.

Ms. Isabella Aboderin, African Population and Health Research Center, delivered a presentation entitled "Long-term care for older persons: sub-Saharan African realities". There is already a substantial need for LTC in sub-Saharan Africa, and this need is likely to expand. While the percentage of people aged 60 or over in the region is relatively low (4.5 per cent in 2015), the total number of older persons is high - at 46 million in 2015, a number that is projected to increase to 165 million by 2050. There will be a considerable, and likely growing, prevalence of functional impairment among the older populations, and consequently, a substantial expanding need for LTC.

Ms. Aboderin explored to what extent commitment at the international level, including relevant rights treaties, Sustainable Development Goals 3 and 5, and the WHO Global Strategy on Ageing and Health, translated to regional and national policy architecture in sub-Saharan Africa. At the regional level, under the developmental policy framework, the African Union (AU) Policy Framework and Plan of Action on Ageing was adopted in 2002. Later, under a rights-based framework, the AU adopted a Protocol on the Rights of Older People in 2016. However, to date, the Protocol has neither been ratified nor entered into force. At the national level, countries have adopted policies on ageing, and several Governments have referred to older persons in their constitutions and legislation. Within this context, care for older persons has been provided within family settings, with women dominating the provision of care. In terms of access to care by family members, non-negligible gaps exist, with recent literature suggesting the complete absence of family caregivers in some contexts (around 19 per cent in southwest Nigeria[11]) and temporary absence in others. In terms of quality, there are complexities and ambiguities around the definition of LTC for older persons. The term is a complex construct with multiple dimensions that include content, processes and outcomes. It is person-centred, aims to maximize the role and self-care of older persons, and aspires to ensure the dignity and well-being of older persons and to optimize their intrinsic capacity and maintain their functional ability. However, some of these aspects might contradict cultural scripts in sub-Saharan Africa that speak against it, for example, maximizing self-care. Therefore, considering context-specific issues in LTC is important.

There are large gaps in the availability of qualitative studies in sub-Saharan Africa on care of older persons. Available studies have been inconsistent, lacked consideration of older persons' wishes, and focused on abuse of older persons including accusations of witchcraft. Surveys, on the other hand, have looked at various measures as indicators of quality of care including: older persons eating alone, lack of access to biomedical care, as well as the level of hygiene as an indicator of neglect. Studies point to experienced loss of dignity, depression, declining functional autonomy, and death. The literature suggests that quality gaps are more pronounced in contexts of poverty, leading to the family care "dilemma" of whether to neglect one's own economic activities and opportunities and obligation to one's offspring to support older kin, or to neglect older kin care and fulfil one's obligations to one's offspring. Ms. Aboderin cautioned against referring to "trends" in care within the sub-Saharan African context given the weak empirical basis, and to instead refer to the "common view" that

[11] Gureje et al. 2006.

family care is declining with social change that is presumably driven by: rural-urban migration, female labour force participation, morbidity and mortality caused by HIV and AIDS, as well as the loosening of extended family norms.

The landscape of organized care remains largely undocumented for most of the sub-Saharan Africa region. However, there have been some relatively well-established systems of LTC in Mauritius, Seychelles and South Africa. In other countries, there is a more uncoordinated expansion of care services dominated by two service models: charitable welfare care institutions and private for-profit services. Although expanding, the provision of care thus far remains patchy with wide access gaps. The population groups that typically have access to LTC include the poorest and the most affluent, with limited access for most older persons. Geographically, the services are clustered in urban metropoles, with little access in small towns and rural areas. It was also noted that older persons with special needs, such as those suffering from dementia, continue to have little or no access to care services.

Evidence points to gaps in quality in terms of the delivery of person-centred care; opportunities for purposeful, culturally-relevant activities; maximization of the role and self-care of older persons; promotion of intrinsic capacity; and access to requisite medical care. Deficits in care quality among charitable and welfare services are even greater. Ms. Aboderin noted several underlying operational gaps including reliance on lay agency staff often working as volunteers as well as a lack of qualified staff with geriatrics skills; lack of conducive working conditions for caregivers; lack of standard quality assurance processes; lack of basic amenities, space, hygiene and financial resources; and lack of integration with the provision of medical healthcare services. Nonetheless, there are emerging novel and promising community-based or home-based care models that retain central family involvement, such as those in Ghana, Kenya, South Africa and Tanzania. In terms of care quality regulation, Ms. Aboderin noted that by and large, emphasis in policy architecture within sub-Saharan Africa is on who ought to provide the care. Some policies and bills, such as those in Mauritius and South Africa, do address to some extent quality of care in organized LTC, yet there continues to be a virtual omission of quality organized and, especially, family-based care. There are no formal regulatory mechanisms in countries of the region, except for South Africa, Mauritius and Seychelles, which have some public oversight, standards and monitoring mechanisms that only focus on organized care. Mechanisms to enforce quality standards in these countries are much less developed.

To date, there continues to be a lack of debate over the quality of family and organized LTC in sub-Saharan Africa. Cultural and political scripts that reinforce the notion that family care and respect for older persons is part of Africa's identity are barriers. These support the assumption that there is nothing amiss with family LTC, as well as resistance to considering the provision of organized LTC. There also remains a lack of awareness of the ultimate purpose and aims of LTC, of what quality care encompasses, and of the evidence regarding the extent of care it provides. A third barrier to the lack of debate over care quality is the overriding youth-focus of the population and the development agenda, and the resolve of countries in the region to benefit from the demographic dividend, which marginalizes issues of LTC and renders ageing issues in general of little relevance, if any. Against this backdrop, Ms. Aboderin addressed the relevance of "ageism" and a "rights-based approach" as useful lenses and levers when addressing LTC in sub-Saharan Africa. She asserted that ageism is likely not a main explanatory factor behind LTC quality gaps in the region, as older

persons are favoured in other spheres such as social protection and continue to enjoy priority over younger generations in the context of resource constraints. On the other hand, Ms. Aboderin noted that while a "rights-based approach" is necessary, it is not sufficient to enhance LTC quality in the region. There is an additional need for awareness-raising as well as to pinpoint the relevance of LTC to the broader youth-focused development agenda, for example, by addressing how an organized LTC economy could be a potential source of job creation for African youth.

In conclusion, Ms. Aboderin noted the "Common African Position on Long-Term Care Systems for Africa" and elaborated on some of the points captured in the document, which is considered a statement of direction and which serves as a basis to move the discussion forward. Ms. Aboderin was a key contributor to WHO's report entitled "Towards long-term care systems in sub-Saharan Africa", which provides an overview of LTC across the region and presents recommendations for countries to establish LTC systems.

During the discussion that followed the presentations, the participants highlighted the following key points:

- There is a need to reorient perspectives on LTC from being an economic burden to functioning as an investment.

- It is important to be mindful of how to strategically realign LTC as an investment proposition in youth policies, especially in countries that prioritize taking advantage of the windows of demographic dividends.

- There is a need to raise awareness of how organized LTC offers additional job creation opportunities, reduces barriers for women seeking work, as well as decreases the pressure placed on children who may be coerced into family-based caregiving responsibilities.

- While ageism was not considered the most relevant explanatory factor behind LTC quality gaps in sub-Saharan Africa, pervasive ageist assumptions continue to exist in care provision and are sometimes very subtle in nature and often unrecognized or overlooked.

- Families and family values, in relation to care, are a gendered argument. Women are the majority of family-based caregivers for older persons, and suffer from the stigma that family care is of poor quality. It is important to showcase that families providing care for older persons may be impacted by low income, HIV or AIDS burden, or migration of economically-active family members, all of which contribute to lower quality of care for older persons. There is a need to assess the opportunity cost implications of family care provision, bearing in mind that this form of care cannot be sustainably relied upon.

- Cash-for-care schemes and supplementary care allowances are important steps towards reducing the pressure on families providing care for older persons.

- There is a need to move beyond the dichotomy enshrined in people's thinking as regards "family care" versus "LTC". Raising awareness is key.

- It is important to consider HIV and AIDS care structures that have evolved into models for provision of care to older persons as good examples of models of care.

- There is a cultural framing of care that is evident in the contrast in cultural norms and views between regions that affects older persons' access to care. The related lack of standardization of LTC terminology is problematic. For example: Europe (homes); Lebanon (hospitals); Thailand and Costa Rica (volunteer provision of long-term care). There is therefore a need for international efforts to map cultural terms globally.

- Cultural framing of care should also consider what older persons want. There are older persons who do not wish to be a burden to their families or to be exposed to family tensions, while others feel that receiving care from strangers could be alienating and disengaging. Older persons themselves must be part of the debate.

- It is crucial to ensure that older persons are care-literate, so that they are better prepared to formulate preferences and make decisions about their own care.

Policy recommendations

1. Recognize and embed paid and unpaid care work for older persons, long-term care, as quality and legitimate work in laws, policies and strategies, in line with SDG target 5.4.

- Unpaid care work should be part of a long-term care system, including integrated health and social care and support, aligned with the World Health Organization's global strategy and action plan on ageing and health and other internationally-agreed commitments.

- Reduce the burden of unpaid care work, in particular of women, by promoting the redistribution of care responsibilities and access to respite care, and ensuring affordable access to quality public services and social security support.

- Support the provision of training and support for unpaid caregivers and of education, career opportunities, and equal access thereto, for paid caregivers to improve quality of care.

- Enhance the development, adoption of, and adherence to, accreditation and qualification standards and certification of paid care work.

- Address both age and gender stereotypes of care work and encourage men to join the care economy.

- Distinguish between unpaid care work for older persons and that for children in policies and strategies, including the different support systems that such types of care entail.

- Ensure that mechanisms are in place that provide opportunities to older persons to participate in policy processes regarding care.

- Develop and operationalize the concept of care literacy to promote recognition of the value of care and what it involves, to support caregivers and to improve the quality of care.

- Recognize the synergies as well as differences between the rights and well-being of unpaid care givers and those of care recipients.

2. Recognize and protect the rights of all care workers, including migrant care workers, in line with SDG target 8.8.

- Consider the care economy within the ILO decent work context, including with regards to terms and conditions of care work, wages, protections and benefits.

- Initiate the process of ratification of the ILO Domestic Workers Convention (No. 189), and enhance efforts to enact it locally through laws and regulations that improve migrant domestic workers' labour and social rights.

- Ensure that, at the national and local levels, international and internal migrant domestic workers are accorded the same legal rights – and ability to exercise such rights - and entitlements as the host population, including to formal work arrangements, social protection, healthcare services, family life, organize through trade unions and civil society, among others.

- Adopt proactive policies that tackle xenophobic attitudes towards all migrant workers and acknowledge migrant workers' contributions.

- Regulate sponsorship schemes, including through licensing and certification and standardizing contracts, to help prevent abuse of migrant domestic workers.

- Tailor policies to take account of the different vulnerabilities, including economic and psychological, faced by caregivers when care work comes to an end.

- Foster an enabling environment for and engagement in social dialogue in the field of care, such as through policies which promote workers' organizations, as part of the decent work agenda. [UN addition, based on experts' comments]

3. Develop approaches to reframe long-term care as a positive social and economic investment proposition, in particular through the lens of the care economy.

- Develop a new global policy framework around the long-term care economy, which is expected to see particularly significant growth and to provide a major source of employment expansion. [Partial UN addition]

- At all levels of Government, develop, expand and improve long-term care systems through the framework of the care economy.

- Explore entry points--and make the case--for developing synergy between the youth and ageing agendas, in particular regarding demographic dividends, on the care economy and more broadly.

- Explore and promote older persons' care cooperatives as a model for care delivery

4. Recognize the right to integrated, person-centred care for older persons, long-term care.

- Include the right of older people to long-term care as part of the right to universal health coverage.

- Include long-term care as part of the right of older people to social protection.

- Explore the linkages among poor quality care, gaps in decent work for caregivers, and violence against older persons, especially women, and formulate measures to draw attention to and address such linkages, in particular to protect older persons' rights.

5. Develop cooperation/collaboration among health, social, gender, labour and finance sectors on long-term care policies and programmes across levels of Government and among entities of the United Nations system.

- Governmental ministries/departments should enhance and promote cooperation with and among stakeholders, including civil society organizations.

- Call upon intergovernmental regional bodies to clarify and develop concepts and standards regarding care, especially regarding migrant care workers.

- Improve inter-agency coordination at the United Nations system level on promoting and improving care systems and on strengthening the protection of the rights of care recipients and caregivers.

6. Develop metrics and indicators to monitor progress towards achieving the above goals.

7. Undertake, support and promote research to inform action by all stakeholders on the above goals.

- Develop an evidence base to examine and address common assumptions around the reality of long-term care for older persons, family care, as well as the benefits of quality, accessible and affordable care—from employment generation to gender equality—across resource settings and about both local caregivers and migrant care workers.

- Improve understanding of the magnitude of unpaid care work through evaluation of time spent.

- Improve understanding of unpaid care work by utilizing finer categories in surveys to distinguish it from domestic work

8. Incorporate care for older persons, long-term care, as a focus in mechanisms to implement and monitor the Sustainable Development Goals.

9. Explore and promote ways in which new technologies can support decent care work as well as the autonomy and inclusion of all older persons. [UN addition, building on experts' comments]

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