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Identification of Long-term Care Challenges in Europe

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Abstract: **Background:** Changes in demographic structures and especially the dynamic ageing of the population lead to an increased demand for care services. Finding ways to provide them efficiently has become one of the challenges for developed countries. The choice of the research issue is a consequence of recognising the fact that in recent years it has increasingly emerged as an area of practical and theoretical reflection in many scientific disciplines, including management and health sciences.
Research objectives: The aim of the study is to characterize characterising selected aspects of the organisations and functioning of long-term care in EU countries, describing the related initiatives taken by the European Commission and identifying the challenges faced by decision-makers and managers in the said service sector.
Research design and methods: The paper is based on the analysis of European documents, Eurostat database and literature review. It provides numerical analysis of current and prospective variables such as: average population age in EU 28, projected population age structure, population aged 65+, long-term care expenditure.
Results: Analysis of the available statistical data unambiguously confirms that increasing life expectancy, combined with low birth rates, leads to a significant quantitative increase in the proportion of older people in the overall population structure of EU countries. There is also no internationally accepted and standardised definition of what constitutes long-term care and thus no possibility of reliably identifying needs in this area. In many Member States, long-term care systems are characterised by horizontal interdependencies with health care and social care systems. Consequently, they may and do apply different criteria for long-term care eligibility, needs assessment, social protection scope and the catalogue of services and benefits offered.
Conclusions: The evolving social structures, the increasing introduction of artificial intelligence solutions and the situation after COVID-19 are changing the conditions of long-term care functioning, hence the reflection on the directions of these transformations is essential to properly formulate public policy practices.

Keywords: social economy, crises, pandemic, Covid-19, business model, transformation
JEL Codes: I13, I18

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1. Introduction

Changes in demographic structures and especially the dynamic ageing of the population lead to an increased demand for care services. Finding ways to provide them efficiently has become one of the challenges for developed countries. The aim of the study is to identify and describe key conditions for the functioning of long-term care in EU countries. In this article, the author focuses on characterising selected aspects of the organisations and functioning of

long-term care in EU countries, describing the related initiatives taken by the European Commission and identifying the challenges faced by decision-makers and managers in the said service sector. A particular area of interest is the assessment of human resources and working conditions as a prerequisite for the effective implementation of tasks related to the provision of services for people whose health condition does not allow self-care.

The choice of the research issue is a consequence of recognising the fact that in recent years it has increasingly emerged as an area of practical and theoretical reflection in many scientific disciplines, including management and health sciences. These two research perspectives complement each other since they make it possible to look at the organisational aspects of the activity of long-term care providers as a problem in shaping the living and health conditions of citizens who have to use services provided by care institutions due to their health and family members' inability to provide care. It should also be noted that the evolving social structures, the increasing introduction of artificial intelligence solutions and the situation after COVID-19 are changing the conditions of long-term care functioning, hence the reflection on the directions of these transformations is essential to properly formulate public policy practices.

2. Literature Review

Concept and identification of long-term care needs

The organisation of long-term care differs not only between the Member States but also within them. There is also no internationally accepted and standardised definition of what constitutes long-term care and thus no possibility of reliably identifying needs in this area. In many Member States, long-term care systems are characterised – in the absence of close interaction and with transparent cash flows – by horizontal interdependencies with health care and social care systems. Consequently, they may and do apply different criteria for long-term care eligibility, needs assessment, social protection scope and the catalogue of services and benefits offered.

In most Member States, long-term care is not defined as a specific branch of social security or a separate area of policy, but is covered by different social care and health care provisions. At the European level, the Court of Justice concluded that long-term care benefits are benefits aimed at improving the health and quality of life of those who need care and, as such, are to supplement health insurance benefits (Regulation (EC) No 883/2004). As indicated above, in many Member States long-term care is financed from different sources and organised at different levels of authority and institutional structures. In terms of regulation, funding and provision of services, long-term care provision can be closely linked to (or form part of) policies on health care, social care, housing, housing support services or persons with disabilities. This horizontal division can hinder the coordination of long-term care and even the provision of services. In some cases, the competencies of the entities responsible for the creation and delivery of long-term care may also be vertically divided between the national, regional and local institutional levels, which adds to the difficulty of preparing a rational, logical, coherent and effective system that responds to the real needs reported by citizens (Spasova et al., 2018).

While looking for a ground to create common solutions, a standardised definition of this social and organisational issue was proposed. The definition of long-term care in the EU was proposed by the Social Protection Committee in its first comprehensive report *Adequate social protection for long-term care needs in an ageing society* (2014). The referenced study defines long-term care as „a range of services and assistance for people who, as a result of mental and/

or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care." The daily living activities for which help is needed may be the self-care activities that a person must perform every day (Activities of Daily Living, or ADLs, such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling bladder and bowel functions) or may be related to independent living (Instrumental Activities of Daily Living, or IADLs, such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone)" (European Commission and Social Protection Committee (SPC), 2014). Although, in general, long-term care consists in providing services that enable a person to function in society, it should be distinguished – although the two concepts are connected – from the concept of social support understood as „the formal (government services and NGOs) and informal (family and friends) connections or relationships, based on empathy and trust, particularly useful in times of stress, where a vulnerable person interacts to find help by means of information, accompaniment or physical material" (Carabott, 2018).

The descriptive, rather than prescriptive, way of defining long-term care proposed in the EU document and hence the indication of the *delict* in which the estimation of long-term care needs takes place, makes it difficult to use it in the collection of statistical data, thus making it impossible to unambiguously estimate the potential number of beneficiaries. From the point of view of the criterion for inclusion in the group requiring long-term care, it is most useful to use international scales of ADL/IADL.

However, it should be emphasised that there is a certain arbitrariness in the process of assessing a person's need for long-term care or services or in the assessment of the extent of social protection in each Member State, resulting from the individualisation and contextualisation of the catalogue of restrictions and the level of difficulty of self-care and the ability to function well in the living environment, cognitive decline/aphasia and the inclusion of other indicators (e.g. social environment, availability of family support, medical history). Therefore, one may venture to say that the contextualised national data on the results of the needs assessment cannot quite provide an unequivocal basis for estimating the number of people in need of long-term care in the Member States. The data obtained using fuzzy measuring tools is not fully comparable between the Member States due to different assessment criteria and the exclusion of cases that are specific but not infrequent, e.g. people in need of long-term care who do not apply for any benefits for example because they are aware that their income or assets are too high for them to be able to receive the benefits from public funds. In this context, it is important to emphasise that due to the different types and extent of long-term care needs (for both health care and social care), there is in fact no service which would be legally and organisationally uniform for all Member States and could be defined as long-term care delivery. Apart from the general framework, there is a considerable variation in the planned and currently functioning long-term care solutions. This seems appropriate, since such care should be an individual response to different needs, resulting from the pursued model of social policy and the wealth of the state.

The modes of delivering health services

In recent decades, developed countries of the world started facing the problem of finding socially just and economically efficient methods of delivering health services (Frączkiewicz-Wronka, 2009), especially to people who require long-term care services due to their health condition. The solutions functioning in this field in EU countries can be divided into two, often

coexisting, approaches, i.e. institutional and non-institutional. The distinction between them is a consequence of the model of public policies pursued, specifically social and health care, and relates to the organisational and legal conditions of service provision. Focusing on the second criterion, we note that institutional long-term care is provided by qualified personnel employed by organisations dedicated to people who need to be supervised by medical professionals for an extended time, regardless of whether their care needs arise from physical or mental frailty, disability or other factors. It can also be provided in the form of coordinated home care, in which case the service is provided in the patient's home, but the service is conditional on the provider being licenced to provide medical care and employed by a care institution. In contrast, non-institutional long-term care is usually provided in the recipient's home by the people around them – family members, friends or neighbours – who are not formally employed as professional medical carers and provide their services on a voluntary basis without remuneration. The most distinctive feature of non-institutional care is the emotional connection between the recipients and providers of services and the latter's lack of specialised, certified training (Oliva-Moreno, Trapero-Bertran, Pena-Longobardo, Del Pozo-Rubio, 2017). The development of both institutional and non-institutional long-term care requires the design and implementation into the internal legal and organisational framework of solutions accepted and acceptable – at least to a basic extent – by the EU Member States. The development of formal care only complements, rather than replaces, informal care provided by members of the family network and helps better satisfy care needs.

3. Material and Methods

The paper is based on the analysis of European documents, Eurostat database and literature review. It provides numerical analysis of current and prospective variables such as: average population age in EU 28, projected population age structure, population aged 65+, long-term care expenditure. The most reliable information, and therefore used by the Social Protection Committee to estimate the number of people in need of long-term care services, are those obtained from surveys carried out in each EU country as part of the European Health Interview Survey (EHIS). The data collection process conducted under this scheme focuses on self-care limitations as described in the ADL and/or IADL which are considered the most important and standardised, hence the SPC's decision about the possibility of using them to operationalise long-term care needs.

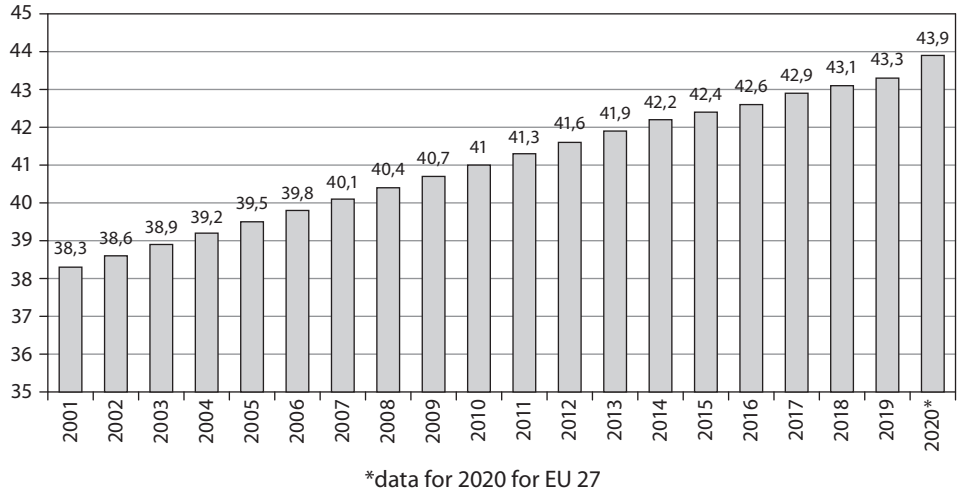
4. Results

Demographic changes and their consequences for provision of long-term care

The most important factor influencing the operation of long-term care providers are demographic changes and their consequences for healthcare systems. Analysis of the available statistical data unambiguously confirms that increasing life expectancy, combined with low birth rates, leads to a significant quantitative increase in the proportion of older people in the overall population structure of EU countries.

It is projected that in the next 20 years, the number of people aged 65 or over will increase by 41% – from 92.1 million in 2020 to 130.2 million in 2050, the number of people aged 80 or over will increase by 88% – from 26.6 million to 49.9 million, and the age dependency ratio (the

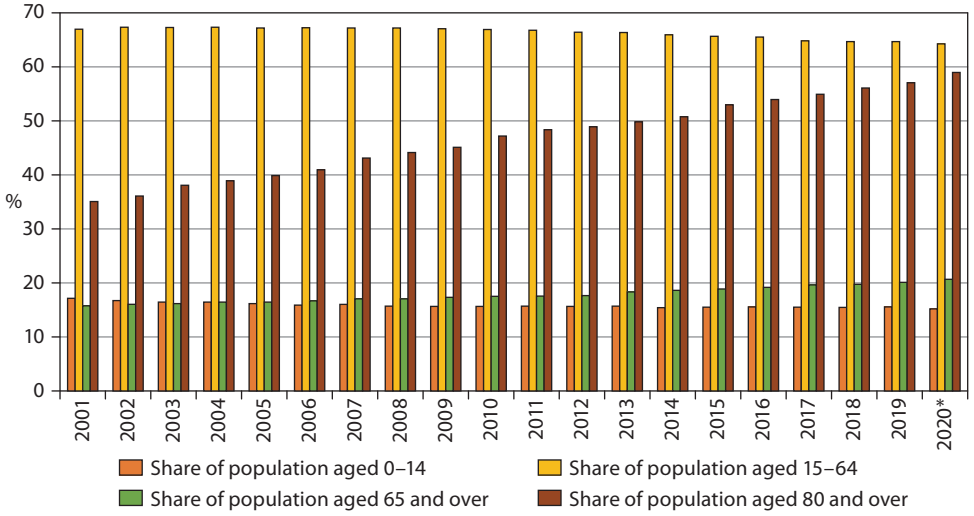
ratio of the number of persons of non-working age to the number of persons of working age) will rise from 32 to 52, a jump of more than 62% (European Commission, 2020).



*data for 2020 for EU 27

Figure 1. Average population age in EU 28 in the years 2001–2020

Source: Own elaboration based on Eurostat, Population structure indicators at national level [demo_pjanind] (Accessed: 27 August 2021).



*data for 2020 for EU 27

Figure 2. Population age structure in EU 28 in the years 2001–2020

Source: Own elaboration based on Eurostat, Population structure indicators at national level [demo_pjanind] (Accessed: 27 August 2021).

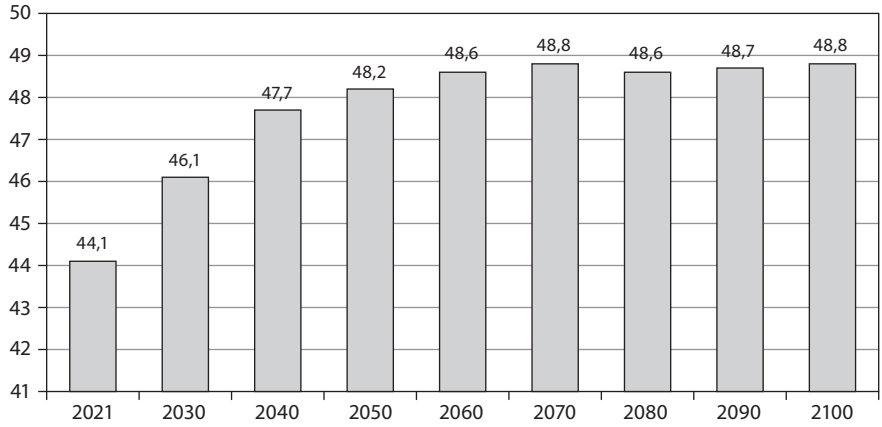


Figure 3. Projected average population age in EU 27 in the years 2021–2100

Source: Own elaboration based on Eurostat, Demographic balances and indicators by type of projection [proj_19ndbi] (Accessed: 27 August 2021).

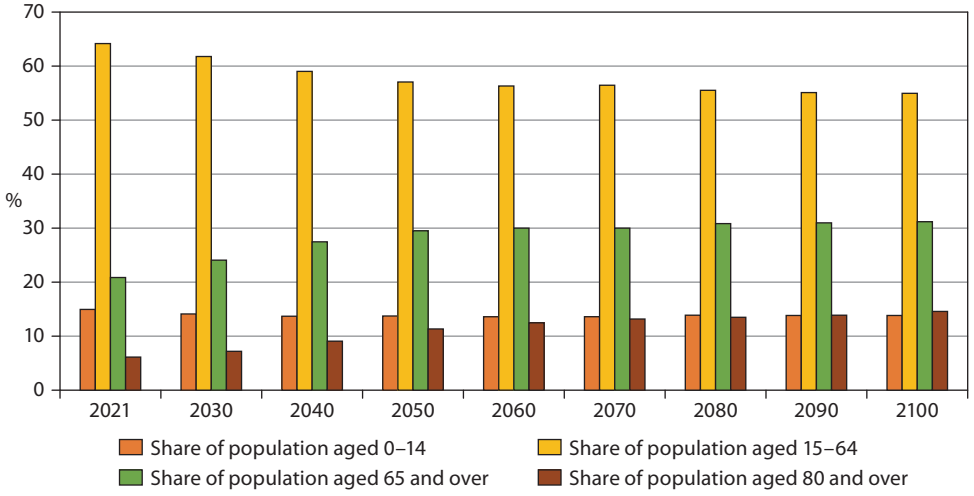


Figure 4. Projected population age structure in EU 27 in the years 2021–2100

Source: Own elaboration based on Eurostat, Demographic balances and indicators by type of projection [proj_19ndbi] (Accessed: 27 August 2021).

It is obvious that the demand for long-term care increases with age and is particularly prevalent among people in the 65 and over age group. In this age group, 47.8% of the population perceive themselves as people with disabilities who are restricted when performing many everyday tasks (Irzyniec, Nowak-Kapusta, Franek, Drzazga, 2016). In the context of assessing changes in the demand for elderly care, in addition to the information on increasing life expectancy, it is equally important to know whether these additional years of life are spent in good health, allowing for independent functioning, and to what extent these years are marked by helplessness and dependence (Elderly care in Poland 2022).

The observed increase in long-term care needs leads to the search for solutions that will support the efficient and effective delivery of such services to those in need. The European countries' recognition of the indicated development trend as one that is important and affects the conditions for achieving sustainable development was reflected in the preparation and announcement, jointly by the European Parliament, the EU Council and the European Commission on 17 November 2017, of the document establishing the European Pillar of Social Rights. This document sets out the key principles and rights for a renewed process of convergence toward better working and living conditions for the citizens of Member States. Of relevance to the issue at hand is Principle No. 18 of the aforementioned document, which states that „everyone has the right to affordable long-term care services of good quality, in particular home-care and community-based services". The above-mentioned provision means ex lege the establishment at EU level of the right to long-term care as an area of social policy, and thus paves the way for the search for effective solutions with regard to managing institutions which cater to such needs. Detailed activities related to the implementation of the European Pillar of Social Rights, including the announcement that in 2022 the European Commission will prepare a policy framework to guide the development of this system and ensure better access to quality services for people in need, were presented in a package of operational documents in March 2021 (European Commission, 2021a).

The observed growth of interest in identifying the conditions for the functioning of long-term care providers is a consequence of the impact of dynamic transformations taking place in the environment where organisations providing health and care services operate. The growing need for long-term care and the emerging drivers for its development prompted research into various aspects of the operation of organisations that provide this type of service.

Working-age population

The decreasing share of the working-age population observed in all EU countries will make it even more difficult in the coming years to finance the expenditures related to population ageing, including expenditure on long-term care, threatening the sustainability of the current health care and social care systems and increasing the risk of poverty among those who need care and their families. The observed phenomenon is justifiably worrying, as public expenditure on long-term care is projected to be the fastest-growing in the category of social public expenditures (compared to the expenditures on social care and pensions) in all Member States (European Commission, 2018). In the future, many Member States will face the challenge of developing sustainable systems for financing long-term care to overcome the expenditure growth. In view of the crisis caused by the COVID-19 pandemic, this will not be an easy task. At present, the level of long-term care expenditure in relation to GDP varies greatly across the 27 EU countries. According to the data from the System of Health Accounts, the currently estimated total expenditure on long-term care as % of GDP in 2018 ranged, for example, from 3.9% in the Netherlands, 2.1% in Germany, 0.9% in Italy and Portugal – to 0.01% in Bulgaria. Unfortunately, the limited, incomplete and often incomparable data collected in individual countries make it difficult to carry out a reliable analysis of this phenomenon.

In accordance with the usual eligibility conditions in public systems, which set a minimum threshold of long-term care needs, it is common to focus on difficulties classified as „severe" (as referred to in the EHIS survey). The Figure 6 illustrates the information available on this subject in each Member State.

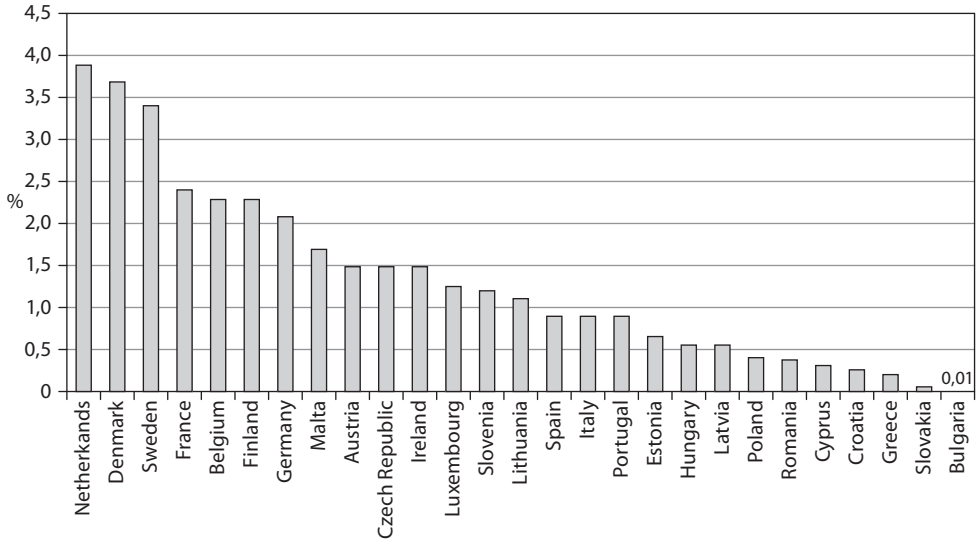


Figure 5. Estimated long-term care expenditure as % of GDP in 2018

Source: Own elaboration based on Eurostat, Reported long-term care expenditure as % of GDP [hlth_sha11_hchf] (Accessed: 27 August 2021).

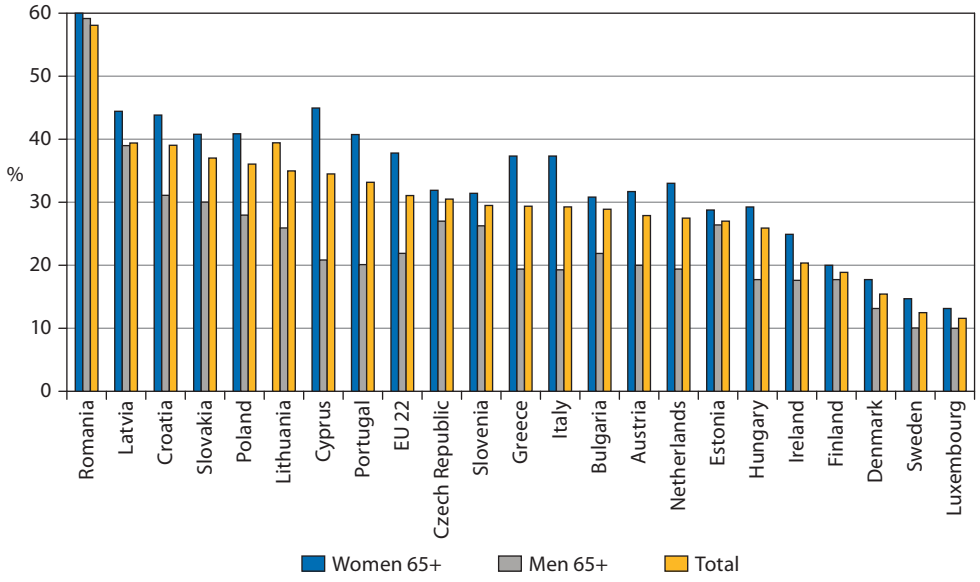


Figure 6. Share of population aged 65+ living in private households who have severe difficulties with personal care or household activities

Source: (European Commission, 2021b, p. 29).

On average, in the European countries that provided the data collected in the third edition of EHIS, 30.9% of people aged 65+ required long-term care in EU-22 (data from 2019), with

a clear variation in needs depending on gender. Women rate their health condition much lower than men. At the time the report *Long-term care report Trends, challenges and opportunities in an ageing society* (European Commission, 2021b) was prepared, analysts did not have data from the third edition of EHIS for countries such as Belgium, Germany, Spain, France and Malta, hence the indicators characterising the situation in these countries are not included in the summary (Figure 6), but analysis of the data available for the second edition of EHIS (2014) showed that, respectively, 36%, 24.9%, 15.2%, 25.9% and 34% of the total population aged 65+ had at least one major difficulty as assessed according to the ADL and/or IADL scale.

Analysis of the presented data not only leads to the conclusion that there is a need to think about creating economic and organisational support for the effective functioning of long-term care but also leads to the question of how, in terms of shaping labour resources, to prepare the system for the rapidly growing needs and yet the limited public funds that can be allocated to their implementation. It is difficult to find a satisfactory solution to a challenge formulated in this way because, as indicated earlier, long-term care institutions are not seen as desirable employers, the work there is both physically and emotionally exhausting and poorly paid, and the volume of public money must be allocated taking into account the needs of other sectors as well e.g. defence, environmental protection, internal security, etc.

Employment and working conditions in long-term care

Long-term care is provided by both formal and informal – mostly women – carers. This section characterises working conditions in an institutional system, i.e. one where services are provided by qualified carers employed in institutions operating in the service sector. The institutional long-term care sector is the employer for approx. 6.3 million people, representing 3.2% of the total EU workforce (Eurofound, 2020). Labour resources in long-term care include many professionals employed both in the direct process of service provision as well as in administrative structures. In addition to administrative staff, the sector employs support staff (e.g. cleaners, cooks), social care workers (e.g. assistants for the elderly) health care workers (e.g. general or geriatric nurses) and other carers employed in long-term care institutions. Long-term care workers perform their roles in collaboration with other professionals, especially those employed in hospitals, primary and specialist health clinics, social and health insurance institutions, as well as social workers and informal carers. The currently dominant perspective on deinstitutionalisation also imposes on them tasks related to working with organisational actors and community leaders, including representatives of people with disabilities or the elderly (e.g. Councils of Senior Citizens) (Frączkiewicz-Wronka i Kozak, 2018; Frączkiewicz-Wronka, Kowalska-Bobko, Sagan, Wronka-Pospiech, 2019). The vast majority of the total labour supply of formal long-term care workers is employed as nurses or personal assistants – in the Member States, respectively 67% and 33% (European Commission 2021b, p. 124).

This working environment is characterised by heavy feminisation (88% women), a relatively high – 45 years – median age and a very worryingly high already in 2019 – almost 38% – share of workers aged 50 and over (European Commission 2021b, p. 63). Due to growing needs, according to forecasts prepared by the European Centre for the Development of Vocational Training (CEDEFOP), between 2018 and 2030, 3.2 million jobs will be created in this system for professionals working in health care organisations and about 3.8 million for personal care workers. If this does indeed happen, it will be a good signal after a significant decrease in the average for the Member States between 2011 and 2016. During this period, the number of long-term care workers per 100 people aged 65+ fell from 4.2% to 3.8% (OECD, 2020). Almost all Member

States are struggling to achieve the optimum number of employees, in particular qualified care staff (mainly nurses) (Eurofound, 2020). Various factors may contribute to increased staff shortages in the future. These especially include the expected increase in demand for institutional long-term care due to the growing elderly population, as well as current trends, such as the increasing participation of women in the labour market resulting in decreased ability to meet care needs within family structures and the increased mobility of people, especially from the poorer Member States, which may affect the availability of informal carers. Analysing the structure of the geographical origin of long-term workers, we note that currently, in the countries of the so-called „old" Union, already around 20% of the resources do not originate from the country in which the employee is working (Eurofound, 2020). This phenomenon can be viewed both positively and negatively. The report referred to earlier reads „although the mobility of workers is one of the key elements of the EU acquis and involves many opportunities" (e.g. helps to alleviate shortages in the host Member States), the mobility of long-term care workers may entail challenges for the Member States from which they migrate. Firstly, it can exacerbate workforce shortages in these countries, especially since they themselves are struggling or will struggle with population ageing. Some Member States that export care workers fill the gaps by independently importing workforce, from other EU or non-EU countries. For example, Hungary attracts care workers from abroad, mainly from ethnic Hungarian communities in Romania, and Poland from Ukraine. Secondly, outflow countries invest in the education and training of care workers but then cannot use the skills they have developed because the graduates of different levels of education choose to work abroad. But it should also be pointed out that „many mobile workers send remittances home to their families, who then spend this money in the home country", and if the migrants become expats and return to their countries of origin for work, „they bring their experience acquired abroad, which can help to enrich local practices" (European Commission 2021b, p. 63). Other factors that may increase workforce shortages in long-term care are mainly those highlighted above, such as the ageing of the workforce and, as a consequence, the retirement of many existing employees. Not without significance is also the competition on the labour market from other sectors offering more attractive employment opportunities and better working conditions, thus resulting in the drainage of an already shallow market of long-term care workers.

Most employees among nurses and personal carers in long-term care institutions have a secondary or higher level of education while the access to some professions is strictly restricted by law regulations, which is important for the quality of provided care but hinders the access for those who have skills not confirmed by formal qualifications. This, in turn, has an indirect negative impact on the numerical growth of labour resources. Requirements for skills and qualifications in long-term care are becoming increasingly complex, which on the one hand, may exacerbate staff shortages, but on the other hand, may also contribute to making work in the sector more attractive. Its appeal may also be increased by the application of multiple information and communications technology (ICT) solutions, which will partially allow to replace human labour with artificial intelligence. On the positive side, telecare and online interventions reduce travel time, are usually shorter than on-site visits and their organisation is more flexible. Using ICT for documentation preparation can reduce the time spent on office work, allowing carers to focus on core tasks related to patient care, improving both working conditions and the quality of care. Technology and artificial intelligence used in monitoring patients can reduce the number of staff needed during night shifts to monitor vital functions. Care robots can also take over physically demanding tasks, such as lifting the patients, and

online platforms bringing together people in need of (mainly home) long-term care with persons providing care will better serve to match supply and demand if, of course, they are properly managed and equipped (Mosca, van der Wees, Mot, Wammes, Jeurissen, 2017). However, in order to take full advantage of the potential benefits of technology for long-term workers, it is necessary to invest in the development of their digital skills (Zigante, 2020).

The assessment of the working environment by long-term care workers confirms that they are aware of its importance, but also reveals the lack of satisfaction with working conditions. According to the 2015 survey data, 71% of long-term care workers had a sense of doing useful work, but only 22% said they were satisfied with their working conditions. Particularly negative was their assessment of the wage levels and the social working environment including exposure to the consequences of the, not at all rare, traumatic relationships with patients (often resulting from their multimorbidity, dementia and other old-age diseases that impair social functioning) and health consequences perceived as particularly distressing (Eurofound, 2020).

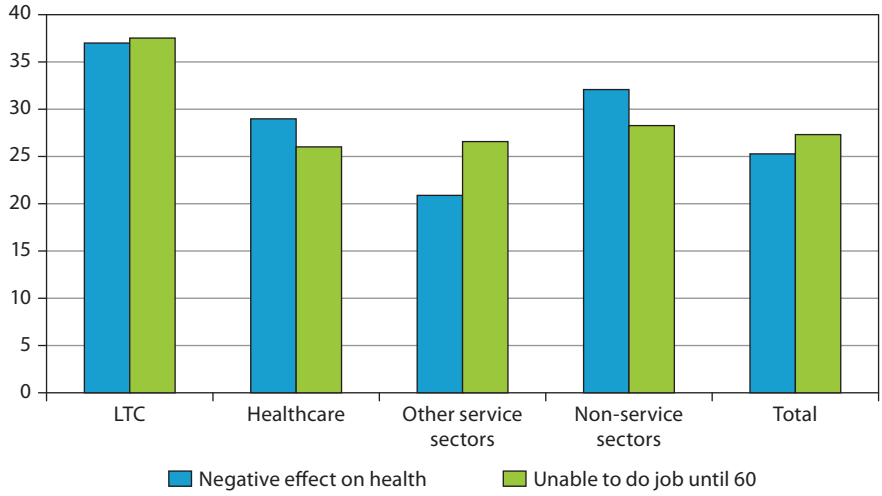


Figure 7. Work and health, EU-27 and UK

Source: (European Commission, 2021b, p. 63).

The difficult working conditions are reflected in a significant share of long-term care workers facing health problems, which is confirmed by the survey results shown in Graph 7. Long-term care sector workers perceive their work as resulting in far greater adverse health effects than workers in other sectors of the economy; they are also more likely to believe that they will not be able to continue working in their current job until the age of 60. In concluding the discussion of employment and working conditions in institutional long-term care, it should be noted that in recent years many Member States have been taking measures to improve the attractiveness of this sector. The main ones concern wage increases as well as opportunities to improve qualifications by creating new fields of study and providing training for people who want to certify their skills and thus become employable in long-term care institutions.

5. Discussion

The growing needs in terms of financial, legal and organisational preparation of the entities of the health care, social policy and public management system for the necessity of securing the health and care needs resulting from dynamic demographic changes intensify the work toward solutions to this problem not only within individual EU Member States but more broadly – at EU level. For many years, the dynamic demographic changes and their consequences for the health care and social security systems, affecting all EU countries, have been the subject of numerous analyses conducted by both theorists and practitioners, and their results contribute to the design of new methods for dealing with the identified problems. Observed since the 20th century, the increase in life expectancy and the sudden growth in the number of people with disabilities – due to the increase in the number of the so-called older age cohorts (80+) (Szarota, 2010) – are what directs the attention of decision-makers who shape the foundations of public policies toward the search for appropriate (with regard to the emerging needs) organisational solutions for long-term care. It is particularly important to correctly identify the so-called care gap. The care gap, i.e. unmet care needs, is defined as the difference between the identified care needs resulting from the elderly person's health condition, degree of autonomy, age, family status, economic status, cultural resources (individual characteristics of the individual) and the help and support received. The care gap is identified on two levels. The first level (Care Gap I) is the unmet care needs within the family and social networks that constitute the so-called informal support networks for the individual. In other words, this gap is determined based on the difference between the care needs of the individual and their satisfaction by relatives and unrelated persons (neighbours, acquaintances, friends). Care Gap I can be bridged by providing formal institutional and community support. Care services provided at the place of residence of the elderly person, as well as semi-institutional and institutional assistance should reduce the degree of unmet care needs. Therefore, the second level of unmet needs is defined as Care Gap II. It forms when the assistance received from family and unrelated persons, as well as the purchase of care services, assistance provided by non-governmental organisations and assistance provided by local and central government are insufficient to satisfy the individual's care needs. Given the diversity of elderly care models in EU countries, one of the new challenges faced by the EU is the need for partial standardisation, across the Member States, of indicators reflecting the scope, access, scale of needs and solutions used to support the development of institutional and non-institutional long-term care, in order to harmonise the identification of the care gap.

As a result of the emerging challenges in recent years, EU policy-makers are paying special attention to the preparation of effective institutional solutions for the growing number of people who are unable to secure the services they need to live with dignity in their community through their own efforts, slowly moving towards a systemic settlement of the revealed social issue at EU level.

Since 2014, a key role in this process – even though long-term care policy-making is generally the responsibility of the Member States – has been played primarily by the European Commission, i.e. the executive body responsible for current politics, overseeing the work of all agencies and managing EU funds. This body, using economic, awareness-related, legal and other instruments, initiates and supports the implementation of practices that enable the effective provision of high-quality care services to people whose health condition prevents them from living fully independently. On the date indicated, the first comprehensive report was prepared

and published on behalf of the European Commission, identifying the three most important organisational challenges faced by national governments, i.e. (1) a rapid and huge increase in the needs for care of dependent persons, (2) an inadequate number of qualified personnel willing to work in entities providing long-term care, and (3) the creation of opportunities conducive to the provision of the desired quality of services in relation to the indicated growth of expectations and revealed shortages in the health professional market (European Commission and Social Protection Committee (SPC), 2014).

The growing awareness among political decision-makers of the gap between the demand for and supply of long-term care services has led to a number of measures being proposed and actually taken in recent years in order to foster the implementation of effective long-term care solutions at the European level. The most important of these include:

- creating a knowledge repository to make better use of available data in order to monitor the impact of the dependency of an increasing number of people on society and the labour market;
- identifying the adequacy of the degree of social protection to the consequences of the risk of dependency;
- strengthening cooperation and continuing joint work on the development and application of tools for measuring the level of effective social protection in long-term care by the European Commission and the OECD;
- supporting mutual learning activities by promoting good practices under the open method of coordination;
- increasing in the volume of EU funds allocated, mainly within the cohesion policy, to the development and standardisation of long-term care;
- implementing strategies to prevent the emergence of negative development trends (European Commission, 2014, p. 23).

As indicated above, long-term care policy-making is ex lege the domain of the Member States, however, the application of the open method of coordination made it possible to agree, within the Social Protection Committee, on common objectives for the accessibility, quality and sustainability standards of health care and long-term care being developed, as well as to search for ways of effective management in institutions providing services in these areas. Since management is only possible if objectives are set, resources for their implementation are allocated, employees are mobilised and the results are controlled in terms of the pre-set objectives, the experts of the Social Protection Committee, following this rule, have started work on the preparation of a common to the Member States catalogue of indicators assessing this accessibility, sustainability and quality in the existing long-term care solutions. The aim of this action is to create a base that will be useful for assessing the current state and charting a course for change. Selecting indicators, followed by collecting adequate data and monitoring it, is expected to contribute to the preparation of a formula/tool for the operationalisation of the implementation degree of the recommendations put forward by the European Commission and enable proper orientation of organisational activities and introduction of necessary adjustments. Important for the achievement of the indicated objectives was the preparation of recommendations concerning (a) maintaining budgetary sustainability despite the numerical growth of the group of potential beneficiaries of long-term care services, (b) access to long-term care services, (c) monitoring the situation on this labour market, mainly women's (d) creating solutions to support the legal and economic position of persons providing informal long-term care.

Not without significance for the efficiency and sustainability of long-term care systems are the consequences of population migration between the Member States. According to statistics, 13.3 million EU citizens were living in a Member State other than their country of origin in 2019 (European Commission, 2020). The observed directions of migration reveal that these flows can mitigate the negative effects of ageing in the inflow regions while simultaneously aggravating already negative demographic trends in the outflow regions, often facing not only population decline but also the aggravation of unfavourable relations between the pre-working age, working age and post-working age population. This phenomenon is all the more worrying because the outflow concerns not only countries and regions with relatively weaker economies, but also those with underdeveloped institutional support systems for the disadvantaged and with a low level of social capital which (if it were at a high level) could, even if to a limited extent, contribute to the activation of non-institutional forms of long-term care provision. Increased mobility also means that children often work far from their parents' place of residence and, consequently, are unable to care for them, shifting this responsibility to public institutions.

6. Conclusions

The presented considerations focused on the characterisation of selected aspects of long-term care treated as an important area of state activity. The invoked Principle No. 18 of the European Pillar of Social Rights, which emphasises the rights of every citizen of the Member States to affordable care services, in particular institutional, home and community-based care, obliges national decision-makers to take active measures to redefine public policies, including in particular health and social protection, so that that the objectives set out in the European Commission documents are implemented in organisational reality. This should be done through public management practices and access to EU funding, including in particular resources of the European Social Fund Plus (EFS+) and the new economic instrument prepared in the era of COVID-19 for economic recovery and strengthening cohesion. These financial instruments are to be used both for public investments and for reforms aimed at strengthening resistance to changes, including those resulting from the observed significant increase in demand for long-term care.

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