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Challenges in Long-term Care of the Elderly in Central and Eastern Europe

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DECENT WORK TECHNICAL SUPPORT TEAM AND COUNTRY OFFICE FOR CENTRAL AND EASTERN EUROPE

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Foreword

Long-term care of the elderly is an imminent policy issue for countries facing profound demographic transformations due to ageing. It has recently been attracting growing attention in Central and Eastern European (CEE) countries. Providing care to the elderly is not a new social issue. Frail elderly and disabled persons have always been part of societies. Over the years they have been cared for predominantly at home by their families and the communities they belong, but also at various private and public institutions. However, recent demographic and social transitions have imposed new challenges on the intra-family provision of long-term care, which relies heavily on unpaid female carers. The increased participation of women in the labour market and changing family structures create limitations on the potential supply of caregivers within families. Therefore, there is a greater need of formal long-term care for the increasing number of elderly people.

Countries provide formal long-term care, in cash and in-kind benefits, through social insurance (mainly health insurance and old-age pension supplements), social services (with or without income-tests), social assistance (usually means-tested), or a combination of these. Currently, the provision, arrangement, and financing mechanisms of formal long-term care services vary markedly between countries. For instance, Nordic countries have a long experience in providing long-term care through social services at the municipal level. More recently, some countries such as Germany, Luxembourg, and the Netherlands have established a new branch of social insurance specifically to finance the costs of long-term care. These variations reflect the differences in countries' needs, availability and condition of long-term care services, and the family-caring traditions and customs in each country.

There is a considerable amount of research addressing various aspects of long-term care in the OECD and European Union (EU) countries. However, CEE countries – both EU member states and non-EU member states – face their own complex challenges in securing accessible, adequate and sustainable long-term care. While CEE countries anticipate a growing number of elderly persons in need of long-term care as a consequence of global population ageing, these countries still need to improve their institutional care infrastructure and develop the mechanisms to support home-based care. Furthermore, the increasing number of migrant care workers from CEE countries – many of whom are women – will further restrict the potential supply of carers.

The purpose of this report is to shed light on the growing long-term care challenges in social protection, with a particular focus on the CEE countries. This report is organized as follows: Section 1 presents the key issues relating to long-term care. Section 2 reviews the current provision of long-term care systems in four CEE countries. Section 3 analyses the migrant care workers from Ukraine and Poland. Section 4 summarizes these findings, and discusses their policy implications in the future.

This report is based on the draft prepared by Zofia Czepulis-Rutkowska, Institute of Labour Study and Social Policy, Poland. The final report was completed by Kenichi Hirose, Senior Social Protection Specialist, ILO Decent Work Technical Support Team and Country Office for Central and Eastern Europe. Katarina Stanic provided supplementary information on the Serbian system. Comments provided by Xenia Scheil-Adlung and Thorsten Behrendt of the ILO Social Protection Department have been reflected in this report. Laura Salomons, Emma Ferencz and Athena Bochanis provided assistance in the preparation of this report.

We hope that this report will contribute to the policy discussion on the future development of formal long-term care systems in Central and Eastern Europe.

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1. Growing need of long-term care in CEE

1.1 Long-term care in the framework of social protection

Long-term care can be defined as a range of health and social services for persons who are dependent on help with their daily activities over an extended period of time. These include the activities of daily living, known as ADLs (bathing, dressing, eating, getting in and out of bed or off the chair, toileting and continence) and the instrumental activities of daily living, known as IADLs (preparing one's meals, cleaning, doing laundry, taking medication, getting to places beyond a walking distance, shopping, managing finances, and using the telephone or Internet).[1] These long-term care needs are due to the physical or mental disabilities or other chronic morbidity that result from ageing. Long-term care services may be provided in a variety of settings including institutional, residential or home care.

Regarding the scope of social security benefits, major international legal instruments refer to the nine principal branches of social security covered by the ILO Social Security (Minimum Standards) Convention No. 102 (1952). These are medical care, sickness benefits, unemployment benefits, old-age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivors' benefits. However, because the issues associated with long-term care emerged relatively recently, long-term care is not explicitly incorporated into the traditional framework of social security benefits. In this sense, long-term care is sometimes referred to as a new social risk.

To illustrate this, we refer to the main EU legislation regarding the coordination of social security for migrant workers within the EU (Regulation 883/2004/EC) which does not include long-term care benefits in its material scope. There is one article (Article 34) which refers to the overlapping of long-term care benefits with medical care benefits. For this reason, the coordination of long-term care benefits is determined by the Court of Justice of the European Union. In one case, the Court ruled that long-term care benefits should fall under the coordination rules, and should be treated as medical care benefits in the absence of general rules concerning the coordination of long-term care benefits. A Decision of the Administrative Commission for the Coordination of Social Security Systems (Decision S5 of 2 October 2009, entered into force on 1 May 2010) states that the concept of medical care and maternity benefits in kind, in accordance with the case law of the European Court of Justice, must include benefits in kind provided to persons reliant on care. These benefits in kind are essentially intended to supplement medical care benefits in kind in order to improve the state of health and the quality of life of persons reliant on care. These benefits in kind can include nursing care and home help provided at home or in specialized establishments, purchase of care equipment, or work carried out to improve the home environment. Although this Decision is a step forward, it does not fully resolve the complex issue of long-term care, as national systems differ and long-term care benefits are also provided by social services, which are not included in the material scope of the coordination regulations.[2]

Although long-term care and health care share common aspects, their aims are essentially different. While health care services aim to change one's health status through medical treatment and rehabilitation, long-term care aims to support people's ability to live their own lives as independently as possible

1. Personal care services to assist with ADLs are often provided in combination with basic medical services, including nursing care, preventive care, rehabilitation and palliative care. On the other hand, care services to assist with IADLs are mostly provided in the home care setting.

2. Nevertheless, it is reported that a special task force has been established to discuss solutions for the inclusion of long-term care into the EU coordination rules. See Jorens and Spiegel (2011).

through assisting them with their daily activities according to their needs. This is why the bulk of long-term care services are still provided informally by family carers, and the care recipients, usually at a later stage in life, have a strong preference to receive care at home from their family members. Moreover, large numbers of elderly persons hospitalized for a long period for non-medical reasons due to a shortage of nursing care facilities (the so-called "social hospitalization") could impede the proper functioning of the health system and put additional burdens on health care financing.

The ILO Social Protection Floors Recommendation No. 202 (2012) stipulates that the national social protection floors comprise at least four basic social security guarantees: (a) access to essential health care, including maternity care; (b) basic income security for children, providing access to nutrition, education, care and any other necessary goods and services; (c) basic income security for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and (d) basic income security for older persons. A basic guarantee for long-term care benefits for older persons could also constitute one element of the national social protection floors although the Recommendation does not explicitly refer to long-term care.

1.2 The magnitude of future long-term care needs

Data on the expenditure on long-term care are scarce, especially in non-EU countries. Therefore, we rely on data from the EU and OECD countries here. It should be noted that the public expenditure on long-term care covers the costs of formal long-term care and excludes the economic value and costs of informal care, and that national data collections considerably underestimate the costs of care provided by the private sector.

In 2013, the total public expenditure on long-term care in the OECD countries accounted for 1.7 percent of GDP. There is significant cross-country variation in the expenditure on long-term care, ranging from less than 0.5 percent to 4.3 percent of GDP. Though a large majority of formal long-term care is provided in home-care settings, 62 percent of total long-term care expenditure occurs in institutional settings.

With respect to EU countries, the public expenditure on long-term care was estimated at 1.6 percent of GDP in 2013. According to the European Commission's 2015 Ageing Report, the public expenditure on long-term care in the EU is projected to increase to 2.7 percent of GDP by 2060 (a 67 percent increase in expenditure) under the baseline scenario, or to 4.1 percent of GDP (a 149 percent increase in expenditure) under the risk scenario. Such a rapid increase can be ascribed to the increase in the number of elderly in need of long-term care, and the fact that a large part of long-term care expenditure consists of services which increases more or less in line with wages.

While life expectancies measure the average remaining years of survival at a particular age considering the current mortality level of a country, health expectancies measure the average remaining years that a person of a particular age can expect to live without disability, taking into account both mortality and disability. Therefore, the difference between the life expectancy and the health expectancy can be used as a measure to assess the demand of long-term care in a country. For the purpose of this study, we use the commonly used indicators of health expectancies in EU countries called the "Healthy Life Years", which are based on the limitations on daily activities.

Figure 1. **Life expectancies by health status at age 65 by sex, EU and EFTA member states, 2013**

Source: European Health and Life Expectancy Information System, 2015.

Figure 1 presents the life expectancies and healthy life years at 65 years of age by sex for 29 EU and EFTA member states in 2013. The limitations in daily activities are divided into moderate and severe.[3] There is a significant difference in the period with activity limitations between men and women. The unweighted average values of these 29 countries show that the period with limitations at 65 years is 8.3 years for men and 11.7 years for women. In particular, the average period with severe limitations is 2.9 years for men and 4.6 years for women.

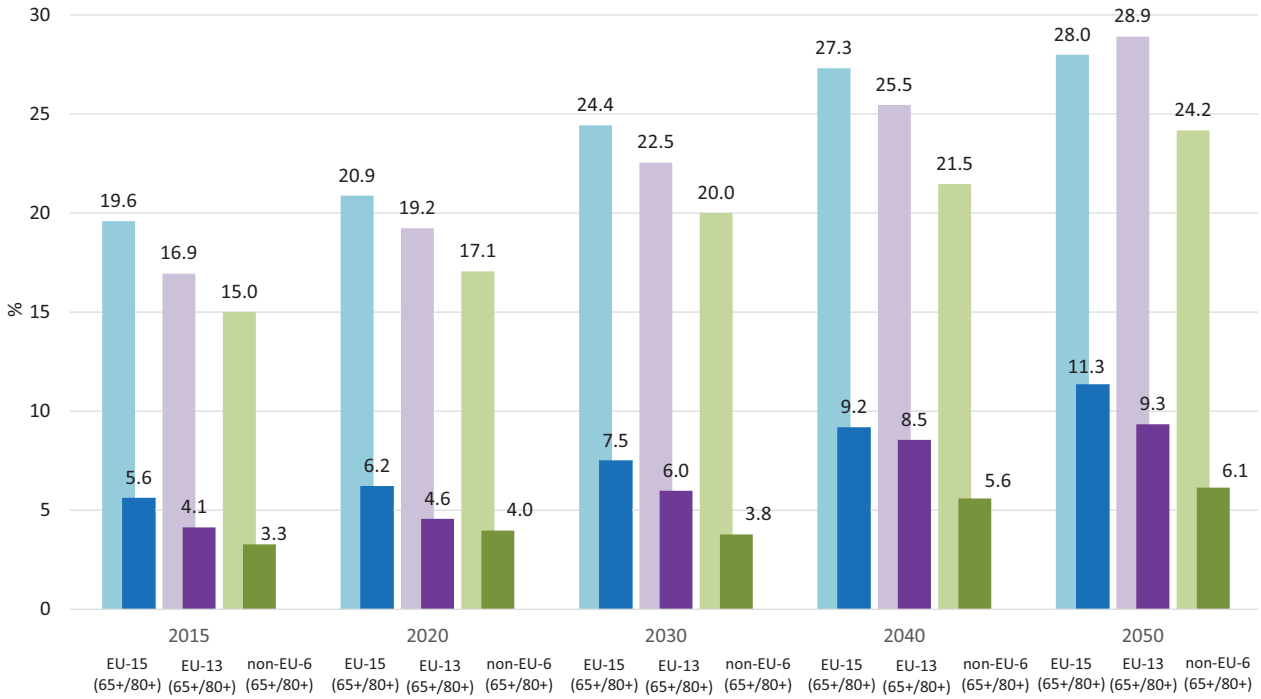
These countries also exhibit a much larger variation in healthy life years than in life expectancies. The countries can be broadly classified into four groups. The first group of countries has both above-average life expectancies and healthy life years (the Nordic countries, Iceland, Ireland, Luxembourg, and Malta). The second group has both below-average life expectancies and healthy life years (Germany, Greece, Italy, the Baltic countries, and most CEE countries except for Bulgaria and the Czech Republic). The third group has above-average life expectancies but below-average healthy life years (France, the Netherlands, Switzerland, Spain, and Portugal). The fourth group has below-average life expectancies but above-average healthy life years (Bulgaria and the Czech Republic). Consequently, countries in the second and third groups exhibit longer years of life with activity limitations.

These observations indicate that the need for long-term care increases with age, and that the risk is concentrated at ages above 75 years for men and above 80 years for women. If future extensions of life expectancies are not accompanied by corresponding improvements in the health expectancy, the resulting increase in the number of dependent elderly will require more long-term care services.

Figure 2 compares the projected share of the population aged 65 years or more to the population aged 80 years or more for 2015–2050 for three groups of countries. The first group includes the 15 original EU countries (EU–15). The second group includes the 13 CEE countries that became EU Member States after 2004 (EU–13). The third group is comprised of six non-EU countries in South and Eastern Europe (Albania, Bosnia and Herzegovina, FYR Macedonia, Moldova, Serbia and Ukraine). As population ageing is a global phenomenon, the percentage of the elderly population is projected to steadily increase in all groups. The EU–13 countries are estimated to have a greater share of the population aged 65 years or more than the EU–15 countries by 2050. For the population aged 80 and above, the EU–13 countries and the six non-EU countries are estimated to attain the current levels of the EU–15 countries by 2030 and by 2040, respectively. These observations indicate that albeit some delay the CEE countries will eventually face at least the same magnitude of demand of long-term care as the countries in Western Europe are currently facing.

3. To evaluate healthy life years, activity limitations are defined as the difficulties that an individual experiences in performing an activity due to their health conditions for at least the last six months. The resulting data should be interpreted with care, since the activity limitations and their severity are based on elderly people's self-perceived health status and may be influenced by cultural and social factors.

Figure 2. Projected percentage of population aged 65 years or more and 80 years or more, EU–15, EU–13 and six non-EU countries, 2015–2050



Source: Eurostat, EC–EPC (AWG) 2015 population projections.

2. Review of the current long-term care systems in four CEE countries

This section summarizes the current provision of long-term care systems in four countries in Central and Eastern Europe: the Czech Republic, Poland, Serbia and Ukraine. We analyse the roles of informal and formal care, available services in cash and in kind, the administrative and financing mechanisms, and recent policy trends. This section is largely based on existing sources.

Table 1 summarizes the basic demographic and economic data of the four countries. In spite of their differences in population size, all of these countries show similar trends in population ageing. The percentage of the elderly population (aged 65 years or more and 80 years or more) is expected to double between 2013 and 2050.

Table 1. Basic demographic and economic data, the Czech Republic, Poland, Serbia and Ukraine, 2013 and 2050

	Czech Republic	Poland	Serbia	Ukraine
Population (thousands)	10,516	38,063	7,182	45,373
% of population aged 65 or more	12.9	10.6	13.8	11.7
% of population aged 65 or more (2050)	27.5	29.9	25.2	23.3
% of population aged 80 or more	3.9	3.8	3.8	3.5
% of population aged 80 or more (2050)	8.4	9.5	7.1	5.5
Life expectancy at birth (years) (A)				
Men	75.2	73.0	71.8	65.7
Men (2050)	81.7	80.8	78.2	69.8
Women	81.3	81.2	77.5	75.7
Women (2050)	86.6	86.8	82.4	78.8
Healthy life expectancy at birth (years) (B)				
Men	66.0	63.0	63.0	59.0
Women	71.0	71.0	67.0	67.0
Difference (A)–(B)				
Men	9.2	10.0	8.8	6.7
Women	10.3	10.2	10.5	8.7
Life expectancy at 65 (years)				
Men	15.7	15.5	13.9	12.5
Men (2050)	20.1	20.1	17.4	13.4
Women	19.3	19.9	16.8	16.4
Women (2050)	23.5	23.9	20.3	18.1
Healthy life years at 65 (years)				
Men	8.5	7.2	—	—
Women	8.9	7.8	—	—

	Czech Republic	Poland	Serbia	Ukraine
Women's labour force participation rate (% of working age population)	65.1	60.1	53.2	68.5
GDP per capita (USD PPP)	28,900	23,926	13,380	9,143
Expenditure on long-term care (% of GDP)	0.7	0.8	—	—
Expenditure on long-term care (% of GDP) (2050)	1.4	1.7	—	—

Note: For 2050 estimates, the Czech Republic and Poland data are from the EC 2015 Ageing Report, and Serbia and Ukraine data are from the UN World Population Prospects 2015 revision.

Source: European Commission "*The 2015 Ageing Report*"; Eurostat; IMF World Outlook (2015); Labour Force Survey of Serbia (2013); SILC; UN World Population Prospects (2015 revision); World Bank; World Health Organization.

2.1 The Czech Republic[4]

In the Czech Republic, formal long-term care is provided predominantly through social services. The social service elements of long-term care were enhanced by the passage of the Act on Social Services (Act. No. 108/2006 Coll.) in 2006. In addition, health care services for those in need of long-term care (such as nursing care and health monitoring) are provided in hospitals for the chronically ill and in the geriatric departments of general hospitals. The costs are financed by health insurance and moderate patient co-payments.

The existing social services for long-term care include residential services (such as homes for the elderly and people with disabilities, special regime homes, and weekly care centres), home services (including personal assistance, domiciliary services, emergency assistance), outpatient services (such as service centres and day care centres), as well as community services managed at the municipality level. Social workers are authorized to decide if residential or home care services should be provided.

In general, certain payment is required to receive social services. The maximum users' payment to cover accommodation and food in a residential care institution is 85 percent of their pension (or 75 percent at weekly care centres). The costs of care services in residential care institutions are capped by the care allowance amount granted to the user. To cover the financial gap, the registered professional care providers are subsidized by the Government according to the State's pricing policy.

Although there are a relatively high number of beds in residential care institutions in the Czech Republic, more than 80 percent of care for the elderly is provided by the family, mostly by women. The main informal care providers are children (around 50 percent), spouses (20 percent), other relatives (10 percent), and friends (15 percent). Research shows that more than two-thirds of care recipients did not use any services provided by registered providers, less than 20 percent use residential services, less than 10 percent use home services, and less than 5 percent use outpatient services.

In 2006, the Czech Republic introduced the care allowance, a non-contributory benefit paid to persons who are dependent on other persons' assistance. The entitlement and the amount of the care allowance are determined at the municipal level, based on a medical assessment conducted by the Medical Assessment Service and a social worker's evaluation made during their home visit.

4. The main references in this subsection are: Sowa (2010); Nemec (2014); Österle (2011) Chap. 4.

Depending on the assessed degree of dependence, the monthly care allowance provided to persons over 18 years of age is differentiated into four levels: 800 CZK[5] for first degree (light dependence), 4,000 CZK for second degree (medium dependence), 8,000 CZK for third degree (heavy dependence), and 12,000 CZK for fourth degree (total dependence).[6] However, this allowance is not the full reimbursement of the costs of informal and formal care. A pilot survey in six localities conducted in 2011 shows that the care allowance covers 55 percent, on average, of the total cost of care. As a result of emergency austerity measures in 2011, the amount of the first degree care allowance for person aged 18 years or more was reduced to 800 CZK from the previous 2,000 CZK, although the allowance can be increased by up to 2,000 CZK for low-income families.

In 2014, the care allowance was paid to 331,641 persons, more than 80 percent of whom were older than 75 years. Of the total recipients, 33 percent were of first degree dependence and 33 percent were of second degree dependence. The expenditure on care allowances totalled 20.4 billion CZK, or 0.48 percent of GDP. The expenditure on care allowances accounts for around 70 percent of the total public expenditure on long-term care, or 0.7 percent of GDP in 2013.

The introduction of care allowance marked an important shift from the previous system, which granted allowances to persons taking care of a relative or other person in a home-care setting, and also granted pension increments for elderly persons living alone. The direct payment of cash allowances to persons in need offers them the option to choose providers and the possibility to decide their individual care plan. If a recipient uses the care allowance to pay an informal personal carer, usually a family member, this will at least provide partial financial compensation for them (although it may also make family members, often women, confined to care work at home). If the care allowance is used to purchase formal home care services, it can contribute to the development of professional home-based services by public and private care providers.

A 2011 pilot survey of care allowance recipients and care providers in six localities indicated the following findings:[7]

- Around 66 percent of the surveyed care allowance recipients received informal care from family members and were likely to remain in family care in the future, 15 percent used professional social services and intended to use them in the future, 12 percent used professional social services but did not intend to use them in the future, and 8 percent would like to move from family care to professional services.
- A large portion (estimated at about 60 percent) of the care allowance was used to purchase medication not covered or only partially covered by health insurance. The care allowance was also used to cover transportation costs, cleaning services, and goods for daily use. Less than 25 percent of recipients used it to pay for formal social services, and only 10 percent used it to pay an informal personal carer.

In lieu of this situation, it has been proposed that part of the care allowance be replaced by a service voucher, although this measure has not been implemented yet. The Government has also stated its intention to promote the development of formal home services to facilitate the transition from institutional to home care.

5. 1 euro = 27.279 Czech koruna (CZK) (average for 2015) (source: www.ecb.europa.eu).
6. Ministry of Labour and Social Affairs website.
7. Ministry of Labour and Social Affairs (2011).

Due to a lack of effective coordination, several discrepancies have been identified between the services provided by the health system and the social service system. While the health system is largely centralized, the administration of social services has been gradually transferred to regional and local levels. At the same time, due to the existing disparity in financial resources, the quality of care services in long-term health facilities is lower than that of the residential and home services.

Since the introduction of health insurance in 1992, there has been a tendency to separate the "care" function from the health system in the Czech Republic. An earlier proposal suggested establishing an integrated long-term care system, with a view to transferring the administration of long-term care services from the health system to the new system. So far the proposal has not yet been implemented.

2.2 Poland[8]

Of the four countries analysed in this section, Poland currently has the lowest share of the population aged 65 years or more, but is expected to have the highest value by 2050. Poland also exhibits the largest increase in life expectancy for both sexes. Research shows that 15 percent of women and 13 percent of men aged 65–69 years need the help of another person, and 54 percent of women and 36 percent of men aged 80–84 years need such help.

The family is traditionally the main care provider in Poland. People, especially women, exhibit a significant commitment to care for their family members. This is observed in the high co-residence index rates (elderly parents residing with their children), and in the high percentage of non-working women aged 50 and above. This is due to strong 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.

In Poland, services and benefits for long-term care are delivered through the health, social assistance and social insurance systems.[9] Both cash and in-kind benefits are available, but benefits are largely in kind. Public expenditure on long-term care was estimated at 0.74 percent of GDP in 2010, of which 0.30 percent went to institutional care, 0.07 percent to community care and 0.37 percent to cash benefits.

The health system provides for both institutional and home care. Institutional care is provided through care-treatment establishments (ZOL), nursing-care establishments (ZPO), and palliative care homes. These facilities gained importance after the health reform in 1999. Some evidence shows that patients are admitted in the internal medicine wards for longer periods if they have no other place to go. Home care is provided by community nurses or long-term care nurses. The latter was introduced in 2004. Medical services are financed by the national health insurance system. Patients are required to cover the costs of their accommodation.

For people who cannot take care of themselves at home, residential care is provided in care home facilities. Since the 1980s, different types of care homes have been established for the elderly, chronically ill, mentally ill, intellectually disabled adults, intellectually disabled children and youth, and physically disabled. Residential care is not exclusively dedicated to the elderly, but in most care homes a majority of residents are elderly.

8. The main references in this subsection are: Grabusińska (2013); Mossakowska *et al*. (2012); Szczerbińska (2006); Golinowska (2010); Derejczyk *et al*. (2008); Błędowski and Wilmowska-Pietruszyńska (2009).

9. It should be noted that the term "long-term care" is used only in the General Health Insurance Act.

In 2014, there were 804 care homes with 79,010 beds. Of these, 591 care homes (with 64,918 beds) were managed by local governments, and 213 homes (with 14,092 beds) were managed by non-public bodies, mostly religious groups or other NGOs. For-profit private entities that meet the legally required standards can run care homes as well.

Residential care services are financed through local government budgets, State subsidies, and user payments. State subsidies cover approximately 75 percent of the total costs. Residents are required to pay for their accommodation, up to 70 percent of their income. If their families earn income above a certain threshold, they are also required to make payment to the residential care institutions. Health care institutions are preferred for this reason, as they require no payment from the families. Local governments cover any shortfalls.

Since the early 1990s, care homes in Poland have significantly improved in terms of accessibility and the quality of their services. However, they should be accessible throughout the country, and their services in respect of the attitude towards beneficiaries could still be improved.

Home-based care is provided through community care services, which consist of normal care services and specialist care services. Social Assistance Centres assess one's needs, based on a home visit and interviews, and decide on the service to be provided.

There are also family care homes, which provide day and night care in a home for three to eight persons. Though this type of homes can provide more customized services to the elderly people, the number of these homes in the country is quite limited.

Specialist care services are available for persons who need special services because of a specific health condition. These services are delivered by a qualified professional staff.

In 2014, a total of 88,880 persons received community care services, amounting to 321.5 thousand PLN.[10] Of these 4,410 elderly and chronically ill persons received specialist care services, at the cost of 14.7 thousand PLN. On the other hand, 12,330 mentally ill persons received specialist care services were provided to, at the cost of 82.2 thousand PLN.

Community Support Centres offer basic day care services. In 2011, there were 1,380 Community Support Centres with a total capacity of 68,000 persons, and 100,000 persons received these services in that year.

Community care services are financed through the municipality budget.[11] The service users are required to contribute financially, depending on the material situation of the person in need. Despite the growing importance of community services, the number of services rendered is considered unsatisfactory and the quality of services is questionable. More funding should be allocated for further expansion of community care services.

Social insurance and social assistance systems provide different types of cash benefits. Within the pension system, a supplement is payable to all pensioners over 75 years of age. This supplement amount is relatively low, at 208 PLN per month while the minimum pension was 880.45 PLN per month in 2015. In addition, a care supplement is paid to the pensioners in need of care from the pension system.

10. 1 euro = 4.1841 Polish zloty (PLN) (average for 2015) (source: www.ecb.europa.eu).

11. This does not include care services for persons with mental illness or intellectual disability, which are financed through the State budget.

Care allowances are another cash benefit paid by municipalities to cover part of the expenditure for caring for dependent persons. The care allowance is only 153 PLN per month and is not indexed. Persons in need of long-term care in difficult situations can also be supported by social assistance. However, due to the low benefit levels and ineffective targeting, it is widely acknowledged that these cash benefits have little impact on long-term care.

Currently, the special care allowance (specjalny zasiłek opiekuńczy) is payable to persons who had to quit the jobs or cannot work[12] because of their obligation to take care of a disabled family member. The allowance is 520 PLN per month, and is paid if the per capita income of the family is 664 PLN or less. In contrast, the nursing benefit (świadczenie pielęgnacyjne) is payable for parents who had to quit the jobs or cannot work because of their obligation to take care of a disabled child. Recently, this benefit has been increased significantly from 800 PLN to 1,200 PLN in 2015 and to 1,300 PLN in 2016, and will be indexed from 2017 onwards. This benefit is not income-tested. There is also a proposal to introduce a single cash benefit for family carers.

In the context of the growing awareness of the need for formal long-term care, several initiatives have been undertaken with support from government authorities.

- After several years of deliberation, a Working Group in the Senate presented a proposal in 2009 to create a single long-term care system by introducing universal long-term care insurance, with a contribution of 1–1.5 percent of a person's income. Although a draft law was prepared, it was not submitted for parliamentary discussion.
- In 2011, the Senate started preparing legislation on nursing vouchers to be given to private caregivers. The voucher would be financed through the State budget, and its amount would vary between 800 PLN and 1,200 PLN depending on the care needs. This plan has not yet been implemented.
- The Government and the Parliament have focused more attention on prevention. In 2013, the Ministry of Family, Labour and Social Policy created a new Department for the Policy for Senior Citizens.

2.3 Serbia[13]

By 2013 Serbia had attained an advanced stage of ageing population, with 13.8 percent of its population is aged 65 years or more. However, the projected share of elderly by 2050 is slightly less than those of the Czech Republic and Poland.

A survey of elderly persons not in long-term care institutions conducted in 2013 by the Ministry of Health indicates that 11.1 percent of the population older than 65 years and 33.3 percent of the population older than 85 years have difficulties in performing the activities of daily living, while 37.6 percent of the population over 65 years and 71.6 percent of the population over 85 years have problems with the instrumental activities of daily living.[14]

Traditionally, the elderly in Serbia rely primarily on the support of their families. According to the Family Law, adult children have a legal obligation to provide care and financial support for their dependent parents. A survey in 2012 shows that 77.8 percent of elderly people who need assistance in

12. Prior to 2015, the special care allowance was payable only to those who had actually resigned the work due to their care duties.
13. The main references in this subsection are: Arandarenko and Perisic (2014); Matkovic (2011); Matkovic and Stanic (2014); Österle (2011) Chap. 7.
14. Ministry of Health and Institute for Public Health (2013); IPSOS (2013).

daily living activities rely on their families, 12.6 percent rely on their relatives, neighbours and friends, 2.3 percent use paid care, and only 0.7 percent rely on publicly organized assistance.[15]

In Serbia, a cash benefit for long-term care, called the attendance allowance, is provided by the contributory social insurance system (administered by the Pension and Disability Insurance Fund) and the non-contributory social welfare system.[16] Originally, this allowance distinguished between insured employees and pensioners and the rest of the population. However, as a result of recent legislative changes (such as the introduction of an augmented attendance allowance for those with severe disabilities)[17] these two have become more intermingled.

The attendance allowance is provided to persons who are unable to perform the activities of daily living due to illness or disability. The eligibility of the attendance allowance is assessed by the Disability Committee of the Pension and Disability Insurance Fund, based on the health status of the person in need of care. Income and assets are not taken into account.

Table 2 summarizes the statistics of the attendance allowance as of December 2015. The following observations are made:

- The average amount of the attendance allowance paid by the Pension and Disability Insurance Law was 16,105 RSD[18] per month. The number of recipients aged 65 years or more was 48,848 persons (including 9,159 persons receiving an augmented allowance).[19] For comparison, the poverty threshold in 2014 was 11,340 RSD per adult, and the minimum net wage in December 2015 was 22,264 RSD.
- Under the Law on Social Welfare, the basic amount of the attendance allowance was 9,942 RSD, which was paid to 6,818 persons aged 65 years or more. In addition, an augmented attendance allowance of 29,670 RSD was paid to 3,681 persons aged 65 years or more with severe disabilities. For the recipients of the attendance allowance under the social insurance system, if the allowance amount is lower than the amount under the social welfare system, the difference is paid from the social welfare system.
- The number of attendance allowance recipients aged 65 years or more is 59,347 which accounts for 4.5 percent of the population of the same age group. Of these, the number of recipients aged 80 years or more is 29,670 which represents 10.3 percent of the population of the same age group. It is estimated that the public expenditure on long-term care cash benefits for the population aged 65 years or more amounted to 12.6 billion RSD (9.4 billion RSD under social insurance and 3.2 billion RSD under social welfare), or 0.32 percent of GDP.

15. The "Care for older people" survey was conducted by the IPSOS for the study of Matković and Stanić (2014).
16. In Serbia, the scope of the social welfare system based on the Law on Social Welfare (Law No. 24/2011) covers social assistance for the poor and social services for the disabled and elderly who need care.
17. According to the Law on Social Welfare, "severe disability" refers to a full disability for a single impairment or at least a 70 percent disability for two impairments.
18. 1 euro = 120.73 Serbian dinar (RSD) (average for 2015).
19. The number of attendance allowance recipients of all ages was 73,686. In November 2015, the average attendance allowance was 15,182 RSD, and was paid to around 74,000 persons of all ages.

Table 2. Statistics of the attendance allowance in Serbia, December 2015

	Number of recipients aged 65 years or more	As % of the population of the same age group	Number of recipients aged 80 years or more	As % of the population of the same age group	Average monthly allowance (RSD)
Pension and disability insurance (exclusively): Basic allowance	39,689	3.0%	20,431	7.1%	16,105
Recipients of the both systems	9,159	0.7%	3,480	1,2%	26,813
Social welfare: Basic allowance	6,818	0.5%	4,039	1.4%	9,942
Social welfare: Augmented allowance	3,681	0.3%	1,720	0.6%	26,813
Total	**59,347**	**4.5%**	**29,670**	**10.3%**	**—**

Source: Pension and Disability Insurance Fund and the Ministry of Labour, Employment, Veteran and Social Affairs.

A survey conducted in 2012 showed that 72 percent of the recipients did not use the attendance allowance to obtain care services, but rather used it to contribute to their family income. Only 22 percent of recipients spent the attendance allowance on private services, and 5 percent spent it on public services.

Residential care is provided both in public and private institutions. The placement in a public long-term care institution is decided by the Centre for Social Work at the municipal level. Centres for Social Work are legally required to first examine whether care services can be provided at home, and to propose institutional placement only if there is no alternative option.

In 2014, Serbia had 40 public elderly care institutions. These include elderly homes and gerontology centres, most of which were inherited from the socialist regime. These institutions accommodated a total of 7,941 persons (of whom 84.7 percent are aged 65 years or more), but 343 persons were on the waiting list for residential care.[20]

Residential care in public institutions (for accommodation and non-medical care) is financed by the State budget and by user payments. Medical costs are financed by the Health Insurance Fund. The user payment depends on their health status and the type of institution they stay. In 2010, the average user payment was around 25,000 RSD, while the maximum user payment was 30,000 RSD. The State will cover the costs if the user or their relatives cannot afford the user payment. It is estimated that about 20 percent of the residents of public residential institutions are supported by the State.

In 2014, the public expenditure on residential care for 7,742 persons totalled 3.2 billion RSD, or 0.08 percent of GDP.[21] This amount does not include user payments, which had exceeded the public expenditure in 2011.

In recent years, there has been a rapid growth of private providers offering residential care for the elderly. In 2011, there were 99 registered private elderly homes, 72 of which were located in Belgrade, with 2,675 total residents. The payments required for private residential institutions are much higher (generally two to five times) than those required for public institutions.

20. Republic Institute for Social Protection (2015).

21. The public expenditure includes the State budget allocated for care services, equipment and investments, and subsidies for user payments, as well medical services financed by the Health Insurance Fund (source: Ministry of Labour, Employment, Veteran and Social Affairs website).

However, even if the users of private institutions are taken into account, the total number of elderly persons receiving residential care is still less than 1 percent of the elderly population.

The Social Welfare Development Strategy, adopted by the Ministry of Labour and Social Policy in 2005, describes the existing public long-term care network as "insufficient, overcrowded, poorly maintained, often isolated from the city and run by professionals who have inadequate skills and capacities to deal with the multi-dimensional needs of the elderly."

Elderly persons in need of institutional care may be referred to foster care. Although foster care has been increasingly utilized to provide care for children without parental care, the provision of foster care for the elderly has remained largely undeveloped.

Local governments are responsible for community-based services, which include home care, day centres and clubs.[22] However, it is widely acknowledged that these services are extremely underdeveloped and suffer from low coverage and large regional disparities. There is also a lack of effective coordination between the central and local governments.

The Centres for Social Work in local governments play a key role in providing home-based services. The users may be required to make co-payments (between 200 RSD and 350 RSD per home visit). These home-based services have been rapidly expanding in recent years.

According to a survey on social welfare services, home-based services were provided to 14,500 elderly persons in 124 local governments in 2011 (out of 145 total). However, at least 1,693 persons were on the waiting list. The survey also revealed that about two-thirds of local governments provide home-based assistance services for more than one hour per day, while the remaining one-third of local governments provide this service for only a few hours per week. It is estimated that the total budget of local governments for home assistance (excluding donor funding or user co-payments) was 840 million RSD in 2011, or 0.03 percent of GDP.

The latest survey, conducted in 2015, shows that home-based services were provided to 14,266 elderly persons (or 1.1 percent of the population aged 65 years or more) in 104 local governments. It is estimated that the total budget of the local governments for these services (excluding donor funding or user co-payments) was 988 million RSD, or 0.025 percent of GDP.[23]

Within the health system, long-term medical care is provided in the secondary and tertiary care hospitals (usually in departments of the prolonged treatment and care). Due to the shortage of residential and home services, coupled with free health care for elderly citizens, it is common that the elderly in need of care are accommodated in hospitals for an extended period.

Palliative care at the primary level is provided through home treatments or in health care centres. However, more than 40 percent of health care centres do not offer services for home treatment and care, and when they do, these services are provided as part of the general health protection services. The Institute for Gerontology and Palliative Care in Belgrade, with 177 beds, is the only institution specialized in home treatment and palliative care. In Belgrade, about 2,000 elderly persons receive medical and palliative care at home.

22. In 2013, there were clubs for the elderly in 29 local communities covering 17,062 elderly persons.

23. Centre for Social Policy (CSP) and Social Inclusion and Poverty Reduction Unit (SIPRU) website.

The costs of health services are financed through the Health Insurance Fund, with a modest co-payment by the patient. According to the National Health Accounts estimates, the public expenditure on long-term care from within the health system was 0.08 percent of GDP in 2011.

Table 3 presents crude estimates on the utilization and expenditure of public long-term care in 2011. Only 7.3 percent of the population aged 65 years or more receive some form of publicly provided long-term care services and benefits. The total public expenditure on long-term care in 2011 is estimated at 0.53 percent of GDP.

Table 3. Estimated utilization and expenditure of public long-term care in Serbia, 2011

Services/benefits	Estimated number of beneficiaries/users	As a % of the population aged 65 years or more	Public expenditure (2011, % of GDP)
Attendance allowance	62,000	5.0%	0.36%
Institutional and foster care	12,000	1.0%	0.06%
Community-based services	15,000	1.2%	0.03%
Long-term health care	At least 2,000(*)	0.1%(*)	0.08%
Total	**91,000**	**7.3%**	**0.53%**

Note (*): Belgrade only.

Source: Pension and Disability Insurance Fund; Ministry of Labour, Employment, Veteran and Social Affairs; National Health Accounts; CSP and SIPRU website; Republic Institute for Social Protection (2015).

The current public provision of long-term care in Serbia suffers from fragmented delivery mechanisms and a lack of coordination between the central and local governments, which entails the poor access and low quality of the long-term care services. In-kind benefits provided in both home-based and institutional settings are particularly insufficient. As a result, family members carry the burden of providing care for the elderly with cash benefits, which only partially compensate the opportunity costs.

These long-term care needs are recognized in various strategic documents adopted by the government. With a view to acceding to the EU, Serbia faces a huge challenge in translating these strategies into action.

2.4 Ukraine[24]

In Ukraine, demographic projections indicate a significant increase in the share of the population aged 65 years or more and the population aged 80 years or more. However, the difference between the life expectancy and the healthy life expectancy is two to three years shorter in Ukraine than in the Czech Republic, Poland or Serbia. Also, due to a large difference in the life expectancy between women and men, there is a relatively high share of elderly widows.

Currently, the need for long-term care for the elderly is not recognized as an imminent issue in Ukraine. Although there is no data to support this assertion, it is widely acknowledged that long-term care is provided predominantly by family members and relatives.

24. The main references in this subsection are: Maynzyuk and Dzhygyr (2011); Tolstokorova (2013).

According to the Law on Basic Principles of Social Protection of Labour Veterans and Other Elderly Citizens in Ukraine (Law of Ukraine 1993/No. 3721-XII), cash allowances are payable to elderly persons living alone and to persons who provide care for elderly persons living alone. The level of these allowances is linked with the subsistence minimum.[25] Lone elderly persons who are assessed to be in need of constant care and receive welfare services at home from government agencies are entitled to a monthly allowance equivalent to 50 percent of the subsistence minimum for persons unable to work, which is 537 UAH[26] in January 2016. This allowance is the same amount as the social assistance provided to persons who do not qualify for contributory old-age pensions. Persons providing care for the elderly living alone can also receive a cash compensation equivalent to 10 percent of the subsistence minimum for persons able to work, which is 137.8 UAH in January 2016. These allowances are financed by the local governments.

Institutional long-term care services in Ukraine are provided by facilities in the social care system, administered by the Ministry of Social Policy. Elderly and disabled persons without relatives can be accommodated in nursing homes, which provide medical services and assistance with daily living activities. Elderly persons with relatives can be accommodated in nursing homes if there are vacancies only on the condition that the resident covers the full cost. In 2014, there were 290 public nursing homes for the elderly and disabled, accommodating more than 51,000 persons (of whom 44,000 were adults). In addition, there were 658 community centres, which provide assistance in medical and social services to more than 1.4 million persons.[27] Nursing homes and community centres are financed by the local government budgets. However, many local authorities are facing the challenge to secure necessary resources in the local government budgets to provide these services effectively.

Some home care services are provided by social workers at the local level, such as purchasing medicines and daily goods, and providing assistance in housekeeping and health care services.

In terms of health services for persons requiring long-term care, Ukraine has only 20 special hospital departments for chronically ill elderly patients, 21 departments of nursing care, and 31 hospitals for war veterans and war invalids, with about 17,000 beds in total. In addition, there are 20 hospices with 538 beds. Geriatric care is also limited in scope. On the other hand, Ukraine has a relatively high number of acute care hospital beds per 1,000 population (almost twice the EU average), and the majority of hospitals do not distinguish between acute care patients and chronic patients requiring long-term care. As a result, a considerable number of elderly persons are admitted to general hospitals for non-medical reasons. For example, hospitals often serve as a shelter for vulnerable elderly persons during the winter months.

In Ukraine, health care is financed by the State and the local governments, with 18.5 percent coming from the State budget and 81.5 percent from local budgets in 2014. The quality of medical services is low, as many medical institutions suffer from staff shortages, outdated equipment, and a lack of medicine. Implementing a long-standing proposal to introduce a contributory social health insurance scheme would create a fiscal space for financing health care services including long-term care, and achieve more equitable and efficient health care financing.

25. In January 2016, the subsistence minimum is 1,074 UAH for persons unable to work and 1,378 UAH for persons able to work.
26. 1 euro = 24.19 Ukrainian hryvnia (UAH) (average for 2015).
27. State Statistics Service (2015).

The current long-term care provision in Ukraine relies critically on informal family carers. The formal care provided by the social and health systems is inadequate to respond to the growing number of elderly persons who will need long-term care in the future. Furthermore, the increasing volume of Ukrainian migrant workers will negatively affect the number of potential family carers.

The Government's policy reform process is stagnating under the current unfavourable socioeconomic and political circumstances in Ukraine. In this context, there is an increasing number of domestic workers who also provide care services at home. Though the incidence of informal employment is generally high in the domestic services sector, intermediary agencies of domestic workers have been emerging in recent years. Another increasingly popular long-term care arrangement in Ukraine is based on reverse mortgage contracts, which may include financial benefits or in-kind provisions of long-term care. Long-term care based on reverse mortgages is provided by commercial entities, and have been promoted by some local authorities. These phenomena testify to an emerging long-term care market in Ukraine. However, the development of a legal framework for regulating private service providers is still underway.

3. Migrant care workers: A case study of the global care chain in Poland and Ukraine

As a consequence of the increased labour mobility across borders, an increasing number of migrant workers are involved in care work both formally and informally. This section analyses the migrant care workers in Poland and Ukraine.

3.1 Poland – country of emigration and immigration

(1) Labour migration from Poland

The free movement of people within the EU has resulted in a large number of Polish emigrants. The post-crisis economic downturn has also encouraged a greater number of Polish workers to seek employment abroad. The number of Polish persons temporarily residing abroad is much greater than the number of those in permanent residence.

At the end of 2013, the number of Polish citizens temporarily residing abroad (for longer than three months) was 2,196,000, of whom 81.5 percent were within the EU (642,000 in the UK, 560,000 in Germany, 115,000 in Ireland, 103,000 in the Netherlands and 96,000 in Italy) and 200,000 were in the US.[28]

The majority of Polish migrants are employed as unskilled workers, mostly in commerce and in the hotel industry. Many Polish women, especially in Germany and Italy, work as caregivers, nannies, and domestic workers.[29]

This has made Poland an important link in the global chain of care providers, for Poland not only exports care services but also imports them from neighbouring countries, in particular Ukraine. Meanwhile, the demand for low-qualified persons willing to work in the long-term care sector continues to grow.

(2) Ukrainian migrant workers in Poland

Migrant workers, in particular those from Ukraine, fill an important gap in Poland's labour market created by the emigration of the Polish workforce. In addition to Ukraine's proximity to and cultural affinity with Poland, the liberalization of Poland's immigration policy and the simplification of recruitment procedures have contributed to the recent rise in the number of working immigrants from Ukraine.

A foreigner who seeks employment in Poland is required to obtain a work and residence permit with a maximum period of three years. Alternatively, citizens of six neighbouring countries – Armenia, Belarus, Georgia, Moldova, the Russian Federation, and Ukraine – can work in Poland for a maximum

28. Central Statistical Office (2015).

29. Walczak (2010).

period of six months (previously three months) if they have a registered declaration of intent to hire (employment offer) from a Polish employer.[30]

Tables 4 and 5 present the data on work permits and employment offers issued in Poland for 2011–2015. The following observations can be made:

- Ukrainians are predominant among the legal migrant workers in Poland. In 2015, 76.7 percent of work permits and 97.5 percent of employment offers were issued to Ukrainian citizens. Women comprise more than 30 percent of these workers. Since the introduction of the simplified recruitment procedure in 2007, the number of employment offers rose significantly, mainly driven by the increase in Ukrainian migrant workers applying through this process. The numbers of work permits and employment offers issued for Ukrainians almost doubled from 2014 to 2015.
- More than 40 percent of Ukrainian migrant workers in Poland are employed in agriculture, and only 4.5 percent are employed in domestic services.[31] However, 96.5 percent of legal migrant workers employed in Polish households were Ukrainian. In 2015, 7,585 work permits and 24,733 employment offers for domestic work were issued for Ukrainian migrant workers, mostly women. These numbers increased significantly from 2014 to 2015.

Table 4. Number of work permits issued in Poland, 2011–2015

	2011	2012	2013	2014	2015
Work permits, total	40,808	39,144	39,078	43,663	65,786
issued for Ukrainians	18,669	20,295	20,416	26,315	50,465
issued for Ukrainian women	7,376	8,429	8,956	10,300	15,148
% of work permits issued for Ukrainians	45.7%	51.8%	52.2%	60.3%	76.7%
% of women in work permits issued for Ukrainians	39.5%	41.5%	43.9%	39.1%	30.0%
Work permits for domestic work	4,365	4,483	5,014	5,780	7,585
issued for Ukrainians	3,835	4,026	4,558	5,395	7,306
% of work permits for domestic work issued for Ukrainians	87.9%	89.8%	90.9%	93.3%	96.3%

Source: Own calculations based on data from the Ministry of Family, Labour and Social Policy.

Table 5. Number of employment offers for migrant workers issued in Poland, 2011–2015

	2011	2012	2013	2014	2015
Employment offers, total	259,777	243,736	235,616	387,398	782,222
issued for Ukrainians	239,646	223,671	217,571	372,946	762,700
issued for Ukrainian women	104,373	86,073	98,213	143,956	257,718
% of employment offers issued for Ukrainians	92.3%	91.8%	92.3%	96.3%	97.5%
% of women in employment offers issued for Ukrainians	43.6%	38.5%	45.1%	38.6%	33.8%
Employment offers of domestic work	11,564	7,289	5,796	12,783	24,964
issued for Ukrainians	11,044	6,749	5,425	12,525	24,733
% of employment offers of domestic work issued for Ukrainians	95.5%	92.6%	93.6%	98.0%	99.1%

Source: Own calculations based on data from the Ministry of Family, Labour and Social Policy.

30. Kindler *et al.* (2016) describes the Polish legislations concerning domestic workers and Poland's migration policy. This study also conducted interviews with Ukrainian migrant domestic workers in Poland, some of whom provided care for children and the elderly.

31. The "domestic services" category includes housekeeping, cleaning, childcare, and care for the sick and elderly. The tasks assigned to domestic migrant workers include cleaning (30 percent), child care (6 percent), and care for the elderly or sick persons (10 percent).

However, the official statistics do not capture the whole picture of migrant work in Poland. In particular, many migrant domestic workers and caregivers work informally or with an irregular status. Although the introduction of a simplified recruitment procedure has made it easier for Ukrainian and other citizens to obtain legal employment in Poland, not all of them fully adhere to the Polish regulations. Some legal migrant workers take up additional informal work with another household, which is usually part-time work paid "under the table." Others continue to work in Poland after the expiration of their visa at the risk of penalization.[32]

Although it is difficult to determine the actual number of Ukrainians working in Poland, research conducted in 2010 shows that 7 percent of Polish households paid for some form of domestic help, and 10 percent of them employed foreigners.[33] These data suggest that the actual number of migrant domestic workers (estimated at around 100,000) is more than three times the number of legal migrant domestic workers registered in 2015.

A majority of Ukrainian domestic workers come to Poland for a period of less than six months. The typical practice of Ukrainian domestic workers in Poland is to jointly rent apartments and work for several families. Before returning to Ukraine, they recommend a relative or friend in order to maintain their place of employment for the next visit. This results in a circulating migration pattern between the two countries.

3.2 Working conditions of Ukrainian migrant care workers

Ukraine has high rates of emigration. Globally, it has the fifth highest number of emigrants, following Mexico, India, the Russian Federation and China. Since the 1990s, employment has become the most significant reason for migration.

According to the Migration Policy Centre, 5.5 million persons, or 11.7 percent of Ukraine's population, resided outside the country in 2012. Their primary destination is Russia (3.6 million). However, more than one million Ukrainians resided in the EU, with 230,000 in Poland, 200,000 in Italy and 150,000 in Germany. Ukraine receives a significant amount of remittances from Ukrainian citizens abroad. In 2010, remittances through bank transfers amounted to 5.6 billion USD, equivalent to 3 percent of GDP.[34]

In the framework of the ILO–EU project "Effective Governance of Labour Migration and its Skill Dimensions," a survey on Ukrainian migrant workers was conducted in 2012 by the State Statistics Service of Ukraine.[35] This was the second nationwide labour migration survey after the first survey conducted in 2008. The 2012 survey shows that 1,181,600 Ukrainians between 15 and 70 years of age had worked or searched for work abroad during the 30 months from 1 January 2010 till 17 June 2012.

Based on the microdata collected in the above survey, we have especially compiled the data on Ukrainian migrants who worked as care providers. The key observations can be summarized as follows:[36]

32. Kordasiewicz (2010).
33. Golinowska (2010).
34. Migration Policy Centre (2013).
35. ILO (2013).
36. Due to the small sample size (N=24), the statistical characteristics of the Ukrainian migrant care workers are calculated without taking into account the sampling weights.

The number of Ukrainian migrant care workers during the survey period is estimated at 42,800, which represents 3.6 percent of all migrant workers. It should be noted that these surveyed care workers do not only work for the elderly, but may also work for children or the disabled. Additionally, there were 113,400 Ukrainian domestic migrant workers, some of whom are likely to have also provided care, although this cannot be quantified from the survey data.

More than 95 percent of Ukrainian migrant care workers were women. The average age was 46.0 years, and 46 percent of them were married.

The major destination countries for the Ukrainian migrant care workers were Italy (42 percent), Poland (21 percent), the Russian Federation (17 percent), Spain (13 percent), and Austria and Germany (4 percent each).

The migration patterns of Ukrainian care workers differ by their country of destination. In particular, the labour migration to the Russian Federation exhibits a pattern distinct from that to the EU countries.

- A total of 50 percent of the Ukrainian care workers to Russia travelled several times a year, and the other 50 percent travelled monthly. In EU countries, 63 percent of Ukrainian care workers travelled at most once a year, and the remaining 37 percent travelled several times a year.
- The duration of the stay of Ukrainian care workers in Russia was, on average, shorter than in the EU countries. In Russia, 50 percent of the Ukrainian care workers stayed less than one month, and the remaining 50 percent stayed one to six months. In the EU countries, 18 percent of Ukrainian care workers stayed one to six months, 33 percent stayed six to 12 months, and 49 percent stayed more than 12 months.
- Almost all Ukrainian care workers in Russia stayed there under temporary registration. In contrast, 28 percent of Ukrainian care workers in the EU worked under temporary registration, 27 percent had both residence and a work permit, 15 percent had a work permit, 26 percent had no documents, and 4 percent entered their destination country with a tourist visa.

In the survey, 75 percent of respondents cited the low pay in Ukraine as their primary motivation for working abroad. It is estimated that about 25 percent of Ukrainian migrant care workers earn less than 500 USD per month, 45 percent earn between 500 and 1,000 USD, and 30 percent earn more than 1,000 USD.[37]

Almost all Ukrainian migrant care workers (more than 95 percent) were employed in households. A large majority of their employment contracts (88 percent) were based on an oral agreement. In total, 80 percent of these employment contracts included weekly days off, and 25 percent of them included overtime pay.

On average, 25 percent of Ukrainian migrant care workers worked between 40 and 50 hours per week, 42 percent worked between 50 and 60 hours per week, 25 percent worked between 60 and 80 hours per week, and 4 percent worked more than 80 hours per week.

Statistics also show that 42 percent of Ukrainian migrant care workers had white-collar job qualifications (of whom 20 percent had a nursing diploma), 25 percent had blue-collar job qualifications, and 33 percent had no professional qualifications before travelling abroad.

37. The responses made in different currencies have been adjusted using current exchange rates, assuming uniform distribution within each income band.

From the analysis, the key characteristics of the Ukrainian migrant care workers are summarized as follows:

- Ukrainian migrant care workers are mostly women. A large majority are employed in households based on an oral agreement. Most care providers work more than 40 hours per week, reflecting the nature of the work. Only one-quarter of employment contracts provide overtime pay, although a majority have weekly days off.
- The wages they receive are mostly higher than the average wage in Ukraine, which was 3,026 UAH per month, approximately 368 USD, in 2012. However, their wage levels in their destination countries are lower than the national average wages in those countries.
- The survey also reveals a skill degrading problem. Namely, a substantial number of Ukrainian migrants with higher professional qualifications are engaged in care work abroad.
- A majority of the Ukrainian migrant care workers in the EU countries stay more than 6 months, and about 40 percent of them have a work permit. In contrast, Ukrainian labour migration to the Russian Federation is more frequent and of a shorter duration. This is due to the fact that a large number of Ukrainian workers use the visa-free entry or the three-month legal stay in Russia to work on a short-term, rotating basis.

The Ukrainian labour migration also highlights some of the social costs borne by the family when one or both parents work abroad. According to a survey of Ukrainian families with migrant workers, 63 percent of them have attained a higher economic status due to the remittances from their migrated members, and only 13 percent responded that their living standard did not change. Thanks to the remittances, children of "transnational families" enjoy greater educational opportunities (through private school or foreign university enrolment), leading to better prospects for career development. However, such children – the so-called "Euro orphans" – are often left under the care of a single parent (if one of them remains), grandparents or with other relatives in Ukraine. There are many reports of the negative consequences in the social and emotional development of these children due to insufficient parental care and supervision.[38]

38. Tolstokorova (2009).

4. Conclusion

4.1 Common challenges in the long-term care systems in CEE countries

From our analysis presented earlier, we observe that CEE countries face shortages of quality long-term care services in both the institutional care and the home-based care settings. In the absence of integrated long-term care systems, the provision of long-term care is fragmented. Moreover, there is a lack of effective coordination between health care and social services, and between the central and local governments. Consequently, the utilization of formal long-term care services is low, and the provision of long-term care becomes primary responsibility of family members and relatives. Reliance on informal family care (including financial support) can be partially ascribed to traditional norms, but it is a legal obligation in some countries such as Serbia and Ukraine.

Current institutional care needs are not adequately met by the existing long-term care institutions. One's right to receive institutional services depends on the discretion of the local authorities, who must restrict admission due to limited vacancies. Many applicants are on the waiting list as a result. This shortage of institutional care is also a cause of "social hospitalization," where the elderly in need of care are hospitalized for non-medical reasons. There is also unequal access to care between urban and rural areas.

Moreover, CEE countries lack adequate support mechanisms for home-based care, including home visit services, day care, or short stays in community-based long-term care facilities. Without enhancing formal support for home-based care, it is difficult to effectively alleviate the care burden currently imposed on family members.

Insufficient supply of long-term care is correlated with low public expenditure on long-term care. The share of the public long-term care expenditure in terms of GDP in the CEE countries is generally less than a half the OECD average. It is 0.7 percent in the Czech Republic, 0.74 percent in Poland, and 0.53 percent in Serbia, as opposed to 1.7 percent in the OECD countries. The budget allocated for improving the service infrastructure and human resources is limited accordingly. Securing the necessary resources to ensure adequate benefits is a common challenge facing all social protection systems. Since the financing of long-term care benefits relies largely on the State and local government budgets, it is particularly vulnerable to the country's unstable fiscal conditions.

Cash benefits in the form of care allowances play a major role in long-term care in countries like the Czech Republic and Serbia. Cash benefits have the advantage of giving beneficiaries the freedom to choose the services according to their priority. However, survey results reveal that a large portion of the allowance is used for purposes other than the direct acquisition of care services. When the supply of formal long-term care services is insufficient, cash benefits may not achieve their intended objective and could lead to the confinement of family members in home care. Furthermore, even if the care allowance is given to family carers, the amount of allowance is not enough to fully compensate the lost opportunity costs. Ineffective targeting of the cash benefits may also make them vulnerable to cuts in times of fiscal pressure. As noted in Section 2, the Czech care allowance in the first degree was cut by 60 percent as part of the emergency austerity measures of 2011. There are limited options for incentivizing the recipients of the care allowance to spend it on formal care services while assuring their freedom of choice. A proposal to replace cash benefits with service vouchers is being discussed in the Czech Republic and Poland, but has not been implemented yet.

In the CEE countries, the public sector dominates the provision of formal care, but the private sector has been emerging in recent years. Though the public sector should continue to play a central role in ensuring essential care for all, there are certain areas (such as food delivery and domestic help) where private providers could work efficiently under proper regulation and quality controls. There has also been experimentation in mobilizing local communities, NGOs and other actors, but they remain on a small scale. What is required is a coherent strategy for institutionalizing and coordinating all types of providers of formal long-term care services.

4.2 Towards a universal long-term care system

The current long-term care systems in the CEE countries impose heavy burdens on family carers and are not socially sustainable. There is a need for a multi-layered system that ensures comprehensive long-term care services and achieves a more efficient sharing of the long-term care risk by society as a whole. The system should offer professional care management, which provides each individual an optimal care package from a wide range of services according to their needs. Communities should play an important role in this process. Furthermore, long-term care services should be coordinated with prevention services, health care services for chronic diseases, and support services for the disabled.

The global policy direction on long-term care is to encourage home-based care supported by community care. This is justified by the preference of the elderly to spend their lives at home, and the cost efficiency of home care in comparison with institutional care. Nevertheless, the CEE countries should continue to invest in their public infrastructures of long-term care services to resolve the current supply shortages and regional disparities.

Since the time of state socialism, the CEE countries have exhibited high female labour participation due to the comprehensive family benefits for childcare. Currently, the female labour force participation rates for these four countries still exceed 50 percent, and three of them (except Serbia) are above 60 percent. Most of the informal caregivers are economically active, often with full-time jobs. For instance, 80 percent of informal caregivers in the Czech Republic maintain a full-time job.

Therefore, the policy to promote home-based care cannot be successfully implemented unless workers are able to manage the conflict between work and care at home. Countries need to implement a set of flexible workplace measures that would allow for a better work–life balance,[39] such as paid care leave and working time arrangements. Particular mention should be made to the changing retirement age for women. Currently, the retirement age for women is gradually raised to reach the retirement age for men, and subject to a further increase in the future due to extension of life expectancies.[40] This will limit the frequently used option for female retired workers to provide care for their parents or in-laws while receiving retirement pensions.

A more efficient societal sharing of long-term care work requires more human resources to provide formal care services. However, there is a critical shortage of long-term care workers globally. A recent ILO study shows that there is a global shortfall of at least 13.6 million formally employed long-term care workers, and 2.3 million of these are needed in Europe.[41]

39. Also referred as "work–family reconciliation" in the context of the Workers with Family Responsibilities Convention, No. 156 (1981).

40. The normal retirement age for women is expected to be 67 years in the Czech Republic by 2044; 67 years in Poland by 2040; 60 years in Serbia; and 60 years in Ukraine by 2020. Most countries have early retirement provisions for workers with full contribution periods (more than 35 years).

41. Scheil-Adlung (2015).

Care work is labour intensive. It is characterized by irregular working hours, exposure to high physical and psychological stress, and the risk of work accidents. In spite of these hardships, their salary level is generally lower than for workers in other related sectors, such as health care. Poor working conditions result in high turnover and low retention rates of workers. Working conditions for care workers should be improved to attract more workers into this sector to fill the gaps in these urgently needed services. It should also be noted that the provision of long-term care services by private sector providers requires an effective governmental supervision of the private providers through regulation and quality controls.

The use of non-standard forms of employment and informal employment arrangements, especially common for domestic work, can expose these workers to multiple disadvantages, including a lack of protection of their labour rights and a lack of social protection coverage. Furthermore, the increased cross-border mobility has led to an increasing number of migrant care workers. For instance, the cases of Polish and Ukrainian migrant care workers, discussed above, present a multi-faceted impact on the workers themselves and on their families back home.

From a broader perspective, issues of fostering employment in the care sector and improving the working conditions of care workers cut across key mandates of the ILO. The ILO and its tripartite partners should provide strong support to resolve these challenges.

Despite the shift of policy focus from institutional to home care, a rapid increase in long-term care expenditure is inevitable in the future. Steps should therefore be taken to enhance the financing structure of long-term care systems. The introduction of revenue sources earmarked for long-term care, through taxation or contributions, is one option to mobilize reliable and necessary resources, although the debate is open.

In the face of profound demographic ageing, long-term care is emerging as a global concern for the elderly and their families. In line with the rights-based approach enshrined in international standards, notably the ILO Social Protection Floors Recommendation No. 202, and in collaboration with other international organizations, the ILO should play a proactive role in supporting national efforts to establish universal long-term care systems as integral parts of comprehensive social protection systems.

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