International Labour Organization

▶ ILO brief

▶ Social Protection Spotlight

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Universal social protection for all carers

A necessity for securing long-term care in the context of population ageing[1]

Key points

The world's population is ageing as an increasing number of countries go through a demographic transition. This phenomenon is emerging more rapidly in low- and middle-income countries than in high-income countries with two out of three older persons today living in low- and middle-income countries. It is projected that this proportion will increase to four out of five older persons by 2050 (UN 2019).

As the world is facing major upheaval owing to climate change, which is likely to impact the health of older persons and their capacity to cope with existing disease burdens, social protection policies need to adopt a life-cycle approach to the prevention of life contingencies that are rarely predictable at the individual level and to secure the protection of older persons when **long-term care (LTC)**, needs arise. An undue burden of care falls on the family, and especially women, whose capacity to maintain autonomy and well-being across the life cycle, including in old age, is undermined. Indeed, while there is no one-size-fits-all solution and countries need to devise solutions appropriate to their own demographic, epidemiologic, socio-economic and cultural contexts, the greater part of LTC is nonetheless provided today by family members. A cycle of impoverishment and gender inequality is hence perpetuated.

In this context, social protection policies need to **secure coverage for all carers along the following orientations:**

- **Support families to provide some of the care across a broader continuum of care complemented by professional services**: this can be achieved, for example, by recognizing spouses as caregivers and putting in place adequate mechanisms such as care credits or benefits for care leave with job protection or any other measure that ensures that caregivers have the flexibility to provide care directly while remaining in the labour force. Additionally, they can be credited for their pension and continue to be covered by social security.
- **Attending to the urgent need to secure decent work, along with social protection coverage, for long-term care workers in the context of population ageing**: this urgency arises from the relatively poor working conditions and social protection coverage gaps that carers experience, which in turn have a detrimental impact on the attractiveness of the sector, global migration dynamics and the overall shortage in health and care worker supply. These elements directly affect the quality of the care that is provided by paid care workers to older persons in need of LTC.

[1] This brief builds on the joint ILO-ISSA working paper Long-term care in the context of population ageing: a rights-based approach to universal coverage (Tessier et al. 2022).

Introduction

The world's population is ageing as an increasing number of countries go through a demographic transition. Fertility rates in many countries are decreasing while mortality rates are declining or stagnating (Wang et al. 2020). This phenomenon is emerging more rapidly in low- and middle-income countries than in high-income countries. Two out of three older persons live in low- and middle-income countries today and it is projected that this proportion will increase to four out of five older persons by 2050 (UN 2019). These changes are occurring in a context of economic and institutional development that tends to be less favourable than when high-income countries began their demographic transition.

In view of such an evolving demographic trend, the ILO Centenary Declaration for the Future of Work, 2019, recognizes the importance of investment in the care economy as a means of achieving gender equality at work. In June 2021, the International Labour Conference (ILC) called Member States and the International Labour Organization (ILO) to consider LTC as an integral part of social protection systems and to invest in the care economy and to support workers with care responsibilities (ILO 2021a). The role of social protection in LTC in the context of population ageing is further discussed in the ILC Report on Decent Work in the Care Economy and it will figure on the agenda of the 112th Session of the International Labour Conference in June 2024 (ILO 2024).

The need for LTC in older persons is determined by both demographic and health status. The demand for LTC services is further influenced by the availability of LTC service providers and the aspiration to equal opportunity and treatment at work of unpaid family workers. While there is ample data on the demographic aspect consistently pointing to ageing, the situation is much vaguer when it comes to obtaining evidence on the health status, functional abilities and intrinsic capacities of older persons worldwide. The data is both scarce and difficult to compare[2]. Nevertheless, the WHO has been able to estimate, based on countries for which data is available, that 142 million persons older than 60 years of age worldwide currently lack the functional ability to meet their own basic needs to dress, take medication and manage money independently (WHO 2021a). This situation is compounded by the inability of many older persons to meet basic needs such as food and housing as they are disproportionally represented among the world's poor (Randel et al. 2017).

Overall, available data suggest that less than a fifth of older persons are concerned by the lack of functional ability to meet their own basic needs to dress, take medication and manage money independently. There is a clear pattern of increased loss of intrinsic capacities with age, especially after the age of 80 (WHO 2021a). Therefore, as longevity progresses, the probability that people will require LTC increases. This trend masks considerable variations, some of which are largely determined by socio-economic and other inequalities. The pattern of increased loss of intrinsic capacities with age is stronger for women than for men, with a widening gap with age (WHO 2021a).

LTC has a noteworthy gender dimension. Women make up the majority of LTC users as well as care providers (both paid and unpaid), making the gender dimension a priority issue for building LTC systems that are rights-based, inclusive and financially and socially sustainable (ILO 2018).

Much of the burden of unpaid care is disproportionately borne by women. Globally, 76.2 per cent of unpaid care work is undertaken by women (ILO 2018). Calculation suggests that if the market-based rate were applied for unpaid care, it would represent 9 per cent of global GDP, which corresponds to US$11 trillion (purchasing power parity 2011) (ILO 2018). Unpaid carers providing many hours of care per week are less likely to engage in employment and more likely to suffer from mental health problems, with women disproportionally affected. When unpaid carers do have a job, it is more likely that it is part-time as combining care and paid work makes a full participation in the labour market difficult, leading to fewer opportunities for promotion and lower salaries. This illustrates that LTC always comes with costs, even if it is provided by family members on an unpaid basis. It is paramount to find ways to share these costs more equitably across society (UN Women 2017).

[2] Three quarters of the world's countries have limited or no comparable data on healthy ageing or on older age groups according to WHO, 2020.

Similarly, the paid care workforce is predominantly made up of women. Around three quarters of people working in health and social care in OECD countries are women, often working in lower-paid jobs (OECD 2020). In the European Union, almost 90 per cent of the LTC workforce are women (European Commission 2021). In the United States, of the approximately 1.5 million of people who were employed in the LTC sector 90 per cent were middle-aged and female and 20 per cent were foreign-born (UN Women 2017).

Working conditions and low pay in LTC provision are common, a factor which contributes to gender gaps in pay and pensions later in life. Hence, addressing the challenges of the LTC workforce would help to tackle gender inequalities in the labour force. How LTC is financed and provided has a major impact on women's ability to live a dignified life while sustaining their participation in the labour force, by helping to reconcile paid employment with unpaid care responsibilities and meeting the rising demand for care. Therefore, it is crucial for social protection systems to:

- Adopt a gender-transformative approach for continuous coverage of unpaid family caregivers and volunteers; and
- Extend adequate social security coverage to all paid health and care workers.

In this way, social protection systems can contribute to care policies that respect the human and labour rights of paid and unpaid caregivers in all care settings and support workers with family responsibilities, in line with ILO Convention No. 111 and Convention No. 156. This spotlight brief explores the current barriers to extending social security coverage to caregivers in light of their diversity of status in employment. It further links the current coverage gaps to the broader decent work deficits in the care economy and their consequences in terms of the quality and continuity of LTC services provided to older persons.

Gender-transformative social protection policies for unpaid family caregivers and volunteers

Unpaid family caregivers

Some 70 countries set a legal obligation for family members to provide LTC to their older relatives when it is needed, thereby limiting collective responsibility for LTC and risk sharing within society (Addati et al. 2022). It is worth noting that some countries also adopt a mixed approach as their family structures and the geographical distribution of their population vary. For example, the traditional Chinese cultural virtue of filial piety makes younger family members primary caregivers for their older relatives (ESCAP 2015). However, owing to the fertility decline (linked to the discontinued one-child policy) and migration from rural to urban areas for employment opportunities by younger cohorts, this traditional model of care has become more difficult to achieve. Thus, some cities, such as Qingdao, have been prompted to explore the possibility of developing LTC insurance (Hong 2021).

While there is no one-size-fits-all solution and countries need to tailor solutions to their own demographic, epidemiologic, socio-economic and cultural contexts, the bulk of LTC is nonetheless provided today by relatives. Unpaid LTC work represents a significant volume of time that cannot otherwise be dedicated to paid employment. In the European Union, while the employment rate of women increased in 2019, 7.8 per cent of women aged 50–65 did not seek employment owing to family responsibilities, compared with 0.8 per cent of men (European Commission 2021). LTC provided by unpaid family members, usually women, compounds a situation where women already perform most of the unpaid work undertaken in the home. This is a statistically significant issue as the time spent by women on unpaid care work represents 4½ hours daily, albeit with significant variations across and within countries (ILO 2018). In turn, this situation impacts the ability of caregivers to remain within or reintegrate into the labour market and thus continue to be covered adequately by social security systems, as illustrated by **box 1**.

▶ Box 1: Women as primary caregivers in Poland

The family is traditionally the main provider of LTC in Poland. People exhibit a significant commitment to care for family members, in particular women. The high index rates of coresidence (older parents residing with their children) and the similarly high percentage of women aged 50 and above not engaged in the labour market are illustrative in this respect. This situation is strongly linked with traditions of family care and the gender division of labour. Coupled with an insufficient supply of public care and a lack of affordable private care, households are left with few alternative solutions or support outside of the family unit.

Source: Hirose and Czepulis-Rutkowska, 2016.

Social protection policies need to support families to provide some of the care across a broader continuum of care complemented by professional services (WHO 2021b). This entails social protection systems becoming gender-transformative as per the principles enunciated in the Social Protection Floors Recommendation, 2012 (No. 202), the ILO Centenary Declaration for the Future of Work and the International Labour Conference (ILC) resolution on Social Protection adopted in June 2021. It is essential to proactively address gender-related contingencies before inequalities become cemented across the life cycle. This can be achieved, for example, by recognizing spouses as caregivers and putting in place adequate mechanisms such as care credits or benefits for care leave with job protection, or any other measure that ensures that caregivers have the flexibility to provide care directly while remaining in the labour force. Additionally, they can be credited for their pension and continue to be covered by social security. Support should be given to family caregivers and tailored solutions found for both those who are engaged in the labour force and those who are not.

Many countries have updated their regulations to allow persons in employment to take care leave (Becker and Reinhard 2018). In this context, social protection systems need to ensure adequate social security entitlements so that unpaid carers are not penalized when they have to interrupt their professional activity to care for a relative. For example, in the United Kingdom, a carer's allowance guarantees financial support of £67.60 per week for family carers who perform care work for more than 35 hours in a week. Similarly, carers who perform unpaid care work for at least 20 hours a week are provided with credits to fill the gap in the record of their National Insurance contributions (The United Kingdom, n.d.). Canada, Finland, France, Germany, Japan and Sweden have adopted similar policies (Fultz 2011). Some countries, such as Germany, include unpaid carers within their social security LTC schemes (see **box 2**). This is a practice that already exists within disability benefits in many countries. Indeed, some disability schemes recognize the costs around care needs, in particular where people living with disability require constant attendance. The constant-attendance supplement is usually added if loss of capacity or functional loss are observed, and care support is required. For example, in Kyrgyzstan, there is a constant-attendance supplement which is paid if the insured requires the constant attendance of others to perform daily functions. A similar benefit is provided in Laos and Rwanda, where a constant-attendance allowance is paid in case the assessed loss of work capacity is at least 81% and the person is receiving care (Laos). In Rwanda, a constant-attendance allowance is paid if the insured requires the constant attendance of others to perform daily functions. A doctor approved or appointed by the Rwanda Social Security Board periodically assesses the disability (ILO 2024). In Mauritius, the Government provides a monthly allowance as well as training for family members giving care to older people experiencing significant declines in capacity (WHO 2017).

▶ **Box 2: Social security for family carers in Germany**

In Germany, unpaid carers providing LTC are covered by social security. They are defined along with other carers in German law (Social Code – Book XI – Social Care – Section 19) as being "people who provide non-professional home care to other people in need of LTC, due to a physical, mental or emotional illness or disability". The LTC insurance scheme has provisions to pay contributions toward statutory pension insurance for caregivers (Wetzstein et al. 2015) and caregivers who provide care for over 14 hours per week are covered under social security (Eurocarers, n.d.). Additionally, unpaid caregivers attending to relatives and who work in companies with over 15 employees are entitled to take care leave of up to ten days and receive a benefit equivalent to 90 per cent of their salary in a situation requiring urgent care. Unpaid leave of up to three months with employment protection and continued social insurance coverage is also available (Eurocarers, n.d.). During the COVID-19 pandemic, recognizing how important it was to facilite family care, the Government raised care leave to 20 days and encouraged access to vocational training for caregivers who wished to go back to work when their care ceased to be required (Eurocarers, n.d.).

Source: (Eurocarers, n.d.; ILO 2022a).

Supporting volunteers

In a number of countries, LTC provision also extends to include some of the care provided by volunteers. This often comes in response to evidence of the effectiveness of community-based volunteers in providing peer support, fostering social integration and cohesion and improving well-being at the community, household and individual levels (Public Health England 2015). The boundaries of volunteer work may be defined very differently in terms of their specific role and the form of activities and care they provide within the continuum of LTC across countries and regions. This further reflects the wide diversity of volunteer work globally (see **box 3**).

Some countries have focused their efforts on providing skills enhancement and psychosocial support for unpaid caregivers (WHO 2021b). For example, Thailand's Home Care Service Volunteers for the Elderly programme fosters volunteering in the community and offers volunteers 18 hours of training. In 2013, there was a total of 51,000 volunteers, individually entitled to receive US$14 per month to cover their travel expenses (Lloyd-Sherlock et al. 2017). In Costa Rica, the Progressive Attention Network for Integral Elder Care, which was established by the National Council for Older People, has set up a body of community-based volunteers distributed across 50 community care networks to support 10,000 older persons identified as being particularly vulnerable to poverty (Lloyd-Sherlock et al. 2017). In Tonga, the Government via the Ministry of Internal Affairs has mobilized volunteers to make home-based visits where they attend specifically to disabled older persons and monitor their diets as diabetes and obesity are endemic among them and increase the risks of functional loss and subsequent demand for care (Carandang 2022). Such efforts as these need to be complemented by measures to ensure the continuity of social protection coverage of caregivers.

▶ **Box 3: Volunteer work**

According to Article 37 of Resolution I: Resolution concerning statistics of work, employment and labour underutilization adopted by the Nineteenth International Conference of Labour Statisticians (October 2013), "Persons in volunteer work are defined as all those of working age who perform unpaid, non-compulsory activities to produce goods or provide services for others. In this context, "unpaid" is interpreted as the absence of remuneration in cash or in kind for work done or hours worked. However, volunteer workers may receive some small form of support or stipend in cash, when below one third of local market wages (for example, for out-of-pocket expenses or to cover living expenses incurred for the activity), or in kind (for example, meals, transportation, symbolic gifts)" (ILO 2013).

While this definition has been internationally agreed upon, its application in practice may greatly vary and some concerns have been raised in the health sector on the over-use of volunteers or their use in contexts that warrant professional remunerated work. Moreover, the 2017 Tripartite Meeting on Improving Employment and Working Conditions in Health Services concluded that "Auxiliary and volunteer workers can also be used to fill the health worker gaps, but regulations are needed to ensure decent work" (ILO 2017).

Articulations with paid care work

Social protection policies therefore need to adopt gender-transformative approaches that allow families to play a role in the continuum of LTC without jeopardizing their social security entitlements and their opportunities for labour market participation. Social protection policies moreover need to support the development of LTC guarantees substantiated by professional LTC services. With women's increased participation in the labour force, there is higher demand for professional LTC services. As women become less available to provide LTC to family members (see **box 4**), there is a need to expand the formal provision of LTC. This, in turn, requires the creation of decent work opportunities and conditions for paid care workers and facilitating the transition from the informal to the formal economy for many of them, as explored in the next section of this brief.

▶ **Box 4: Family care in Asia and the Pacific**

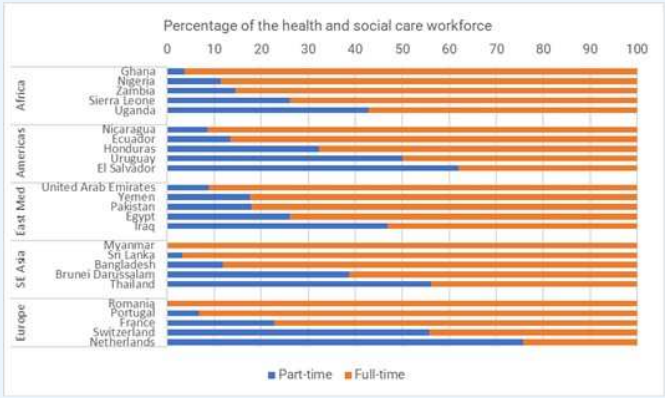
Family care is the default mechanism to ensure LTC for older persons in much of Asia. Some countries – such as China, India, Nepal, Sri Lanka and Viet Nam – have legislation that mandates the family's responsibility to care for older persons. However, in many Asian and the Pacific countries rather than spread the risk across all of society through social protection mechanisms, there is a reliance on unpaid family caregivers, often women. This results in an undue burden on households whose older members have lost their ability to take care of themselves (ILO 2018). To help alleviate that burden, some countries have adopted policies that go some way towards acknowledging the economic significance of the caregiving role, such as through the provision of tax incentives in India, Malaysia and the Philippines. Even when a family is not exposed to financial hardship in the course of caring for their loved ones, it may lack appropriate skills or endure psychosocial distress. To help remedy this situation and support family caregiving, governments in some countries have implemented policies that provide support services, such as counselling in Islamic Republic of Iran, India and Sri Lanka and education and training for paid and unpaid caregivers in China, the Democratic People's Republic of Korea, Fiji, India, Islamic Republic of Iran, Myanmar, Sri Lanka and Viet Nam. Fiji explicitly addresses support for older women caregivers (UNFPA 2017).

Source: ILO 2021b.

Decent working conditions and extension of social security coverage to paid health and care workers

Globally, the care economy is characterized by significant decent work deficits, which can vary considerably depending on the nature of country context, workplace type and cadre of workers (ILO 2022a). The most vulnerable category is personal care workers. They are particularly important in LTC provision, both in institutional settings and in home-based and community care. In high-income countries, they represent more than half of total LTC employment and the majority of them are home-based (ILO 2018), yet salaries are comparatively low and working time patterns with night and broken shifts are more prevalent in home-based care than in other sectors, as illustrated by **figure 1**. Care workers are more likely to experience time spent in being "on call", which all too often is unremunerated (Deutsche Welle 2021).

▶ **Figure 1: Personal care workers' working pattern in selected countries, latest year available.**



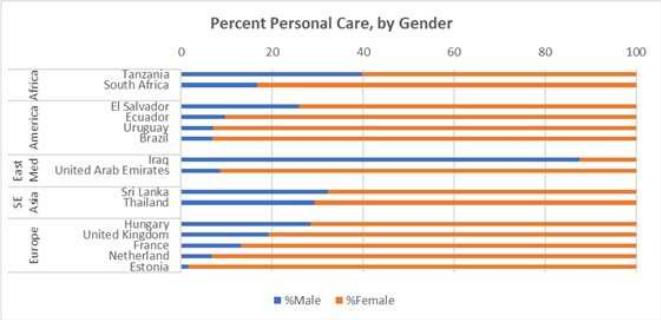
Source: ILO. 2023. What labour force survey data can tell us about the workforce in the health and social care sector.

The isolated nature of work provided in the home can make care workers' environments unsafe, and conflicts of interests between LTC recipients, family members and personal care workers that adversely impact health and safety can arise (ILO 2018). Similarly, the intrinsic nature of the work, if appropriate training and respite is not provided, can also impact care workers' health, such as in the physical exertion needed to support persons with very limited motor capacities or as a result of mental exhaustion resulting from having to care for persons affected by dementia or depression. Owing to inadequate

work contracts and isolation, care workers are at higher risk of experiencing the kind of violence and harassment at work defined in Article 1 of the ILO Violence and Harassment Convention, 2019 (No. 190). This is compounded by the fact that lack of full-time and long-term employment contracts often mean that care workers need to work in multiple facilities or homes in order to make a living. This situation made them particularly vulnerable during the COVID-19 pandemic, where they were at a higher risk of both contracting and transmitting the virus (ILO 2020b).

The paid care workforce is predominantly made up of women. **Figure 2** shows clearly that in almost all the countries featured in it, women are particularly represented among personal care workers, who typically also constitute the majority of formal LTC caregivers. Therefore, the sector is inherently susceptible to the gender discrimination common in labour policies and practices. Indeed, the gender pay gap in the health sector has been found to be over 25 per cent higher than in other sectors (ILO and WHO 2022; WHO 2019).

▶ **Figure 2: Personal care workers[3] by gender, selected countries, latest year available**



Source: ILO. 2023. What labour force survey data can tell us about the workforce in the health and social care sector.

The care workforce is as diverse as the providers across the continuum of care. It is also heterogeneous in terms of skill levels, occupations and employment status. Some LTC workers are licensed health professionals operating in the health sector while others are licensed professionals operating in the social care sector. Further still, many licensed and unlicensed care workers also operate in the home as domestic workers, meaning that they may be subject to different sectoral labour regulations.

Poor working conditions are often compounded by a lack of social security coverage, which in turn is both a source and a consequence of informality.[4] In many countries, care work is to a large extent undertaken alongside domestic work, which is often excluded from social security coverage. The ILO estimates that 61.4 million (81.2 per cent) of all domestic workers are in informal employment – that means eight out of every ten domestic workers, almost twice the share of informal employment of other employees. This impacts their social security coverage. Globally, only half of all domestic workers are legally covered by at least one branch of social security and only 6 per cent of all domestic workers are legally covered for all employment-related benefits. New estimates show the critical discrepancy between legal coverage and the implementation of these laws in practice, which essentially translates into significant gaps in effective coverage. Worldwide, more than 80 per cent of domestic workers are not effectively covered by employment-based social security (ILO 2021d).

Social security coverage needs to be considered within the package of measures that will contribute to facilitating the transition of care workers from the informal economy to the formal economy (see **box 5**). During the COVID-19 pandemic, it came to light that many frontline workers in the health sector, particularly those engaged in temporary, part-time and self-employment and at the lowest end of the skills and wage spectrum, were not themselves benefiting from health and safety measures and were either inadequately covered by social protection or not covered at all (ILO 2020a).

[3] Personal care occupations are in the group 532 under ISCO 08 (and 513 as per former classification ISCO 88) 'Personal Care Workers in Health Services'. These comprise 5,321 (5,132) healthcare assistants, 5,322 (5,133) home-based personal care workers and 5,329 personal care workers in health services, not elsewhere classified.

[4] One of the criteria to identify whether a job is formal or informal is registration for social security. The absence of coverage creates informality.

▶ Box 5: The formalization of care work as a prerequisite for contracting with the social security system in France

"The French Central Agency of Social Security Bodies (Agence centrale des organismes de sécurité sociale – ACOSS), which steers the Social Security and Family Allowance Collection Unions (Union de recouvrement des cotisations de sécurité sociale et d'allocations familiales – URSSAF), has implemented a policy dedicated to the formalization and professionalization of personal care services. The aim is to professionalize and formalize home-help caregiving services, especially for those whose work is associated with aiding older persons to live independently, including domestic workers. Using the 'Dematerialized universal service employment voucher' (CESU+), the process for people to formalize the home help they receive and reduce their tax bill has been simplified.

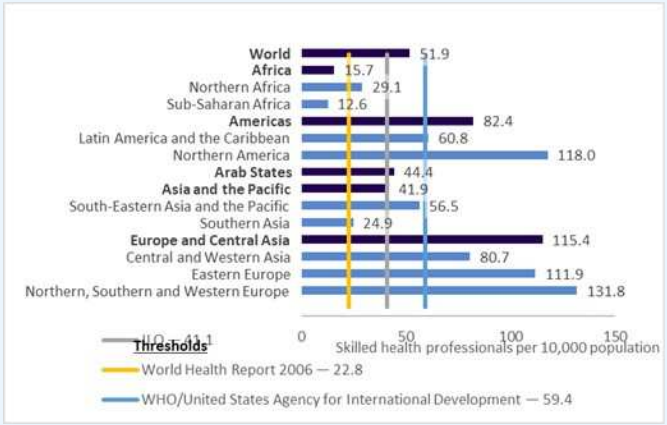
In practice, this entails a simplified online enrolment system, whereby the State bears half of the cost of social security contributions for the caregiver. Similarly, a tax deduction system for part of the caregiver salary has been put in place to support the most vulnerable in need of care. The aim is to ensure the professionalization of home caregiving services and to give those who work in this area formal employment status, with associated rights to social security and professional training."

Source: Social Security and Family Allowance Contribution Collection Network, 2022.

Working conditions and wages are also determined by the marketization and outsourcing of LTC services with the objective of lowering provision costs. Cutbacks in public spending translate into lower prices being paid to LTC providers, with further repercussions on working conditions and wages (ILO 2018). This situation is worsened by the fact that in many countries social protection policies and systems to guarantee access to childcare, healthcare and LTC without hardship are still under development (Scheil-Adlung 2015). With no sustainable mechanism to finance such guarantees, low investments in both formal and informal care provision are widespread.

Poor working conditions and lack of adequate social protection render the health and social care sectors less attractive to workers. The related shortage in health and care workers makes for further impacts on quality of care. Before the outbreak of the COVID-19 pandemic, it was estimated that 17.4 million health workers, comprising approximately 2.6 million doctors, 9 million nurses and midwives and 5.8 million workers from other cadres were needed to attain the SDG health index threshold as of 2013 (ILO 2018). The existing shortage could be further exacerbated by the effects of the COVID-19 pandemic with increased numbers of health workers having left the profession or else declaring their intention to do so on the grounds of dissatisfaction with working conditions and insufficient staffing (International Council of Nurses 2021; WHO 2022). Low- and middle-income countries experience severer shortage than in high-income countries, with a shortfall of 6.9 million in South-Eastern Asia and 4.2 million in Africa (ILO 2018). **Figure 3** illustrates the marked inequalities across regions and subregions with regard to health workforce density. Such inequalities are further reflected in the density of formal LTC workers and residential LTC beds, though the available data is scarce (see **figure 4**).

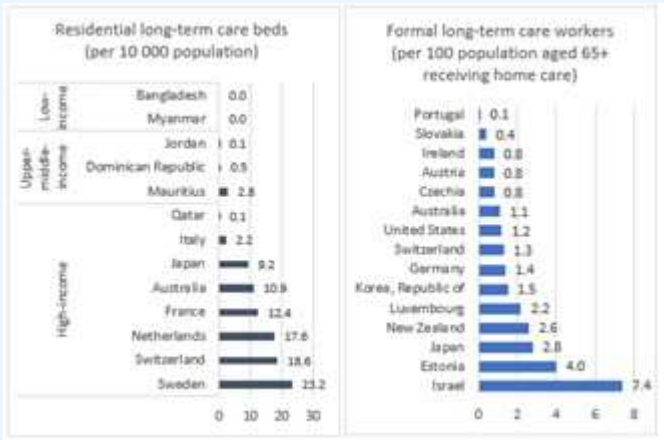
▶ Figure 3: Skilled health staff density against three thresholds across regions[5]



Source: (ILO 2021c).

[5] More details on the use of these reference points can be found at: https://www.who.int/workforcealliance/knowledge/resources/GHWA-a_universal_truth_report.pdf

▶ Figure 4: Inequalities in residential LTC bed density and LTC worker density



Source: WHO World Health Observatory.

This pronounced shortage in countries with fewer resources is partly exacerbated by the globalized labour market for health and social care workers. In many countries, migrant workers in the care economy, whether they are providing care in institutions or in the home, face unique difficulties in having their skills recognized and in gaining access to social security and decent working conditions. Good practices that contribute towards remedying these difficulties include the conclusion of multilateral and bilateral labour and social security agreements, as well as the engagement of actors throughout the supply chain to respect ILO General Principles and Operational Guidelines for Fair Recruitment and the United Nations Guidance on Bilateral labour migration agreements (ILO, ISSA and ITCILO 2021; United Nations Network on Migration 2022). Therefore, greater commitment is needed to level the playing field when it comes to ameliorating working conditions and social security coverage of health and care workers. An insufficient number of ratifications of international Conventions in this respect highlights the urgent need for action (see **box 6**) (ILO 2022a).

▶ Box 6: International labour standards and the protection of health and care workers

International Labour Standards on nursing and domestic work recall the need to secure comprehensive and adequate social protection coverage for all concerned workers as a core part of securing decent jobs. For instance, Article 6 of Nursing Personnel Convention, 1977 (No. 149) states: "Nursing personnel shall enjoy conditions at least equivalent to those of other workers in the country concerned in the following fields: (a) hours of work, including regulation and compensation of overtime, inconvenient hours and shift work; (b) weekly rest; (c) paid annual holidays; (d) educational leave; (e) maternity leave; (f) sick leave; (g) social security."

While those instruments represent a global consensus among governments, employers and workers, decent work is not yet a reality for many in the health and care sectors. A total of 35 countries have ratified Domestic Workers Convention, 2011 (No. 189), 13 of these within the last six years, while the Nursing Personnel Convention, 1977 (No. 149) has been ratified by 41 Member States (ILO 2022a)

In light of the shortage of health and care workers in many countries of origin, it is important to give due consideration to the care needs at both ends of the migration spectrum. For instance, the population in low- and middle-income countries is ageing more rapidly than in high-income countries where most of the reserve of domestic migrant workers and health migrant workers is channelled. In countries of origin, social protection policies guaranteeing access without hardship to such services may not be in place to provide the needed care and support that should urgently be provided to ensure that migration does not translate into an even more acute shortage of health and social care workers in those countries.

Promoting decent work in the care economy implies coordination across health, social care, social protection and employment policies. For instance, certification and accreditation processes can contribute to both enhanced quality assurance and skill profile, recognition and remuneration. In Japan, there is a national “Certified Care Worker” accreditation system. To be certified, two years of study at Government-accredited institutions, graduation from a high school specializing in welfare, or three years’

work experience in care with six months training are required together with passing a nationwide exam (Social Welfare Promotion and National Examination Center, n.d.).

Technological development is likely to have a significant impact on care services and ways of working. The use of technology to achieve more efficient health services will most likely redefine jobs in the health sector and provide opportunities in the form of new types of work and related occupational profiles (see **box 7**). While technological developments might on the one hand enable care workers to focus more on patient care, it may at the same time also result in tasks of greater complexity, risking cognitive and emotional overload for health and care workers. It is therefore important to develop mechanisms that ensure lifelong learning, flexible education and training systems that can anticipate the skills demanded for care workers by the labour market and that also ensure adequate preparation of care professionals for rapidly changing realities (ILO 2019).

▶ **Box 7: Digital training solutions**

Digital solutions are also used to train the different actors involved in LTC. In Mexico, for example, the State Employees' Social Security and Social Services Institute (*Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* – ISSSTE) offers a multimedia training course. This is available via its institutional portal and can be accessed by anyone who needs to acquire knowledge on techniques, procedures and information related to the care of vulnerable and older people with dementia (State Employees' Social Security and Social Services Institute 2017). The Catholic Workers' Circle of the Uruguay Mutual Fund *(Círculo Católico de Obreros del Uruguay Mutualista – CCOUM*) has increased the use of ICT for it to become an essential tool in ensuring equal access to training of nursing staff and thus contribute towards improving the quality of services and patient safety in LTC (Catholic Workers' Circle of the Uruguay Mutual Fund 2016; ISSA 2021).

Ways forward

Investments in LTC need to be envisaged within the scope of broader objectives of universal health coverage and universal social protection, leaving no one behind. In particular, significant gaps in protection remain when it comes to the health and care workers who provide LTC. This situation diminishes the attractiveness of the sector, which is already subject to labour shortages. Compounded by additional decent work deficits, this situation ultimately has implications for LTC service delivery and the quality of such services. The following needs to be considered:

- **Social protection policies need to adopt a gender-transformative approach that allows families to play a role in the continuum of LTC without jeopardizing their social security entitlements and their opportunities for labour market participation**. This can materialize for example in the form of care credits for old-age pension entitlements and care leave benefits.
- **Social protection policies need to support the development of LTC guarantees substantiated by professional LTC services.** This, in turn, requires the creation of decent work opportunities and conditions for paid care workers and facilitating the transition from the informal to the formal economy for many of them.
- **The extension of social security** needs to be considered within the package of measures that will contribute to facilitating the transition of many health and care workers from the informal economy to the formal economy.

In summary, investing in LTC in a way that adequately protects both older persons and caregivers is a critical need in many countries with rapidly ageing populations. The inherent complexity of LTC needs and societal responses highlights the urgency for social protection policies to fully acknowledge the scale of their health impact and in turn to engage with health and employment policies.

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