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Tim Muir

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MEASURING SOCIAL PROTECTION FOR LONG-TERM CARE

Tim Muir*

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ABSTRACT

This report presents the first international quantification and comparison of levels of social protection for long-term care (LTC) in 14 OECD and EU countries. Focusing on five scenarios with different LTC needs and services, it quantifies the cost of care; the level of coverage provided by social protection systems; the out-of-pocket costs that people are left facing; and whether these costs are affordable.

The cost of care varies widely between countries but it is always high relative to typical incomes, meaning that LTC is often unaffordable in the absence of social protection. All countries studied have some form of social protection for LTC, but even where coverage is comprehensive, people pay some of the cost out of pocket. Coverage for home care for moderate or severe needs is often insufficient, leaving people with large out-of-pocket costs. In contrast, all countries studied ensure that institutional care is affordable. Unless family and friends can provide informal care, many people will be unable to afford LTC in their own home, leaving them with unmet needs or at risk of early institutionalisation. Benefits are usually means-tested to provide more support to those less able to afford to contribute, but it is still those with lowest incomes that are most likely to face unaffordable costs. Some countries provide financial support to informal carers, but this rarely comes close to compensating them for the time they spend providing LTC.

When designing social protection systems for LTC, countries need to look systematically at the level of protection provided to people in different scenarios. Many countries aim to support people with LTC needs to remain in their own home for longer, but the results presented here suggest that gaps in social protection make this unaffordable for people with low income. Addressing these gaps should be a priority for future reforms.

APERÇU ANALYTIQUE

Ce rapport présente les résultats du premier exercice international de quantification et de comparaison des niveaux de protection sociale assurés au titre de la prise en charge de la dépendance dans 14 pays de l'OCDE et de l'UE. Partant de cinq scénarios qui recouvrent chacun des besoins et des services différents en la matière, les auteurs ont entrepris de chiffrer le coût de cette prise en charge, le niveau de couverture offert par les systèmes de protection sociale et les dépenses que les intéressés doivent directement assumer, en posant la question de savoir si celles-ci sont abordables.

Le coût de la prise en charge de la dépendance est très variable d'un pays à l'autre, mais il est toujours élevé par rapport aux revenus types, si bien que l'aide et les soins de longue durée sont souvent inabordables en l'absence de protection sociale. Tous les pays étudiés possèdent une forme ou une autre de protection sociale pour la prise en charge de la dépendance mais, même lorsque la couverture offerte est très étendue, les intéressés doivent assumer directement une partie des dépenses. La couverture de la prise en charge à domicile des personnes ayant des besoins modérés ou importants est souvent insuffisante, ce qui contraint celles-ci à supporter de lourdes dépenses. En revanche, tous les pays étudiés s'attachent à faire en sorte que la prise en charge en établissement soit abordable. Si une aide informelle ne peut être fournie par la famille et les amis, beaucoup ne pourront être pris en charge à leur domicile faute d'en avoir les moyens, ce qui les laissera dans l'impossibilité de voir leurs besoins satisfaits ou les exposera à un placement précoce en établissement. Les prestations servies dans ce domaine sont généralement soumises à un critère de ressources, afin qu'un soutien plus grand puisse être assuré aux personnes qui sont peu en mesure de participer aux dépenses, mais l'aide et les soins requis risquent néanmoins de demeurer inabordables pour les personnes aux revenus les plus bas. Certains pays apportent un soutien financier aux aidants informels, mais celui-ci est généralement loin de pouvoir les dédommager pour le temps qu'ils passent à s'occuper de personnes dépendantes.

Lorsqu'ils conçoivent des dispositifs de protection sociale pour la prise en charge de la dépendance, les pays doivent systématiquement prendre en compte le niveau de protection assuré aux intéressés dans les différents scénarios. Beaucoup de pays souhaitent aider les personnes dépendantes à bénéficier d'un maintien à domicile plus long, mais les constats exposés ici montrent que les lacunes affectant la protection sociale rendent cette solution inabordable pour les personnes à faible revenu. Combler ces lacunes devrait être une priorité des futurs efforts de réforme.

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KEY FINDINGS

- **Long-term care (LTC) is expensive leaving many people reliant on social protection.** In all countries studied, the cost of home or institutional care for severe needs is equal to or greater than the median disposable income for over-65s. Unless people have savings they can use to pay for care, or family and friends who can provide care for free, many will be reliant on social protection systems.

- **The cost of long-term care varies widely between countries.** For example, home care services in Sweden are more than twice as expensive as in France and England, relative to GDP. This may in part be due to stricter requirements on the qualifications of staff, or higher levels of pay, which could mean that care is of a higher quality. Sometimes local and geographical factors might contribute, such as the higher cost of travel time when providing home care in rural areas. But countries should also consider whether there are other factors such as excessive overheads causing high costs and whether these can be reduced without affecting the quality of care.

- **People with lower levels of need are not eligible for support in some countries.** In the Czech Republic and Israel, someone with low needs (requiring 6½ hours of support per week) would not qualify for social protection. In England, they would not qualify for the main social care system, but would still receive a cash benefit. Where resources are limited it makes sense to target them on those with the most severe needs, as they are in greatest need of protection. However, people with low incomes can often find it difficult to fund even lower-level care out of pocket and countries need to consider whether people are left exposed to poverty or unmet need when their needs are below the eligibility threshold.

- **Most countries apply some degree of means-testing by income, but low-income people are still left exposed.** Means-testing on income is common, although all countries except for the United States also have a universal element to social protection for LTC needs (this is small in England). Nonetheless, in most countries, older people with low incomes – many of whom are already below or close to the poverty threshold[1] – are left the most exposed to the cost of care. Except in countries with comprehensive coverage (Iceland, the Netherlands and Sweden) and those with well-targeted systems (England and Belgium), home care for even moderate needs is unaffordable to low-income older people. LTC policies in many OECD countries aim to help people to live independently in the community for as long as possible and rates of home care have increased in recent years. Countries need to strengthen social protection systems to ensure that this option is not only available to the relatively wealthy.

- **Some countries limit access to home care on affordability grounds.** Home care is often a more expensive way of managing severe needs than institutional care, so some countries (some Canadian provinces, Slovenia and Korea) limit the number of hours of home care that are covered by their social protection systems. This is a way of ensuring that institutional care is used when it is the cheaper option, which can improve value for money and free up resources to be used elsewhere in the LTC system. However, some older people prefer to remain in the community even with relatively severe needs, so there is a trade-off between controlling public expenditure and offering choice and independence to LTC users.

[1] Defined as 50% of the median income for the whole population

- **Even those with low incomes can in principle access institutional care.** People in institutional care are often required to make a contribution towards their "accommodation costs", but when they (and sometimes their families) have no way of meeting these costs, the shortfall is covered by public social protection systems in all countries studied. In this way, institutional care may act as a "safety net" for those who do not have the family or financial resources to remain in the community. However, eligibility for publicly-funded institutional care is often limited to those with the most severe needs and people with low incomes who fall below this threshold might be unable to meet their needs in any setting.

- **Some countries expect people in institutional care to contribute all of their income except for a "pocket money" allowance.** These allowances can be very small in some countries. For example, in some parts of the United States, people with median income can be left with as little as 1% of their income. England and France also have defined income allowances, but rates are higher at around 10% of income for the median older person. While the Netherlands does apply a similar form of rule, it includes several allowances totalling around 40% of a person's income. Very low rates risk undermining the dignity and independence of the care user, but higher rates could significantly increase costs to the public purse.

- **A minority of countries studied consider people's assets when determining levels of social protection for LTC**. Such rules are slightly more common for institutional care and generally people with higher assets still receive some social protection. However, in the United States, support is completely withdrawn from anyone with high assets and in England they only receive a relatively small cash benefit. In these countries, people with assets are expected to use them to pay for care until they run out of savings and become eligible for social protection. The same is true in Israel for institutional care only. Although views may differ on the degree to which it is reasonable for people to pay for care from their assets, there is a strong case that the ability to pool this risk would be beneficial. The lack of social protection for people with high assets – and homeowners going into institutional care in particular – is a current policy issue in the United States and England, both of which have recently explored the possibility of reforms to address this gap.

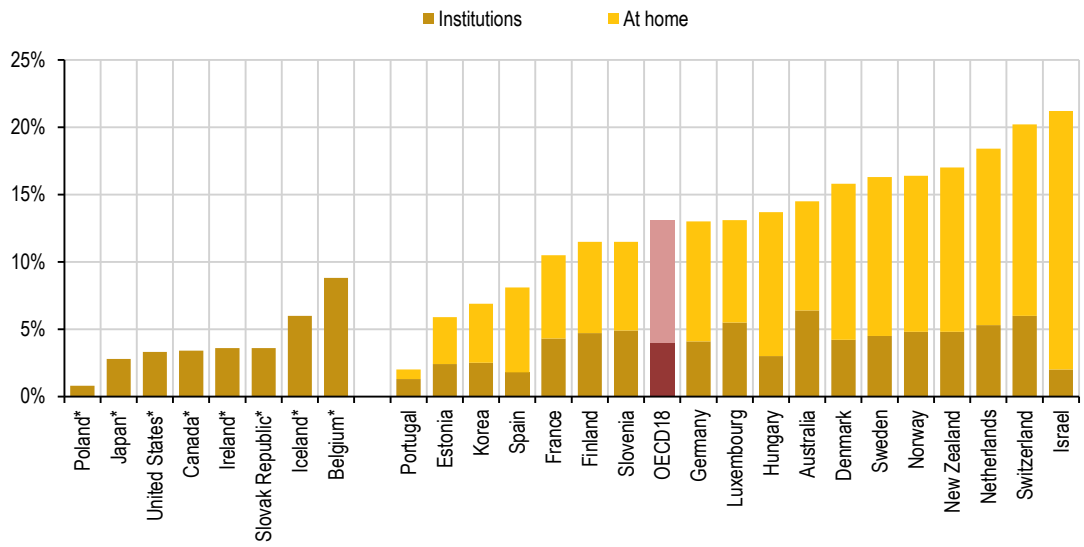
1. INTRODUCTION

The policy relevance of social protection for long-term care

Long-term care is increasingly important, but there is significant variation in whether and how people's needs are met

1. Long-term care (LTC) is an issue of increasing importance to OECD countries. Over the last decade, the share of the population receiving LTC services has grown in almost all OECD countries with a large part of this growth relating to the very oldest in society. However, the number of people receiving LTC varies dramatically between countries. In Portugal, Estonia, Korea and Spain, less than 10% of over-65s are receiving LTC in institutions or at home; in Switzerland and Israel it is over 20% (figure 1).

Figure 1. Proportion of over-65s receiving long-term care in institutions and at home, 2014 (or nearest year)



Source: OECD Health Data 2016
* Country only reports data on LTC recipients in institutions

2. Although the probability of someone needing LTC increases with age, the cross-country variation seen in figure 1 is not in general driven by demographics. The population in Spain, for example, is much older than the population in the Netherlands, yet far fewer people in Spain receive LTC. Nor is it driven by disability rates, which are thought to be similar in most OECD countries (WHO, 2004). Instead it seems likely that the number of people who need help in the course of their daily lives is similar in most countries, but whether and how that help is provided varies.

Needs can be met by formal or informal care, or can go unmet, all of which have a cost

3. People with LTC needs may receive help from a number of sources. For those still living at home, the first line of support is often family and friends who provide unpaid care, often referred to as informal care. Informal care is important in all countries, but is more common in some than in others. The proportion of the people aged over 50 who say that they are informal carers varies from a little over ten

percent in Israel, Slovenia and Sweden, to nearly twenty percent in Belgium and Estonia (OECD, 2015a). Informal care, although unpaid, is not costless. Families and friends give up their time to look after loved ones when they could be using that time for work or leisure. Carers face an increased risk of mental health problems and may find it difficult to remain in work (Colombo et al., 2011).

4. Many people receiving care in their own home have some or all of their needs met through formal care services, provided by professional carers, and most care in institutions is delivered entirely by professional staff. Formal care services can have significant financial costs. There is huge variation in the size of the formal care workforce, with Sweden having over 12 LTC workers for every hundred people aged over 65 and Portugal and Turkey reporting virtually none (OECD, 2015a). However, very low numbers of formal care workers does not necessarily mean that no one is paying for care. In some countries, it is common for undeclared workers (often immigrants) to be hired as carers, and these people would not show up in the statistics.

5. Where people do not have access to, or cannot afford, formal care, and where their families cannot or will not support them, LTC needs will not be met. This leaves them without the support they need to carry out tasks that most people take for granted, such as washing and getting dressed. The absence of support can have a catastrophic effect on people's quality of life, or even lead to early death. However, since people who are not receiving services fall outside of LTC systems, and since they are often unable to speak up about their situation, little is known about levels of unmet need or the impact that this has on people's lives.

Care costs are unpredictable and can be very high, so there is a case for pooling risks

6. LTC needs are inherently unpredictable. It is very difficult for an individual, even once they reach retirement age, to know whether they will develop an illness or disability in the future that leaves them dependent on others. While many people will never need LTC, others may develop severe needs and require intensive support or institutional care. Where these needs are met through formal care they can be expensive, with costs far exceeding typical incomes for over-65s. Moreover, LTC needs can persist over many years, with lifetime costs running into huge sums.

7. Modelling carried out for the *Commission on Funding of Care and Support* in England estimated that around a quarter of people aged 65 today will not need any LTC over their lifetime, while one in ten will have lifetime costs of over GBP 100,000 (Dilnot Commission, 2011). Research from other countries has found similar results[2]. Large and uncertain costs such as these are difficult for individuals to manage on their own. To ensure that they can afford care services if they do need them, they would have to save hundreds of thousands of dollars. For many people this would be impossible, because they simply do not have that amount of money, leaving them exposed to the risk of unmet need. For others it would be sub-optimal, since they would be forced to reduce consumption of other things that could improve their lives.

8. In situations where people face large and uncertain costs, there is a benefit to pooling their risks. Where risks are pooled, people no longer need to make provision for the worst case scenario. Costs are made predictable: each person pays the average cost of everyone in the risk pool. This principle is applied in many aspects of life where insurance is taken out privately (e.g. against the risk of fire) or where risks are pooled on a societal level (e.g. the universal public health coverage provided in most OECD countries). Unpredictable and large costs suggest that risk-pooling would be beneficial for LTC as well.

2 For example, Kemper et al. (2005) estimated that 42% of 65-year-olds in the United States will face no costs over their lifetime, while 16% will face costs of more than USD 100,000

Private insurance options are limited and public social protection is variable

9. Despite the strong case for risk-pooling, coverage of LTC costs is variable across countries. The private sector provides only limited options for pooling the risk of high LTC costs. In most countries there are few private insurance options available, and even where they do exist they remain a niche product covering only a small proportion of total LTC costs (Colombo et al., 2011).

10. There are a number of possible explanations for the lack of private insurance for LTC. Market failures may be important, such as adverse selection: if people are better able to predict LTC risks than insurance companies then high-risk individuals will be more likely to buy insurance, forcing insurance companies to increase prices, which will drive lower-risk people out of the market and lead to further price increases. However, while adverse selection is an important issue for health insurance, it may be less significant for LTC. Where products do exist, they sometimes require people to start paying contributions many years before they are likely to have LTC needs, so they may be unable to predict their level of risk when making buying decisions.

11. However, these long timescales raise another issue: people do not plan ahead due to a myopic view of risk. As with pensions, people tend to undervalue the importance of paying in now to provide them with financial security in the future. In both pensions and LTC, people will not in general make sufficient provision without a degree of incentive or compulsion – and in both areas it is common for governments to try to address this gap through public schemes (funded either through general taxation or earmarked contributions) or by incentivising or mandating private provision.

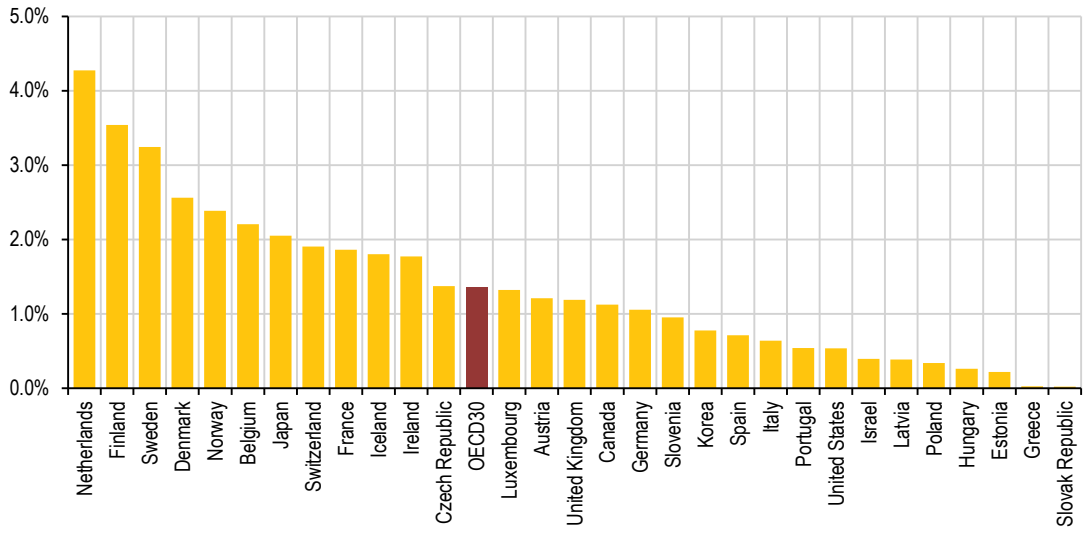
12. Most countries provide some degree of public risk-pooling – or social protection – for people with LTC needs, but the level and type of coverage varies. Some countries, such as the Nordics, have universal, tax-funded social care systems, which provide comprehensive coverage of LTC costs, comparable to the universal health care systems which exist in most OECD countries. Other countries have dedicated social insurance schemes, which can provide relatively comprehensive (e.g. Netherlands and Japan) or partial (e.g. Korea and Germany) coverage of costs. A third group of countries (e.g. Austria, the Czech Republic and Italy) relies largely on cash benefits to support people with LTC needs. The United Kingdom and the United States both have means-tested, safety net systems, under which the poorest are fully covered but the richest get little or no support (Colombo et al., 2011).

Countries need to balance social protection for LTC with concerns about public expenditure

13. The wide range of approaches to providing social protection leads to a wide range of costs to public budgets (figure 2). While Sweden and Finland spend over 3% of GDP, and the Netherlands over 4%, on publicly-funded LTC, Greece and the Slovak Republic spend virtually nothing. Some of this is explained by the relative wealth of countries: many of the countries spending very little public money on LTC are those that can least afford to spend more. However, in other cases the differences come down to the choices that countries have made. Germany and Austria have comparable levels of GDP per capita to Sweden, Finland and the Netherlands, but the latter spend three times as much on public LTC.

14. With ageing populations and rising expectations, public LTC expenditures are projected to rise in the coming decades in all OECD countries (OECD, 2013). As a result, ensuring the fiscal sustainability of public LTC arrangements is among the most important policy priorities for many OECD countries (Colombo et al., 2011). Meanwhile, there is recognition in many countries that social protection for LTC is not always adequate and that some people are left exposed to high costs and the risk of unmet need. Balancing these concerns will be a crucial challenge for LTC policy over the coming decades.

Figure 2. Public expenditure on LTC as a share of GDP (2014 or nearest year)



Source: OECD Health data 2016
Notes: Refers to total expenditure reported as either "health" or "social" LTC under the System of Health Accounts definitions used by by OECD, WHO and the European Commission. Includes spending on LTC for people of all ages, while the analysis in this report focuses on older people (65+). Data for the United States and Israel refer to institutional care only.

The purpose of this report

There is a lack of comparable, quantitative information on social protection for LTC

15. Balancing concerns about costs and coverage is difficult when the information that countries have about the two is asymmetrical. Data on public LTC expenditure is reported under the System of Health Accounts, allowing countries to assess their spending against a common definition of LTC and make meaningful international comparisons (figure 2).

16. Information on what countries get for this money is less comprehensive. Data on user numbers is collected, but – in principle at least – this includes publicly and privately-funded care. Total private expenditure is collected under the System of Health Accounts, but since some private spending happens completely outside of any public system, there is significant under-reporting. Even if private spending were accurately captured, it is difficult to say much about social protection without knowing the degree to which those who pay privately can afford to do so without significantly affecting their wellbeing.

17. In *Help Wanted? Providing and Paying for Long-Term Care*, the OECD looked at how social protection systems are organised and the rules that govern how much support is provided to whom. Grouping systems into three categories – universal coverage within a single programme, mixed systems, and means-tested safety net systems – this report mapped out the programmes that exist in OECD countries, how they are financed, which populations they apply to and the types of benefit they provide (Colombo et al., 2011 – see table 7.1, page 216). However, it was not possible at that point to quantify the effect of these arrangements on the level and adequacy of support that people receive.

This report aims to address that gap by quantifying theoretical levels of social protection

18. The purpose of this report is to address that gap and provide policy-makers with comparable information on which to base an assessment of the effectiveness of social protection systems for LTC in OECD and EU countries. This has been done by taking a bottom-up, theoretical approach to mapping out the cost of care, the level of coverage that would be provided in various scenarios and the out-of-pocket costs that people are left facing. The results presented in this report highlight weaknesses in social protection systems that policy-makers should aim to address in future reforms.

19. The analysis in this report covers 14 out of a total of 41 OECD and EU countries and quantifies social protection for a limited number of scenarios of needs, income and assets. The OECD and European Commission are continuing to work in this area and priorities for future work include expanding country coverage and developing modelling capacity to explore a wider range of scenarios.

2. ANALYTICAL FRAMEWORK

Defining the key concepts: what is social protection for long-term care?

Long-term care refers to the services that older people require to help them carry out personal care and housekeeping tasks, and to maintain social relationships

20. As people grow older, it becomes increasingly likely that they will need help from other people to carry out the activities that make up their daily lives. These activities include things like washing and getting dressed – referred to as personal care, or Activities of Daily Living (ADLs) – as well as housekeeping tasks, like cleaning and shopping – which are known as Instrumental Activities of Daily Living (IADLs). As people become more dependent, they may also find it difficult to maintain social relationships and activities, so may need help with (for example) attending a social club or going out for a walk. Finally, people who are dependent on others often need ongoing medical care to manage chronic conditions and ensure that they remain as healthy as possible.

21. These four categories of support broadly correspond to the definition of LTC used in *A System of Health Accounts* (OECD, Eurostat, WHO, 2011) to define categories of health and social care spending. However, the analysis in this report does not include medical services of LTC. This is partly to limit complexity – while ADL and IADL needs are similar for most dependent people, they may have a wide variety of medical needs – and partly because social protection for medical needs is generally better than for other types of LTC, due to comprehensive health coverage in most OECD countries, and so is a less pressing policy issue.

22. Although people of any age can become dependent on others through illness or disability, this report focuses primarily on older people (aged over 65). In countries where the social protection systems for LTC are the same for people of any age, the results may be applicable to the working age population. However, many countries have different sets of benefits and rules covering different age groups. Understanding social protection systems for older people is the first priority for most OECD countries, but future work may extend this analysis to other groups.

This report focuses on the financial and monetisable aspects of social protection

23. Social protection is usually defined as public actions that are taken to avoid or ameliorate situations or risks that people face, which could have a negative impact on their wellbeing. With respect to LTC, people face the risk that they will become dependent and need help with day-to-day activities. If these needs are not met, or if the care provided is of a poor quality, then their quality of life will suffer. If these needs are met, then this comes with a cost: either a financial cost if professional care services are purchased; or if friends and family give up their time to provide unpaid care and support, this has an opportunity cost and poses risks to their health and ability to work.

24. Public actions can address each of these potential impacts. The risk of needs going unmet can be reduced by ensuring the availability and affordability of high quality formal care services and by removing barriers to families providing care, where they wish to. The financial impact of using professional care services can be moderated by public risk-pooling systems which pay some or all of the costs and reduce out-of-pocket expenditures. Family and friends who provide informal care can be compensated for the opportunity costs that they incur by giving up their time and supported to remain healthy and continue to work.

25. The multi-faceted nature of social protection is crucial to how countries should support people with LTC needs. However, the analysis in this report focuses on the financial (or monetisable) aspects, as summarised in figure 3. Some of the other dimensions have been explored in previous OECD work (box 1) and the results of this report should be seen alongside these analyses to give a more comprehensive picture of social protection for LTC.

Box 1. Previous OECD work on the non-financial dimensions of social protection for LTC

Ensuring the quality of formal LTC services

In 2013, the OECD and European Commission published *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care*. This report looked in detail at how quality of LTC is measured in OECD countries and the policies that are in place to improve it. Measurement of LTC quality was found to be insufficient, lagging well behind other sectors such as health care. The limited measures that do exist capture narrow aspects of clinical quality such as the absence of pressure ulcers – rather than giving a full picture of the quality of life experienced by LTC users – and are available only in a small number of countries. Regulatory standards remain the dominant approach to improving quality, including accreditation of care homes and qualification requirements for staff. Nonetheless, skill levels of staff in many countries are low and requirements for continuous education and ongoing monitoring are rare. The use of mechanisms such as public choice and pay-for-performance to drive quality is in its infancy and more evaluation of these approaches is required. In this context it is difficult to make a quantitative assessment of the effectiveness of social protection systems in ensuring the availability of high quality LTC services. While it may be possible to map out systematically the policies and safeguards that countries have in place, it will not be possible to assess their effect on the wellbeing of LTC users until significant improvements are made in the measurement of LTC quality and outcomes.

Source: OECD / European Commission (2013), *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care*, OECD Publishing, Paris

Providing support to help informal carers remain in work and healthy

In *Help Wanted? Providing and Paying for Long-Term Care* (2011), the OECD looked at the impact that providing care has on the health, wellbeing and labour force prospects of carers, and the policies that countries have in place to mitigate these impacts. Analysis of data from the *Survey of Health, Ageing and Retirement in Europe* (SHARE), as well as other national surveys, showed that carers are more likely to suffer from mental health problems, and have lower employment rates and work fewer hours than non-carers. These issues increase with the intensity of care provided. As well as financial benefits, countries also have policies to help carers to remain part of the labour market (such as flexible working hours and care leave) and to improve their health and wellbeing (such as respite care, counselling and training). Annexes 4.A1, 4.A2 and 4.A3 of *Help Wanted?* (page 139 onwards) summarise the types of support that are available by country. This report quantifies some of these forms of support – cash benefits paid directly to the carer and those paid to the care recipient.

Source: Colombo et al. (2011), *Help Wanted? Providing and Paying for Long-Term Care*, OECD Publishing, Paris

Figure 3. Dimensions of social protection for LTC addressed in this report

Financial dimensions of social protection addressed in this analysis
1. Ensuring that all people who need formal LTC services can afford them 2. Reducing the financial impact of paying for formal LTC services 3. Compensating for the opportunity cost of providing informal care
Other dimensions of social protection not addressed in this analysis
1. Ensuring the availability of formal LTC services 2. Ensuring the quality of formal LTC services 3. Providing support to help informal carers remain in work and healthy

Quantifying social protection for LTC

This report uses four core indicators to quantify different aspects of social protection

26. The definition of social protection given above can be broken down into three stages, each of which is in principle quantifiable.

- First, there is a **situation**: an individual faces a cost, or a risk of incurring a cost, which poses a threat to their wellbeing.
- Then there is a **public action**: the government does something to help mitigate the cost.
- Finally there is the **result** of that action: the risk or cost is diminished or removed.

27. Each of these stages is in principle quantifiable for the financial dimensions of social protection highlighted in figure 3. This approach defines the conceptual framework that is used to analyse social protection for LTC in this report. As shown in figure 4, this framework naturally gives rise to four core indicators.

Figure 4. Conceptual framework and the four core indicators used in this report

	Situation	Public action	Result
Ensuring that all people who need formal LTC services can afford them	**1. The cost of care** The total cost of meeting a person's LTC needs through professional services, relative to their income	**2. Public cost share** The proportion of the cost of professional services that is covered by social protection	**3. Out-of-pocket costs** The costs that a person faces net of social protection, relative to their income
Reducing the financial impact of paying for formal LTC services			
Compensation for the opportunity cost of providing informal care	The opportunity cost of providing informal care – not used as a core indicator	**4. Informal care compensation rate** The total value of social protection provided to the carer and the care recipient if needs are met by informal care, relative to the opportunity cost	The "net" position of informal carers, in terms of the costs incurred and compensation received

The cost of care (section 3)

28. The financial situation faced by people with LTC needs who require professional care services can be quantified by looking at the **cost of care**. There is currently no systematic comparison of the cost of care between OECD and EU countries, so new data has been collected. Looking at the cost relative to a person's income gives an idea of how difficult it is for that person to manage the financial risk of developing an LTC need.

The public cost share (section 4)

29. The public action taken to help people to manage these costs is quantified by the **public cost share**, which is defined as the level of public support provided in a given scenario as a proportion of the cost of care. Where the public cost share is 100%, the social protection system pays the entire cost of care, removing the financial risk completely. The public cost share quantifies the level of social protection from the point of view of the public system, but does not tell us whether this support is adequate from the point of view of people with LTC needs.

Out-of-pocket costs (section 5)

30. The result of public action is that people do not pay the full cost of their care, but they usually pay a part of it. A person's **out-of-pocket costs** are the part of the cost left to the individual by the social protection system, as a proportion of their income. This is the key indicator for understanding the adequacy of social protection, as it directly addresses the first two dimensions of financial social protection: affordability of LTC and the financial impact of paying for care.

31. To assess whether LTC is affordable in a given scenario, out-of-pocket costs are compared to an **affordability threshold**, which defines the maximum level of income that a person can reasonably be expected to spend on LTC. In this report, the affordability threshold is defined as the amount by which someone's disposable income would need to be reduced to leave them at the poverty threshold (half the

median disposable income in their country). If people face costs above this level, they must either forgo some of the care they need or be pushed into poverty.

Compensation rate for informal care (section 6)

32. Some aspects of the costs that informal carers face can be monetised by looking at the opportunity cost of the time that they spend providing care. There are different ways of calculating opportunity costs, but this report looks at lost potential earnings, assuming that the person could otherwise work in a median wage job for the same number of hours. This in itself is not an interesting indicator. For a given scenario it would just measure the median wage in each country.

33. However, it is informative to compare the opportunity cost to the total amount of benefits provided to the family (either to the carer or the care recipient) to calculate the **compensation rate**. This indicator shows the degree to which the opportunity costs are compensated for by social protection systems.

34. The compensation rate is the parallel of the public cost share, in that it shows the level of coverage from the perspective of the system, but does not tell us how adequate this coverage is or whether the net position of the carer is manageable. However, compared to situations where professional care is being provided, it is less clear how to construct an indicator that can assess the adequacy of a given compensation rate. Developing better indicators for informal care may be the subject of future work.

Scenarios of need, income and assets

35. The four indicators described above can be used to quantify social protection for any given scenario. However, people with LTC needs face a range of situations and the adequacy of social protection may be different in each. Meaningful cross-country comparisons must look at how well an equivalent person – in terms of all characteristics relevant to social protection for LTC – would be protected in different countries. The approach used in this project is to define a set of internationally applicable scenarios that specify the **level and type of LTC needs** that a person has, their **income**, and whether they have significant **assets** that they could use to fund their care.

Typical cases of LTC need

36. All countries use some sort of assessment process to determine the level and type of long-term need that a person has, and so whether they are eligible for support. However, these systems vary in both the scoring systems that they use to rate severity of need and in how these scores are applied in practice. There is not a universally accepted international measure of LTC needs, which makes it difficult to compare eligibility thresholds.

37. In order to make meaningful international comparisons of the social protection that "equivalent people" would get in different countries, a set of five "typical cases" of LTC need have been defined (figure 5). These cases span different levels of severity (low, moderate and severe) and different ways in which needs can be met (professional home care, informal care and institutional care) – although to keep to a manageable number of realistic scenarios, only moderate needs are considered for informal care and only severe needs for institutional care. To allow countries to map these cases onto their assessment systems, detailed descriptions of the abilities and limitations of the person in question, the services they require and any relevant assumptions were developed. Full descriptions of the cases can be found at Annex A.

Figure 5. Typical cases of LTC need used in this analysis

	Level of need	How that need is met
1	Low	6½ hours of professional home care per week
2	Moderate	22½ hours of professional home care per week
3	Severe	41¼ hours of professional home care per week
4	Moderate	22½ hours of informal care per week
5	Severe	Institutional care

38. The typical cases were developed from a number of sources, including a set of LTC scenarios that were developed as part of a 2006 review of the UK social care system (Henderson, 2006); the service specifications in social insurance systems, particularly the German system; consultation with academic and government experts from OECD and EU countries; and consultation with a geriatrician to ensure clinical plausibility. This process aimed to define scenarios that are *realistic*, but they are not *representative* of the populations of OECD and EU countries, in that the numbers of people whose situations correspond to each case in each country are not known. Moreover, they do not take into account new models of care such as reablement and assisted living and as such may not represent what is considered best practice in all countries.

Levels of income and assets

39. Most LTC social protection systems take account of a person's financial means in determining the level of support that they receive. In addition to this, the affordability of a given level of out-of-pocket expenditure will depend on the means that a person has to meet these costs. When comparing social protection between countries, it is therefore crucial that the scenarios used have equivalent levels of financial means, in terms of the person's income and assets.

40. Defining comparable levels of income is relatively straightforward. The OECD Income Distribution Database provides the distribution of **net disposable income** – that is, how much money people have in their pockets to spend after taxes and transfers. The analysis in this report uses three levels of income, based on the distribution of disposable income in the over-65 population: low (20th percentile), median and high (80th percentile).

41. The distribution of **assets** is less well understood. The OECD has recently created a new Wealth Distribution Database containing information on the level of wealth, the degree of wealth inequality, wealth composition and indebtedness in 18 OECD countries. As well as the limited country coverage, there are also some limitations on comparability of this data, despite efforts to ensure common treatments and classifications. Two of the most important reasons for this are: differences between countries in the year the data was collected (ranging between 2010 and 2013, for the most recent observation); and differences in the degree of oversampling of rich households across countries (OECD, 2015b).

42. In many countries the lack of data on asset distributions does not matter, because they do not apply an asset test when determining eligibility and levels of support for LTC, but in some the level of assets is very important. To simplify the question of assets, this analysis focuses on just the two extreme cases: a "low assets" case, where someone has zero assets; and a "high assets" case, where they have enough assets to put them above any relevant threshold – or if a number is required, the equivalent of EUR 1 million. Future work will aim to develop a more detailed understanding of this issue.

The data collected

Data requirements and the collection process

43. The five typical cases of need, three levels of income and two levels of assets generate a total of 30 scenarios for which social protection should be quantified by constructing the four indicators described above. This requires the following data for each scenario:

- **The cost of care**
  The total cost that someone in this scenario would face if they had to buy professional care services to meet their needs, in the absence of any social protection.
- **Public coverage**
  The total monetary value of social protection provided in each scenario, including cash benefits and the value of any services provided. By subtracting public coverage from the cost of care, the amount the person would have to pay out of pocket to meet their needs in full can be calculated.

44. Data on the cost of care and the level of public coverage in each scenario was collected through a questionnaire that was sent to all OECD and EU countries. The questionnaire included full details of each typical case (see Annex A) and additional guidance on the assumptions that should be made when responding.

Country coverage

45. The data collection questionnaire was sent to all 41 OECD and EU countries. 14 of those countries are included in the analysis in this report: Belgium, Canada (Nova Scotia and Ontario), Croatia, the Czech Republic, France, Iceland, Israel, Japan, Korea, Netherlands, Slovenia, Sweden, England and the United States (California and Illinois). A number of other countries responded, but results are not yet considered comparable enough for inclusion. A priority for future work on this topic is to expand coverage to as many countries as possible.

Sources of estimates and comparability

46. Estimates of the cost of LTC used in this report have been supplied by country representatives. Although every effort has been made to specify a consistent approach that all countries should use, limited availability of data on costs means that in some cases data may refer to slightly different things. For example, some countries have estimated the cost of institutional care for someone with the needs specified in the relevant typical case, but in other countries the only information available is the average cost of a care institution.

47. The estimates of coverage used in this report have been produced in one of three ways. In some instances the typical cases and assumptions have been applied by country representatives, who have calculated theoretical levels of coverage and supplied these to the OECD. In others, country representatives have supplied information on the rules that govern social protection and the OECD has used this to estimate levels of coverage. In a third group of countries, calculations have been jointly developed and agreed between the OECD and country representatives. Further details on the sources of information for each country, and country-specific notes on comparability, are included at Annex B.

48. Countries have only been included in this report where the data are deemed to be robust enough to make meaningful international comparisons. Nonetheless, when developing LTC policies, it is important not simply to take this data at face value, but to look for explanations as to why social protection for LTC varies between countries and ask whether these explanations match real-world experiences.

3. THE COST OF CARE IN OECD AND EU COUNTRIES

What is this indicator and why is it important?

49. The cost of LTC services in OECD countries forms the basis of any analysis of social protection. It is the cost of these services – and the fact that it can be large relative to incomes – that presents the **financial risk** against which people need protecting. As well as forming the basis of a quantification of social protection, the cost of services is interesting in its own right. Where costs vary between countries, it can be informative to ask why these differences exist and whether countries that pay higher costs are getting value for money, for example through higher quality care. While such questions are beyond the scope of this report, they could be addressed by future research on this topic.

50. Social protection systems in some countries (e.g. France and Japan) split the cost of institutional care into "care" and "accommodation" costs. However, this is not done consistently across countries and costs are not in general disaggregable. For example, if someone needs adapted accommodation because of a care need, it is not clear how to split this into care and accommodation costs. As such, while the primary interest of this analysis is in care costs, the full cost of an institution has been used to ensure comparability. It should be noted that this approach will inflate the cost of institutional care relative to home care. Correspondingly, benefits that help people to pay their food and accommodation costs are included in the analysis, for institutional care only.

The unit cost of LTC services

There is wide variation in the absolute cost of services between countries, which is partly driven by higher labour costs in wealthier countries

51. There is huge cross-country variation in the cost of home care services. An hour of home care can cost from as little as USD 7 in the Czech Republic, up to nearly USD 70 in Sweden. Similarly, institutional care can cost anything from just over USD 160 per week in Croatia, to nearly ten times that amount in the Netherlands.[3]

52. Some of this variation can be explained by the cost of labour. In wealthier countries, the cost of labour relative to other goods is high. As countries become richer and wages rise throughout the economy, wages in the LTC sector also tend to rise. However, in such a labour-intensive service there are few opportunities to improve productivity, so providing care to an equivalent person is likely to take a similar number of hours in all countries. This causes unit costs to rise as countries get richer – a phenomenon known as Baumol's cost disease. This effect partly explains why Sweden and the Netherlands have much higher unit costs for LTC than the Czech Republic and Croatia.

Differences persist after adjusting for relative wealth, suggesting that other factors such as the skill level of staff may be important

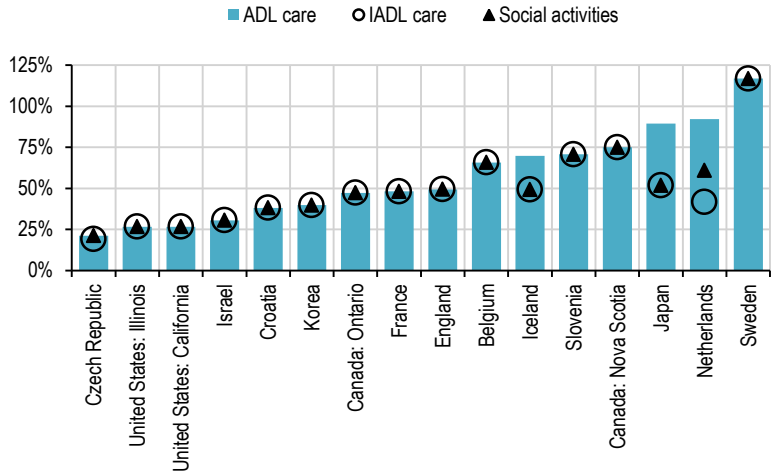
53. Figure 6 shows the unit cost of LTC services relative to the economic output of each country. Hourly costs of home care are expressed relative to GDP per hour worked and (weekly) institutional care costs are shown relative to (weekly) GDP per capita. Even after this adjustment, costs remain highly variable. The cost of an hour of home care in the United States, Israel and France is around a third of

3 Absolute costs are expressed in US dollars, calculated using 2014 purchasing power parities, so they represent the cost of LTC relative to other goods and services in a country.

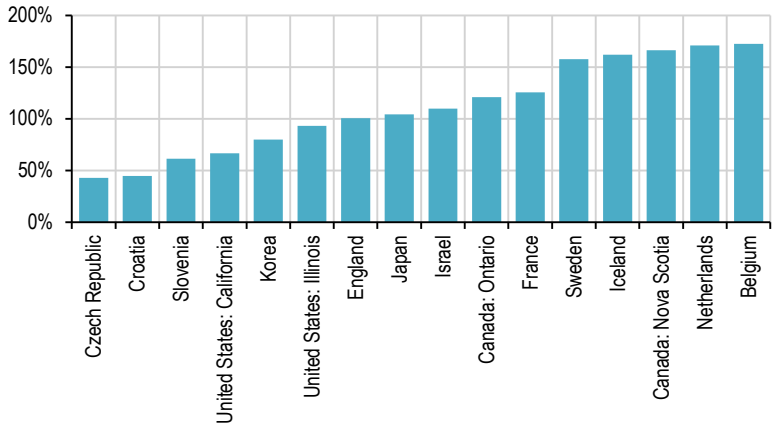
average economic output per hour, but in Sweden it costs around 120% of GDP per hour. Institutional care in Slovenia, Korea and the United States is also cheap, with costs lower than GDP per capita; costs in Belgium and the Netherlands are around twice as high.

Figure 6. Unit costs of LTC services in OECD and EU countries in 2014

Panel A: The cost of an hour of home care, relative to GDP per hour worked



Panel B: The cost of institutional care, relative to GDP per capita



Note: Some countries were unable to provide hourly costs for care that helps people to maintain social activities. In these cases, it has been assumed that this cost is the same as for IADL care.

54. One possible explanation for this is that services in these countries are delivered by different types of staff, with different levels of qualifications and therefore different wages. In the United States, for example, LTC is largely considered an unskilled profession and certified care workers only need around 75 hours of training. By contrast, certified care workers in Japan have three years of training (OECD / European Commission 2013). In the Netherlands, wages vary depending on the type of care being provided. ADL care is often provided by nurses, so has the highest cost, while IADL and social needs are more commonly met by lower-skilled staff.

55. Insofar as differences in cost are driven by the qualifications of staff, higher costs may be reflected in higher quality care. It is also possible that some of the differences are driven by other factors,

such as how care is organised and paid for, and that higher costs may sometimes represent poor value for money. With government finances under pressure in many OECD countries, further exploration of the drivers of cost differences, and their impact on quality, would be valuable.

The weekly cost of care relative to incomes

Most people in OECD and EU countries would not be able to afford formal care for severe needs from their income alone

56. The level of financial risk that people face if they develop LTC needs can be quantified by comparing the cost of care to typical incomes. Figure 7 shows this ratio for someone with severe needs, which could be met either through an intensive package of home care, totalling 41¼ hours per week, or through institutional care. This represents a worst-case scenario that will only occur for a minority of the population; but this worst-case scenario, rather than the average case, is precisely the risk against which social protection systems need to protect people. However these needs are met, the costs would be unaffordable from income for the vast majority of people. The cost of care is equal to or greater than median disposable income for over-65s in all countries, whether care is provided at home or in an institution.

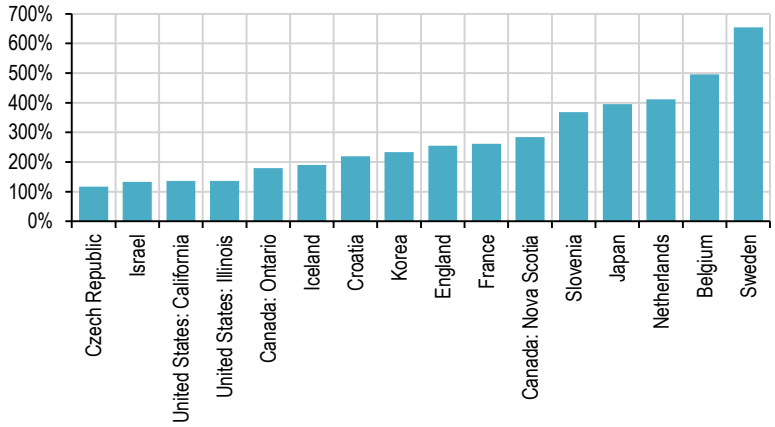
Home care is often a more expensive way of managing severe needs, if all care is delivered by professional carers

57. In most countries, meeting severe needs at home is more expensive than meeting the same needs in an institution. The differences are in practice greater than those shown in figure 7, since institutional care costs include food and accommodation. This may be driven by economies of scale and reduced travel time when caring for multiple people in one location. Travel time can be particularly important where many people with care needs live in rural areas, for example in Slovenia and some parts of Canada.

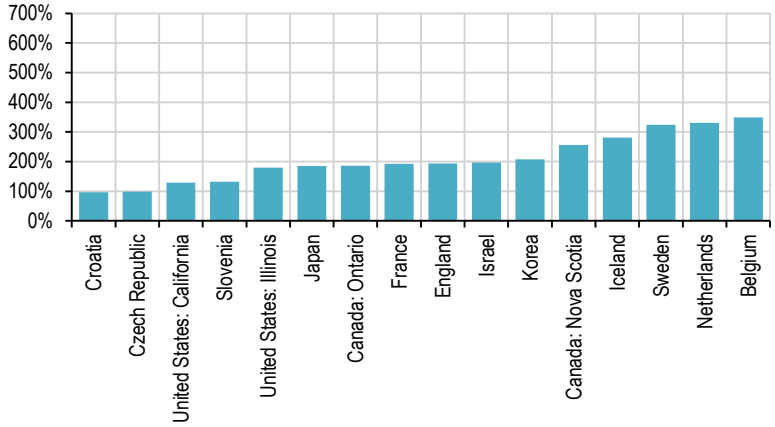
58. This seems on the face of it to run counter to the experience of some countries, which have seen home care as a way of reducing costs. The explanation for this lies in the fact that the costs in figure 7 refer to a scenario in which all needs must be met by a professional carer. In reality, most people living at home have some of their needs met through unpaid care from family and friends, so home care can be cheaper in terms of direct monetary costs, without accounting for the opportunity cost to families.

Figure 7. Weekly cost of meeting severe LTC needs in OECD and EU countries (% of median disposable income for over-65s)

Panel A: The weekly cost of home care for severe needs (41¼ hours)



Panel B: The cost of a week of institutional care



4. PUBLIC COST SHARE

What is this indicator and why is it important?

59. The public cost share is defined in this report as the proportion of the cost of formal LTC services that is paid by the public social protection system. The remaining cost would have to be paid by the individual in order for them to get all of their needs met through formal care services. The public cost share allows us to quantify the **public action** that is being taken to address the financial risks described in the previous section. A higher public cost share indicates a greater share of this risk being absorbed by the social protection system. However, this does not necessarily mean that individuals are better protected. That question is addressed in the following section.

Public cost share by level and type of need

The public cost share varies widely between countries

60. Figure 8 shows the public cost share for people with median income (and no assets they can use to pay for care) who require different levels of home care or institutional care. There is wide variation across countries in all scenarios. For example, people with median income in Croatia will have less than 10% of their LTC costs covered by social protection; in England, France and Korea this will range from 45% to 90% depending on the level of need; but in the Netherlands, Iceland and Sweden at least 90% of the cost would be covered at all levels of need.

The public cost share for institutional care is often lower, reflecting food and accommodation costs

61. The public cost share for institutional care tends to be lower than for home care. This makes sense given that people living in their own home face a range of living costs, such as food, rent (or the opportunity cost of living in their own house) and heating, which are included within the cost of a care institution. This means that people can afford to pay more towards the cost of an institution than they would towards the cost of home care. Some systems explicitly identify "food" and "accommodation" costs and require additional user contributions, but even where this split is not explicit, user contributions for institutional care are higher. As a result, the highest public cost shares for someone with median income in institutional care are 80-90%, compared with nearly 100% in home care.

Some countries do not cover home care for low needs

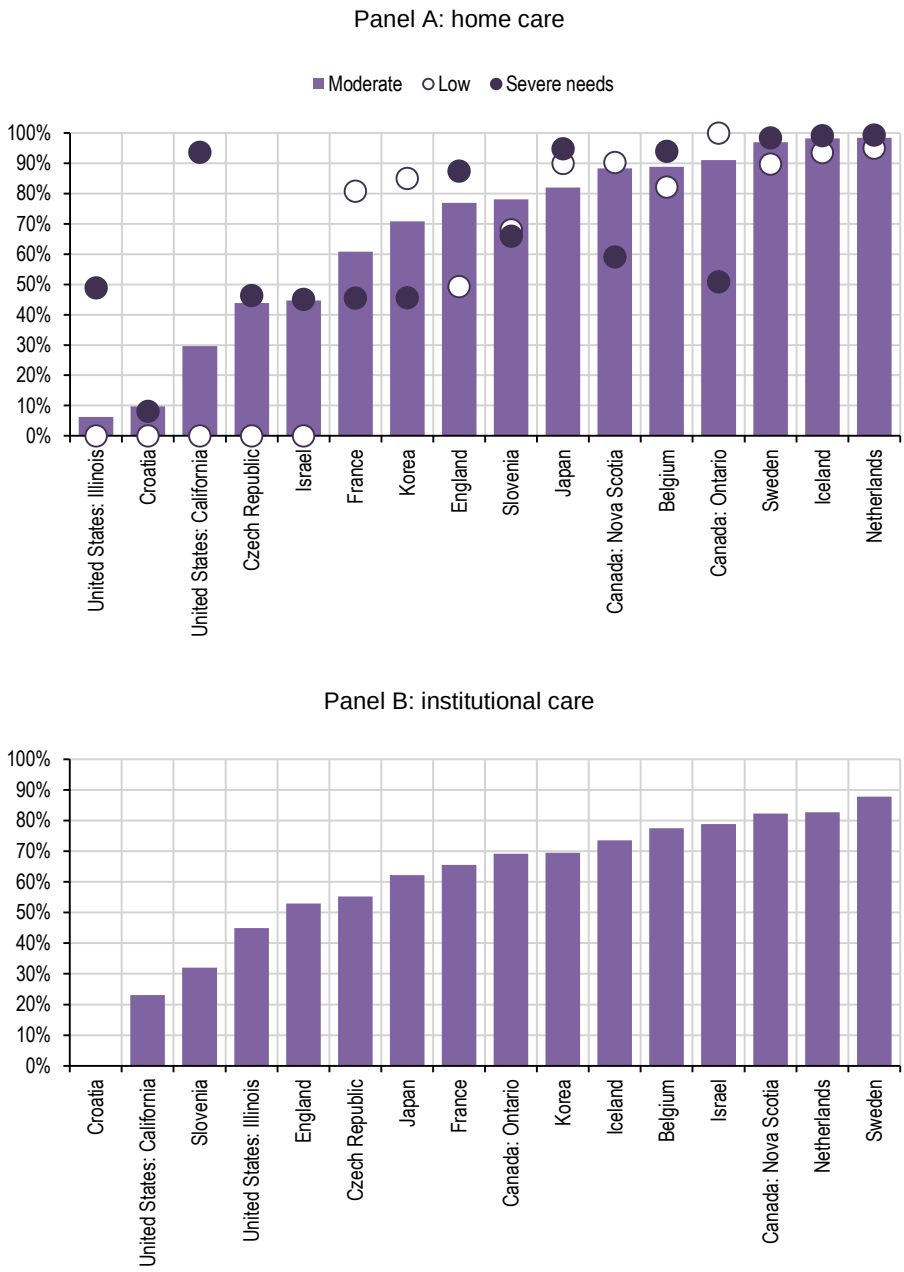
62. All countries apply some sort of eligibility test before people can access social protection for LTC. In some cases, such as France, eligibility criteria are specified in terms of activities of daily living (ADLs); in others, such as England[4], there is a national framework which allows for local flexibility; while in some countries, including Slovenia, there is no national model for needs assessment and local authorities rely on the opinions of doctors, nurses and social workers to determine what care a person needs.

63. In the majority of countries, low needs, defined here as someone who requires 6½ hours of care per week, would be sufficient to qualify for social protection. However, as shown in panel A of figure 8, this is not the case in the Czech Republic, Croatia (except for people with low income, who are not shown in this chart) or Israel. In England, people with low needs do not qualify to the main benefit (social care)

[4] The analysis in this report relates to 2014. From 2015, England introduced new national eligibility criteria that aim to reduce regional variation.

but do still receive a cash benefit in relation to their disability. In the United States, people with median income do not receive support for low needs because they are deemed to be able to afford the cost themselves.

Figure 8. Public cost share for someone with median income and low assets, by level and type of need



Limits on the number of hours of home care lead to low public cost shares for severe needs

64. In most countries, the public cost share increases with need, reflecting the fact that people with more severe needs face higher costs and so are in greater need of social protection. However, in a significant number of countries this seems to go the opposite way. This is often because there is a limit on the number of hours of home care that the social protection system will consider.

65. Canada (Nova Scotia and Ontario) has among the highest public cost shares for people with low and moderate needs. However, the social protection system in Nova Scotia only covers a maximum of 100 hours of home care per month (around 23 per week). Similarly, in Ontario, public support covers the full cost of home care, but only up to a maximum of 90 hours[5] of care in every 30-day period (21 hours per week), except in extraordinary circumstances. If someone wishes to receive more hours of formal services, they would need to pay themselves, resulting in a lower public cost share for higher intensities of care. Similar limits exist in Slovenia (20 hours per week) and Korea (31 hours).

Means-testing

Most countries apply only limited means-testing

66. Except for home care in the Czech Republic and some parts of Canada (Ontario)[6], social protection for LTC is subject to a degree of means-testing, so that poorer people get more support. However, as shown in figure 9, the majority of means tests are not very restrictive, meaning that the public cost share does not vary much between people with high and low income or assets. Benefits are to a large degree universal, although generosity varies. In countries like the Netherlands and Sweden, this means that everyone gets a very high level of coverage. In the Czech Republic this means that the public cost share is always relatively low.

The United States and England have fully means-tested safety net systems

67. A minority of countries apply steeper means tests which lead to larger differences in the public cost share between people with different levels of income and assets. The United States and England have fully means-tested safety net systems which ask people to contribute all of their income apart from an allowance that they are deemed to need for living costs, while support is completely withdrawn from people who have assets that they can use to pay for care. This is reflected in the large differences in the public cost share between people with high and low income and assets – although in England these differences are slightly reduced by the fact that there is a relatively small universal benefit (Attendance Allowance) that runs in parallel to the means-tested system.

Means-testing is more pronounced, and asset testing more common, for institutional care

68. In some countries, the variation in the public cost share for people with different levels of income and assets is greater for institutional care than for home care. The Netherlands, Japan, Canada (Nova Scotia) and Slovenia all apply steeper means tests for institutional care, but still retain a large degree of universality. Although Israel applies relatively little means-testing for home care, residential care is very strongly means-tested, with low income people paying nothing towards the cost of care and people with high assets paying the full cost.

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5 In the first 30-day period for which someone receives care, public support covers up to 120 hours of care. The limit is then 90 hours for each subsequent 30-day period. The 90 hour limit is used for the analysis in this report.

6 Although figure 9 does not show any effect of income on the public cost share for institutional care in the Czech Republic and Ontario, additional support is provided to people who cannot afford to pay their share. However, this only applies to people with incomes below the low income scenario used in this analysis (20th percentile).

Figure 9. Public cost share for different income and asset scenarios

Panel A: home care for moderate needs

Panel B: institutional care

69. Although most countries set levels of coverage dependent on income, most do not consider people's assets in their means tests for home care. Asset testing is more common in institutional care, with France, Israel, and Japan only considering assets in this care setting (figure 10). In France and Japan, asset testing only applies to the part of the cost attributed to food and accommodation.

70. Asset testing rules can be complicated and often distinguish between different types of assets. A house that someone or their spouse is living in is commonly excluded from an assessment of assets, although once they move out of the property and into a care institution, they may be required to sell it and use the proceeds to fund their care. Asset testing for institutional care in France does not require people to

pay additional costs up-front, but some costs are recovered from the estate of the care recipient after their death. In practice, conditions of recovery vary by *département*.

Figure 10. Countries that apply asset tests when determining social protection for home care and institutional care

	Home care	*Institutional care*
Belgium	●	●
Canada: Nova Scotia and Ontario		
Croatia	●	●
Czech Republic		
England	●	●
France		●
Iceland		
Israel		●
Japan		●
Korea		
Netherlands	●	●
Slovenia		
Sweden		
United States: California and Illinois	●	●
	5 / 14	8 / 14

People with high income and high assets can still benefit from social protection, but their relative treatment varies between countries

71. People with high income or high assets may be able to afford to pay for most or all of the costs of LTC themselves, but they can still benefit from social protection. If these people are able to pool the risk of LTC costs, they no longer have to plan for the worst case and can use their resources for other purposes. However, there are very few private insurance products for LTC risks and these cover only a tiny proportion of the population in most OECD and EU countries. The absence of private insurance options, and the market failures that lead to this situation (see section 1), suggest that providing risk pooling – even to people with high incomes or significant assets – is a role that governments could play. Most countries follow this rationale by providing at least partially universal social protection.

72. People with high incomes and those with high assets can in some ways be thought of as equivalent. For example, someone who has saved a certain amount for their retirement could choose to keep this as a lump sum or annuitise it to provide an income. The option that this person chooses would not make them more or less deserving of social protection against LTC costs. However, in practice many countries treat income and assets very differently.

73. In countries with very severe asset testing there is an argument that people with assets get a bad deal relative to those with higher incomes. For example, in England, support is completely withdrawn from anyone with assets greater than GBP 23,250. This means that even people relatively low down the wealth distribution are classified as having "high assets" and expected to pay the full cost of their care (except for a small universal benefit). Meanwhile, older people with high incomes (80th percentile) receiving home care for moderate needs have a third of their costs covered by the social care system (figure 9, panel A).

74. On the other hand, countries that do not apply any asset testing treat those with assets more favourably than those with high incomes. For example, in Israel, France and Canada (Nova Scotia), home care benefits depend on income but not on assets. Someone with high income will pay a larger proportion

of their home care costs than someone with low income – even if the latter has very significant assets and is in practice better able to pay.

75. The analysis of assets in this report is not sophisticated enough to draw quantitative conclusions about the relative treatment of income and assets in different countries – although this will be explored in future work. There are also practical difficulties with assessing people's assets and political difficulties in expecting people to use them to pay for LTC. However, it is important for countries to consider whether the means tests that they apply treat people with different forms of wealth fairly.

Some countries also expect families to pay if they can afford to

76. In some countries (e.g. France and Slovenia) the families of care recipients are legally required to contribute towards the cost of LTC. The level of contribution is generally means-tested, but on the income of the family member, rather than the care user. These payments are not covered by this analysis, which assumes that there are no family members in a position to pay. However, future work may explore this issue and the impact that it has on families.

5. OUT-OF-POCKET COSTS

What is this indicator and why is it important?

77. Out-of-pocket costs are the amount that a person would have to pay from their own resources, after social protection has been taken into account, in order to meet their needs through formal LTC services. This indicator quantifies the **financial risks that people are left facing** when social protection doesn't cover the whole cost of care. In order to assess how large the out-of-pocket costs that people face are, this report expresses them as a percentage of a person's disposable income.

78. Where people are completely protected from all LTC costs then their out-of-pocket costs are zero, but this is rarely the case. People are usually expected to make some contribution towards the cost of their care, but where out-of-pocket costs are small they can afford to do so without being impoverished. However, at some point that contribution will become unmanageable and in analysing the data it is important to have an idea of where that point is. This report defines the **affordability threshold** for people living at home as the proportion of a person's income that they could use for LTC without being pushed into poverty (meaning that their remaining disposable income is lower than the relative poverty threshold in their country, which is 50% of the population-wide median disposable income). Where out-of-pocket costs are greater than the affordability threshold, paying for formal care would push that person into relative poverty. A more likely outcome is perhaps that they would not buy all of the care that they need and suffer a reduced quality of life as a result.

79. People living in a care institution do not face the same living costs as they would in their own home, since food and accommodation are covered within the cost of the institution. The poverty threshold is therefore not an appropriate way to define affordability. In assessing the affordability of institutional care, this report assumes that people can contribute all of their income towards the cost, since their living costs are already met. However, this is a low bar to set and most systems aim to ensure that people in institutional care have at least a small amount of money, which can help them to remain more independent.

Out-of-pocket costs by level and type of need

Social protection for home care in many countries is less comprehensive as needs increase and in some countries out-of-pocket costs for people with moderate needs are unaffordable

80. In all countries studied, out-of-pocket costs for someone with median income receiving LTC at home for low needs are close to or below the affordability threshold (figure 11). This suggests that people who need around 6½ hours of care per week do not usually go without this care for financial reasons. In some cases this reflects the impact of social protection, but in others (such as the Czech Republic, Croatia and the United States) this is the result of the low cost of services relative to incomes.

81. In more than half of these countries, out-of-pocket costs for home care for moderate needs are below the affordability threshold for people with median income. However, in a significant number of countries they are above this threshold, implying that meeting even moderate needs in the community may be unaffordable for those who cannot rely on family and friends to provide unpaid care. These situations arise for a number of reasons.

- In **France**, the main care benefit (the *allocation personnalisée d'autonomie*, or APA) defines maximum packages of care for each level of need, but these maxima are lower than the amount of care that people require in reality. Any additional services must be paid for out of pocket and this is unaffordable for many people. However, some people in France may receive further

support from other sources not included in this analysis. Local governments provide some LTC services and some people may get LTC reimbursed by their health insurance – although the availability of both varies by region. Future work will seek to understand the degree to which these benefits are available and their effect on out-of-pocket costs.

- **Croatia** supports people with LTC needs through cash benefits that do not cover the full cost of care. While there is additional support for people with low incomes (in the form of subsidised services) it is not sufficient to provide an effective safety net, leaving many people unable to afford home care.

- In the **United States**, people are expected to contribute all of their income except for an allowance for living costs. This allowance varies by state, but Illinois, and for people in California who do not have severe needs, it is below the poverty threshold.

82. Support for people who need home care for severe needs is often much less comprehensive. Out-of-pocket costs for this scenario are large and in most countries they are unaffordable to someone with median income. This means that formal home care is not an option for many people who develop severe needs.

Limits on the number of hours covered make meeting severe needs through formal care at home unaffordable, but institutional care acts as a safety net

83. In a number of countries there are limits on the number of hours of home care that the social protection system will cover. Social protection in Canada is comprehensive for people with low or moderate needs, but limited at 23 hours (Nova Scotia) or 21 hours (Ontario) per week. This leaves people with severe needs – who can require around 40 hours of care per week – with high and often unaffordable costs if they have to meet these needs through formal care. Similar limits exist in Slovenia (generally 20 hours per week) and Korea (31 hours). Israel limits both the type and the quantity of care: only ADL needs are covered, up to a maximum of 22 hours per week. In all of these countries, most people can only remain in the community with severe LTC needs if family and friends are providing significant amounts of unpaid care (up to 20 hours per week or more) or if they have savings that they can use to pay for formal services.

84. In contrast, all of the countries studied ensure that all people with severe needs can afford institutional care, even if they can contribute very little towards the cost[7]. In this way, many social protection systems are in effect set up so that institutional care acts as a safety net for people with severe needs who cannot afford professional home care and do not have family to look after them.

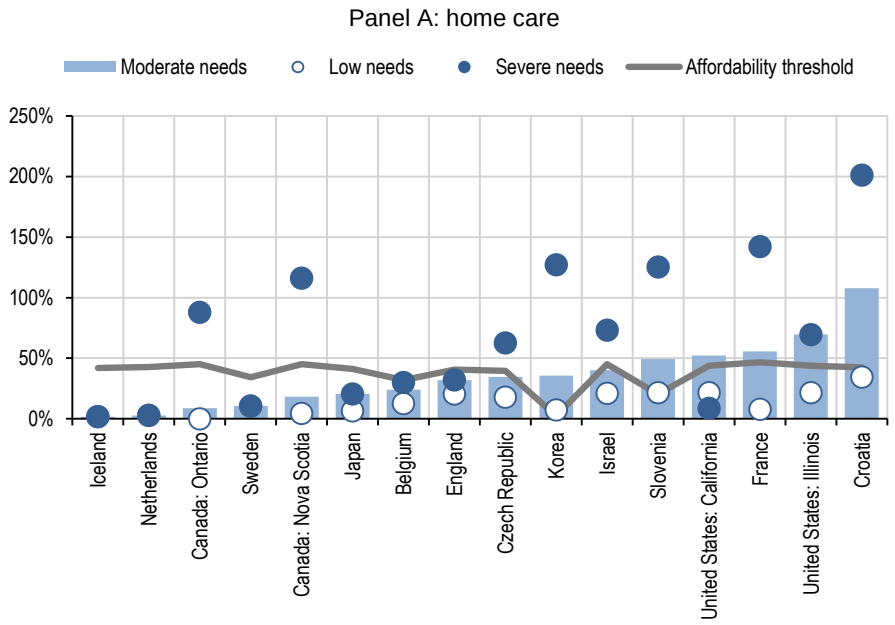
7 People with moderate or low needs may not qualify for publicly-funded institutional care, or may have to pay higher contributions.

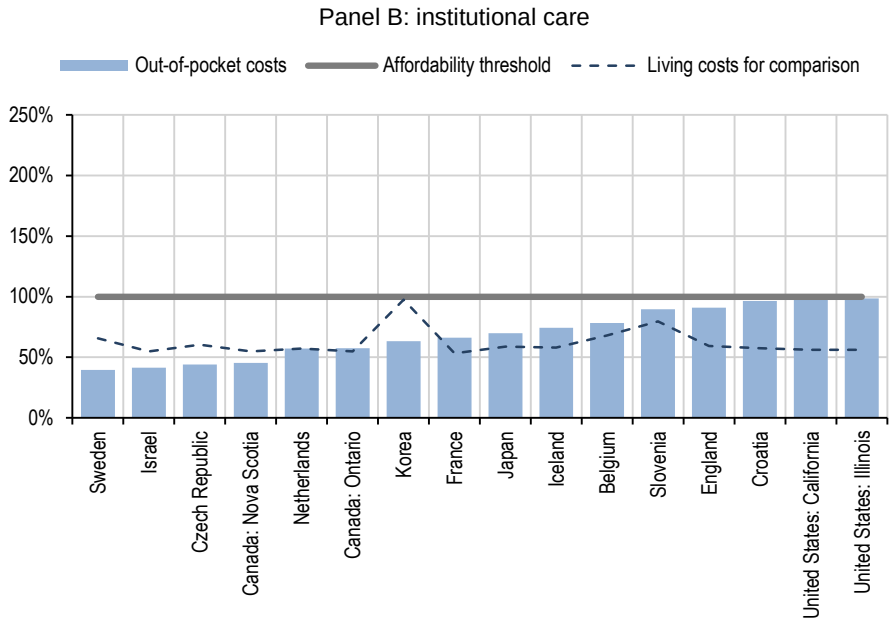
Figure 11. Out-of-pocket costs and affordability for people with median income and low assets

These charts show the **out-of-pocket costs** that people face after social protection is accounted for, as a proportion of their disposable income, for people with median income who are receiving care at home for different levels of need (panel A) and those who are in institutional care (panel B).

To assess whether out-of-pocket costs are affordable, they are compared to the **affordability threshold**. For home care this is the proportion of someone's income they could spend on LTC without being pushed below the poverty threshold (50% of population-wide median disposable income). Since all living costs are included in the cost of institutional care, people are assumed to be able to afford to spend all of their income on LTC.

The inclusion of living costs also means that full coverage of LTC costs in institutional care would not lead to zero out-of-pocket costs. An estimate of the cost of living is included in panel B for comparison, based again on the poverty threshold. Where out-of-pocket costs are below this level, people in institutional care face lower costs than someone without LTC needs living at home.





Supporting people to remain at home for longer gives them control and independence, but can cost more than institutional care

85. There are reasons why it may be preferable for people with severe needs to be in institutional care. For some people this might be a decision about safety and quality of life: people living at home can be at greater risk of hospitalisation, particularly if they have dementia (US Department of Health and Human Services, 2013).

86. Home care for severe needs is also more expensive than institutional care in many countries, so concerns about value for public money are relevant. Limits on the number of hours of home care supported in Canada and Slovenia are designed so that people are moved into institutional care where this is the cheaper option. In other countries, including some parts of the United States (e.g. Illinois), there is no explicit hourly limit but "cost-effectiveness" requirements mean that people will not be supported to remain at home if this is more expensive than institutional care. However, the low cost of home care services in the United States means that this would only apply to someone with very severe needs.

87. Many older people prefer to stay living at home for as long as possible, since this allows them to retain independence and ownership of their environment. Most OECD and EU countries have the stated aim of supporting people to do this. If this aim extends to those without access to informal care then there may be trade-offs to be made between choice and independence for these people and the efficient use of public funds.

88. While Canada, Slovenia and the United States (Illinois) prioritise value for money, other countries such as the Netherlands and England address this trade-off differently and support some people with very severe needs to remain at home, even if it is costly. It is not possible from this analysis to draw a normative conclusion on which approach is best. Although limits on home care coverage can compromise the ability of individuals to make decisions about their own care, they may free up public money that can be used to provide more comprehensive support to others. It is difficult to put a price on choice and independence, but it is important that where countries have policies that encourage people to remain at home for longer, social protection systems are aligned with these policies.

Some countries leave people in institutional care with only a small amount of "pocket money"

89. Care institutions cover the living costs of their residents by providing food and board, so those in institutional care do not *need* to retain much or indeed any of their income for subsistence costs. This is why the affordability threshold in panel B of figure 11 is set at 100% – the equivalent of using the poverty threshold for home care. However, if people are left without any financial resources then they arguably lose some of their independence and dignity. They may be unable, for example, to buy Christmas presents for their grandchildren. As a result, many countries have rules that explicitly ensure that people in residential care are left with at least a certain income allowance – or "pocket money". These rules are summarised in figure 12 for selected countries.

90. It is difficult to define what an adequate income allowance is and there is significant variation between countries. In the United States, income allowances are low and a median income older person would only be left with 1-2% of their income. Croatia has a similarly low allowance, leaving people with around 3% of their income after care costs. In Canada (Ontario), the "comfort allowance" is only 5% of median disposable income, but copayments are capped so most people are left with much more than this. Allowances in England, France and the Czech Republic are a little higher, at around 9-15% of median income, while median income people in institutional care in Iceland and the Netherlands are left with between a quarter and a half of their income.

91. In some countries, such as the United States, Croatia and England, people in residential care typically have to use all of their income apart from this allowance. This reflects the heavily means-tested nature of these systems. In other countries with a greater degree of universality, flat rate benefits (Czech Republic), tax credits (France) or limits on total copayments (Canada: Ontario) mean that only those with low incomes will spend down to the minimum allowance.

Figure 12. Minimum income allowances for institutional care in selected countries (2014)

	Weekly income allowance in national currency	% of disposable income remaining after care costs for someone with median income		Additional information
		Theoretical minimum	*Actual amount remaining after care costs*	
United States: Illinois	7.53	1%	1%	
United States: California	8.78	2%	2%	
Croatia	23.08	3%	3%	
Canada: Ontario	31.85	5%	43%	While the "comfort allowance" was only $138 per month in 2014, there is also a maximum copayment ($1731.62 per month) which means that all but those with very low incomes are left with significantly more than this amount.
England	24.90	9%	9%	
France	22.15 (or 10% of income if that is higher)	10%	34%	A quarter of out-of-pocket spending on institutional care can be claimed back as a tax credit, leaving people with more than the minimum income allowance.
Czech Republic	15% of income	15%	66%	The very low cost of institutional care and flat-rate, universal benefits mean that people with median income are left with more than the minimum allowance.
Iceland	17,238	26%	26%	In addition to the minimum income allowance, no one pays more than ISK 81,900 / week. However, this limit does not affect the median income case.
Netherlands	See additional information	39%	43%	The weekly income allowance includes "pocket money", an allowance for health insurance, a further deduction for people of retirement age, plus 25% of any income above EUR 147 / week.

Out-of-pocket costs by level of income and assets

Despite widespread means-testing, people with low income are left the most exposed to home care costs in many countries

92. As discussed in section 4, social protection for LTC in almost all OECD countries is at least partly means-tested, so that people with lower incomes receive a higher level of public support. However, coverage is not always comprehensive, for example because cash benefits do not reflect the full cost of care or some services are excluded from coverage. These limits on social protection can leave people facing high costs and those with lowest incomes are often the most exposed. In some countries, this can leave the poorest older people without access to formal LTC, unless their needs are severe enough to qualify for publicly-funded institutional care.

93. Figure 13 shows the out-of-pocket payments that someone with moderate needs would have to make to get professional care in their own home if they have low income (panel A) or high income (panel B). People with this level of needs would not usually be considered severe enough to qualify for publicly-funded institutional care. Some countries, such as Iceland, Sweden and the Netherlands, provide comprehensive coverage that keeps out-of-pocket expenditure very low for people with any level of income. In Canada (Nova Scotia and Ontario), out-of-pocket payments are somewhat higher, but still remain relatively manageable for people with any level of income.

94. England and the United States provide steeply means-tested coverage under which people are expected to contribute all of their income except for an allowance for living costs. In general this means that people with higher incomes contribute a greater share of their income towards the cost of care. In England these allowances are greater than the poverty threshold, meaning that low-income older people pay nothing towards the cost of their care. However, in the United States, income thresholds can be significantly below the poverty threshold. Even though low-income older people are already at the poverty threshold, they are expected to contribute towards the cost of their care, pushing them further into poverty.

95. The countries with the largest out-of-pocket costs for people with low incomes are those where some services are not covered by social protection systems (Israel) or where benefits do not reflect the full cost of care (France and Croatia), leaving part of the cost of LTC entirely to the individual. Those with higher incomes can often afford this cost, but those with lower incomes may be left without access to care.

Figure 13. Out-of-pocket costs by income, for someone with low assets (continued overleaf)

These charts show the **out-of-pocket costs** that people face after social protection is accounted for, as a proportion of their disposable income, for people with high and low income who are receiving care at home for moderate needs (panel A) and those who are in institutional care (panel B).

To assess whether these costs are affordable, out-of-pocket costs are compared to the **affordability threshold**. For home care this is the proportion of someone's income they could spend on LTC without being pushed below the poverty threshold (50% of population-wide median disposable income). This proportion is lower for people with lower incomes. Since all living costs are included in the cost of institutional care, people are assumed to be able to afford to spend all of their income on LTC.

Panel A: home care for moderate needs (22½ hours), low income

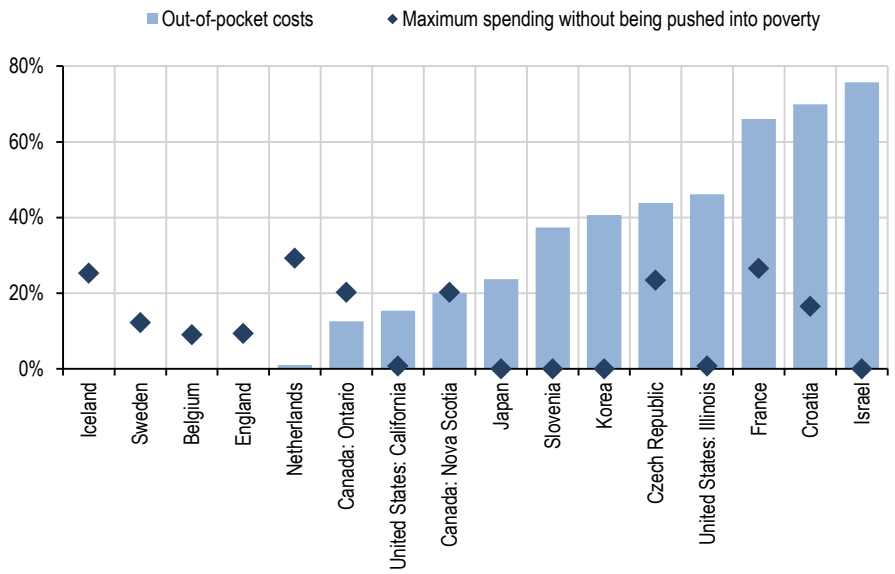
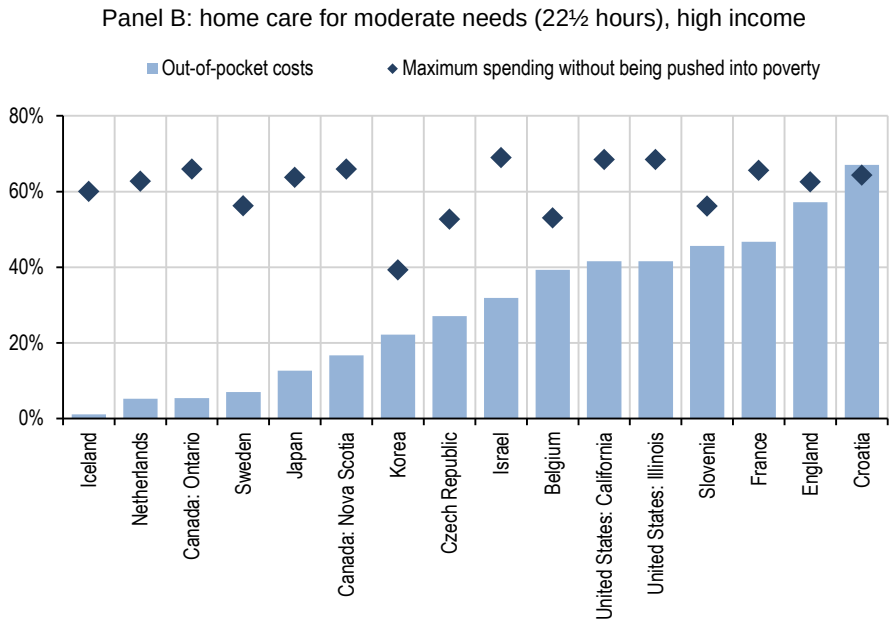
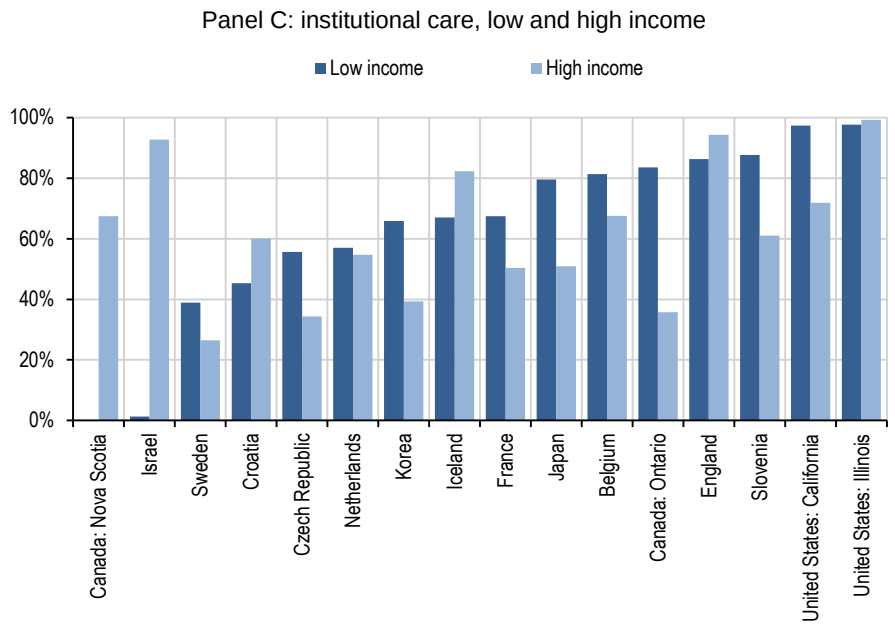


Figure 13. Out-of-pocket costs by income, for someone with low assets (continued)





Steep asset tests in Israel, England and the United States mean that people may have to use significant amounts of assets to pay for care

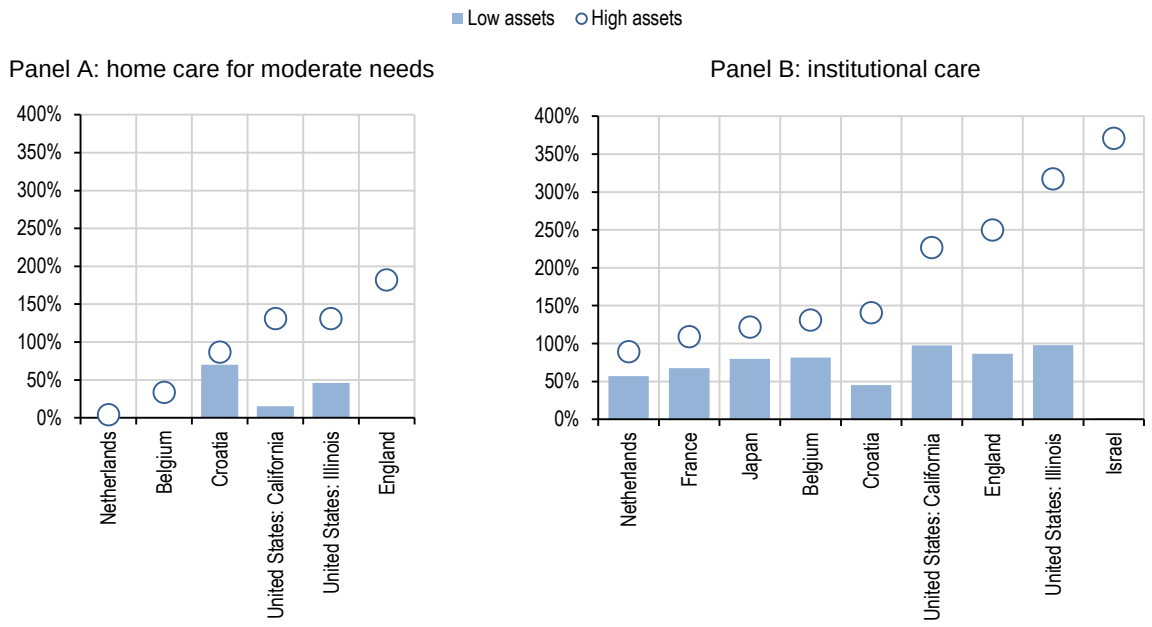
96. As discussed in section 4, some countries look at a person's assets as well as their income when determining the level of social protection that they will receive and this is more common for residential care. Figure 14 shows the effect of these policies on out-of-pocket costs for people with low incomes.

97. In some countries (the Netherlands, France, Japan and Belgium) asset tests are not severe. People with high levels of assets pay more towards the cost of care, but coverage is at least partially universal and

out-of-pocket costs are only slightly higher. People who need LTC in these countries will generally only have to make limited payments from their assets.

98. However, asset testing in England and United States is more pronounced. The same is true for institutional care in Israel, although there is no asset testing for home care. People with high assets in the United States, or those using institutional care in Israel, get no public support at all. In England they qualify only for a relatively small cash benefit. Out-of-pocket payments are much larger for people with high assets and they may have to pay significant sums from their savings. This will be most acute for those who also have low incomes – that is, those who are asset-rich and income-poor.

Figure 14. Out-of-pocket costs as a proportion of income, for people with low income in countries that apply asset tests



Asset depletion can be significant if needs persist for a long time

99. People's savings are generally large compared to their weekly incomes, so the cost of a week of care would not usually amount to a significant proportion of someone's total wealth. However, LTC needs can persist over many months or years, leading to large cumulative expenditures. For people who need many years of care, this could mean using all of their savings. For homeowners who move into an LTC institution, it can mean having to sell their home.

100. The lack of risk pooling for homeowners and those with significant savings has been a major policy issue in England and the United States in recent years. Both countries have sought to develop reforms that add an element of universal protection to their means-tested systems. However, these reforms have been either abandoned or delayed, leaving this policy issue open in both countries.

- In 2010, the United States introduced the Community Living Assistance Services and Supports Act (or CLASS Act), which would have created a voluntary, public LTC insurance system, with benefits funded entirely by contributions (i.e. not from taxation). However, in 2011, it was concluded that the scheme was unworkable and the law has since been repealed.

- In 2011, the *Commission on Funding of Care and Support* recommended that England introduce a lifetime limit on the amount that people pay towards the cost of LTC. Although this scheme was subsequently adopted as government policy, implementation has been delayed until at least 2020 due to concerns about affordability in the face of fiscal constraints.

6. COMPENSATION RATES FOR INFORMAL CARE

What is this indicator and why is it important?

101. Where needs are met by informal care provided by families and friends, there is no direct financial cost. However, informal care should not be considered costless. Families give up their time to look after relatives when they could be using that time for paid work or leisure. People providing large amounts of informal care can suffer also suffer ill-health or find it difficult to remain in employment. Social protection systems can protect people from these risks or provide compensation for the costs that they incur.

102. This report quantifies the monetisable costs that carers face – that is, the opportunity cost of the time they spend caring – by assuming that their time is valued at the median wage in their country[8]. This is the same as assuming that if they were not providing informal care they could be working in a typical job. The opportunity cost is compared with the total level of benefits that are paid either to the carer or the care recipient to calculate the compensation rate.

103. There are some important aspects of social protection for informal carers that are not captured by the compensation rate. The first is respite care policies, which reduce opportunity costs, rather than compensating for them, by reducing the number of hours of care that a person has to provide each week. This is in principle quantifiable and could be added to the compensation rate, but the necessary data has not yet been collected. The second area is the non-monetisable (or less easily monetised) costs to people's health and employment opportunities.

104. More generally, this indicator has been less successful than the previous three. Fewer countries have been able to report robust results: 10, compared with 14 for the other indicators. There are also issues with comparability due to gaps in the methodology. For example, informal care benefits in Belgium depend on whether the carer has given up work to provide care, but this was not specified in the data collection and countries may have made different assumptions. Given crucial importance of informal care, improving the analysis of social protection in this scenario will be a priority for future work.

Compensation rates for people providing informal care for moderate needs

Benefits for informal care can be paid directly to the carer or via the care recipient

105. Informal carers in OECD countries generally receive some financial support from social protection systems, but this support is usually less than if the same needs were being met through professional care. Financial support broadly falls into three categories: "carer blind" systems, which pay the same benefits whether care is provided formally or informally; hourly wages paid to carers; cash benefits paid to care recipients; and cash benefits paid to the carers themselves. The different combinations of these benefits that are available in different countries are summarised in figure 15.

106. Support for informal carers can depend on the characteristics of either the carer or the care recipient and may be arranged entirely at a local or municipal level. This complexity means that it has not yet been possible to make robust estimates of informal care for every country included in the study. At present, this indicator covers 10 countries, with Iceland, Japan, Slovenia and the United States excluded.

8 Median gross hourly earnings are used. In practice people pay taxes on these earnings, but in some countries they will also pay taxes on the money they receive from social protection systems – especially where this is in the form of an hourly wage – so this may be a fairer comparison than looking at net earnings.

Figure 15. Summary of benefits included estimates of the informal care compensation rate

	"Carer blind" systems	Hourly wages paid to carers	Cash benefits paid to carers	Cash benefits paid to user
Belgium			(✓)	✓
Canada (Nova Scotia)		✓	✓	
Croatia				✓
Czech Republic	✓			
England			(✓)	✓
France		✓		
Israel	✓			
Korea		✓		
Netherlands		✓		
Sweden				

(✓) = available but not applicable in the scenario used in this analysis

Notes: Data are not yet available for Iceland, Japan, Slovenia and the United States. Municipalities in Sweden can in principle employ family members as carers and pay them a corresponding wage, but in practice this is extremely rare so it has been excluded from this analysis.

Countries that pay informal carers for their time have the highest compensation rates, despite limits on payments

107. Social protection systems in Canada, France, Korea and the Netherlands provide financial support with the intention that it is used to pay a family member for providing care. The carer blind system in Israel similarly covers a certain number of hours of care, irrespective of whether needs are met through formal or informal care. However, this type of support tends to be subject to limits.

- There may be a **maximum number of hours** of informal care that can be reimbursed. For example, the Korean LTC insurance system will reimburse informal carers at the same rate as professional carers, but only for up to one hour per day on a maximum of 20 days per month.

- There are often **maximum reimbursement rates**, which can be much lower than the cost of professional care – but because the cost of professional care can include significant overheads in some countries, this may not be less than the wages of a professional carer. For example, in Canada (Nova Scotia) and the Netherlands, family carers are paid less than half of the cost of professional services. However, in Canada (Nova Scotia) this is still more than the typical wage of a care worker.

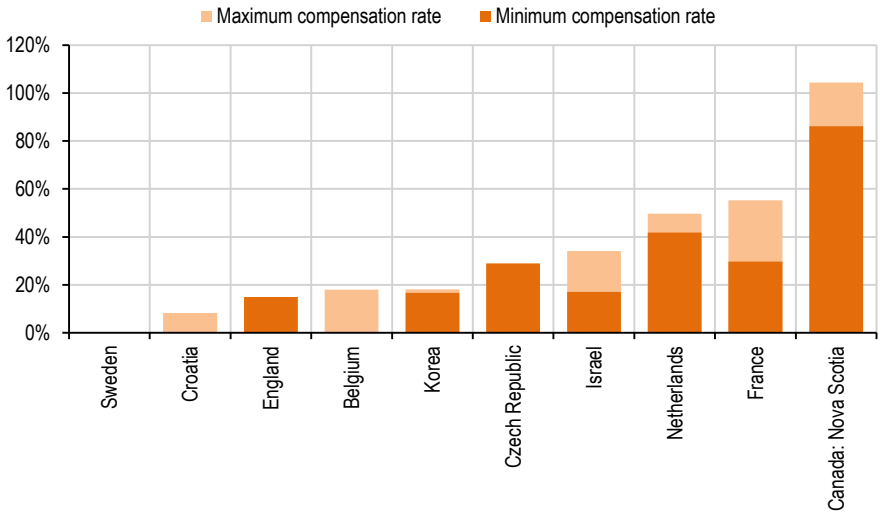
- **Certain types of service may be excluded**. In Israel, only ADL needs are covered by LTC insurance, up to a maximum of 22 hours per week.

- **Certain people may be ineligible.** For example, in France, a spouse cannot be employed as a carer, but a child may.

108. Nonetheless, these countries have the highest compensation rates of all countries studied (figure 16). The highest rate is found in Canada (Nova Scotia), where the wages paid to a family carer plus

Caregiver Benefit (only paid where both the carer and the care recipient have low income) can be as much as the carer could earn in a median wage job.

Figure 16. Compensation rates for someone providing 22½ hours of informal care to a relative with moderate needs



Note: Maxima and minima represent the different levels of benefit paid depending on the financial position of the care recipient and the carer.

Compensation rates vary according to countries' views about the roles of families and the state

109. Countries' policies reveal different views as to whether and how informal care should be compensated. Rather than paying families for the time they spend caring, some countries take the explicit or implicit view that families should support each other and the role of the state is to step in where they cannot manage.

110. In England, this is explicitly built into the system. Local authorities work with the family to decide how much care they can reasonably provide and only what is left will be considered by the social care system. A cash benefit (Attendance Allowance) is still paid to the care user, and where more than 37½ hours of informal care are provided per week the carer also gets a benefit (Carer's Allowance), but these are small and do not constitute reimbursement for time spent caring.

111. Informal carers in Sweden rarely receive any compensation (although in principle this is possible in some municipalities) but this seems to result from a rather different philosophy to that applied in England. There is comprehensive home care coverage and this is not contingent on what the family can manage. The implication is that it is the role of the state, rather than the family, to support dependent people living in their own homes. Perhaps partly as a result of this, Sweden has one of the lowest rates of informal care of any OECD country (OECD, 2015a). Even so, more than one in every 15 people aged over 50 is providing informal care on a daily basis and it is worth considering whether enough is being done to compensate them for this.

Cash benefits paid to care recipients are generally low relative to the opportunity cost of providing informal care

112. Benefits in the Czech Republic are based on an assessment of need but are not linked to the type or cost of the care that the person is receiving. This means that someone receiving informal care receives exactly the same amount as someone receiving professional care – but this amount is lower than the cost of professional care or the opportunity cost of informal care.

113. In Belgium, Croatia and England, people receiving informal care are eligible only for a subset of the benefits provided to those receiving formal services. The benefits amount to no more than a quarter of the opportunity cost of proving care and in Belgium and Croatia they are not available where the care recipient has high income or assets. However, it should be noted that estimates for Belgium are only applicable to carers of retirement age and additional support is available to those who have had to give up work to provide informal care.

Administrative requirements may prevent some people from claiming payment for their time

114. Figure 16 presents theoretical compensation rates, based on the rules and entitlements in each country, but it is not clear that carers always claim the benefits to which they are entitled. Sometimes this may be because they do not have the right information, but in other cases this may be due to the criteria and requirements attached to the benefits.

115. In France, someone receiving informal care (except where the carer is their spouse) can in principle claim the same level of benefits as someone receiving formal services and use this to pay their carer. However, this can only be claimed where a formal contract of employment exists between the carer and the care recipient. Perhaps because of the high level of bureaucracy this involves, or a reluctance to enter into employer-employee relationships with family members, very few people claim this benefit for informal care. As such, while the theoretical compensation rate for France is among the highest in any country studied, in practice most carers receive next to no compensation.

116. Similar, but perhaps less restrictive, requirements exist in the Netherlands. Recipients of a personal budget who are using it to pay a family member must retain proof that these payments have been made. In practice, not everyone who is receiving informal care claims a personal budget, although it is more common to do so for working age disabled people than for older people.

ANNEX A. DEFINITIONS OF TYPICAL CASES

Typical case 1
Home care for low needs

Description of needs	
ADL needs	**Mobility** • Can get in and out of bed independently. • Has limited movement of the torso and problems bending down. • Can walk slowly in the home without a mobility aid and stand without the risk of falling. • Can leave the house without help and go for short walks using a walking frame. • Can travel independently to see a doctor. **Hygiene** • Can dress and undress independently, although this is slow and requires significant effort, especially for dressing the bottom half of the body. • Needs help to get in and out of the bathtub. • Can wash face and upper part of the body with assistance, but back and lower part of the body need to be washed by caregiver. • Can comb hair and brush teeth under supervision. • Has full bladder and bowel control, can use toilet independently and can clean self after defaecation. **Food intake** • Can cut food into pieces and independently consume food and drinks. *Barthel Index score: 17/20*
IADL needs	• **Shopping:** can go to supermarket independently but cannot carry heavy shopping bags. • **Cooking:** can prepare simple meals and arrange delivery of meals-on-wheels (the cost of these meals should not be included in your answers). • **Cleaning:** can do simple housework (e.g. cleaning surfaces) but nothing that requires lifting or bending (e.g. vacuuming the floor). • **Laundry:** cannot do any laundry. *Lawton IADL score: 6/8*
Social needs	This person is able to maintain social activities independently.
Other details	None of the above needs can be met through informal care. If relevant, assume that this person lives alone.
Description of services provided by professional caregiver *Except where support or supervise is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 20 minutes, six times a week • Supervise patient to undress and dress again • Support patient to wash the upper part of the body • Supervise hair care, combing • Wash the lower part of the patient's body and back

	• Cleaning of care area **Bathing and dressing** 30 minutes, once a week • Support patient to undress and dress again • Support patient to get into the bathtub • Support patient to wash the upper part of the body • Wash the lower part of the patient's body and back • Supervise hair care, combing • Cleaning of care area *2 hours 30 minutes per week*
IADL needs	**Laundry** 1 hour, once a week **Cleaning** 1 hour, once a week **Shopping** 1 hour of support, twice a week *4 hours per week*
Social needs	None

Typical case 2
Home care for moderate needs

Description of needs	
ADL needs	**Mobility** • Can get in and out of bed independently. • Has limited movement of the torso and problems bending down. • Can walk around the home only with the use of a mobility aid, but is unable to climb stairs unaided. • Can transfer independently in and out of bed, chairs and toilets using grab rails, which are installed in the home (the cost of these adaptations should not be considered for this questionnaire). • Can leave the house and go for short walks only with assistance and the use of a walking frame. Needs a wheelchair to travel longer distances or remain out of the house for a long time. • Can travel to see a doctor if accompanied by caregiver. **Hygiene** • Requires assistance to dress and undress. • Needs help to get in and out of the bathtub. • Can wash face with assistance, but back and upper and lower parts of the body need to be washed by caregiver. • Can comb hair and brush teeth under supervision. • Has bowel control, can use toilet independently using grab rails which are installed, and can clean self after defaecation. • Has limited bladder control and wears pads which need to be changed twice a day. **Food intake** • Can cut food into pieces and independently consume food and drinks. *Barthel Index score: 11/20*
IADL needs	• **Shopping:** can go to local shops with assistance but cannot carry shopping bags. • **Cooking:** cannot prepare food.

	• **Cleaning:** cannot do any housework or cleaning. • **Laundry:** cannot do any laundry. *Lawton IADL score: 4/8*
Social needs	Unable to maintain any social activities without assistance.
Other details	None of the above needs can be met through informal care. All necessary home adaptations have been installed and the cost of these adaptations is not in scope for this project.
Description of services provided by professional caregiver *Except where support or supervise is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 20 minutes, six times a week • Support patient to undress and dress again • Support patient in washing face • Supervise hair care, combing • Washing the patient's upper body, back and lower body • Application of new sanitary pads, removal and disposal of used ones • Cleaning of care area **Bathing and dressing** 30 minutes, once a week • Support patient to undress and dress again • Support patient to get into the bathtub • Support patient in washing face • Washing the patient's upper body, back and lower body • Supervise hair care, combing • Application of new sanitary pads, removal and disposal of used ones • Cleaning of care area **Incontinence management** 15 minutes twice a day • Application of new sanitary pads, removal and disposal of used ones *6 hours per week*
IADL needs	**Laundry** 1 hour, once a week **Cleaning** 1 hour, once a week **Shopping** 1 hour, twice a week **Prepare meals** 1 hour 30 minutes per day in total *14 hours 30 minutes per week*
Social needs	**Social activity** 2 hours per week (e.g. being taken out for a walk twice a week)

Typical case 3
Home care for severe needs

Description of needs	
ADL needs	**Mobility** • Cannot get up or go to bed independently. Needs to be lifted manually into/out of the bed and positioned in bed. • Can sit independently and has limited use of arms. • Can stand when holding onto a person or object only for short periods of time before losing balance and falling. • Can only make one or two steps before losing balance even when holding on to a person or object, so is put in a wheelchair for most time of the day. Cannot move the wheelchair but needs to be moved everywhere within the apartment or outside the apartment by a caregiver. • Can travel as a passenger when lifted into car/ taxi when accompanied by a caregiver. • Cannot travel regularly to see a doctor, so requires home visits (the cost of these is out of scope of this questionnaire). **Hygiene** • Cannot dress and undress independently. This needs to be completely done by the caregiver with the patient sitting on the bed or bathtub. • Needs to be lifted in and out of the bathtub which is done manually. • Can only wash face with some difficulties and some assistance. Upper part, back and lower part of the body need to be washed by the caregiver. • Needs support when combing hair or brushing teeth. • Has bowel control but needs to be lifted from wheelchair to toilet and cleaned after defaecation; has limited bladder control and wears pads which need to be changed twice a day. **Food intake** • Cannot cut food into pieces but can move food and drink (with straw) to own mouth under supervision. *Barthel Index score: 4/20*
IADL needs	• **Shopping:** cannot do any shopping. • **Cooking:** cannot prepare food. • **Cleaning:** cannot do any housework or cleaning. • **Laundry:** cannot do any laundry. • **Other:** unable to use the telephone or manage money without assistance. *Lawton IADL score: 0/8*
Social needs	Unable to maintain any social activities without assistance.
Other details	Also requires significant healthcare, but this is outside the scope of the project. Has advanced dementia and displays hoarding behaviours and agitated or aggressive behaviours, such as shouting or hitting out. Lives with a spouse who can provide 24-hour supervision, help with taking medicines, and manage the finances but cannot provide any other ADL/IADL care.

Description of services provided by professional caregiver *Except where support or supervise is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 30 minutes, six days a week • Transfer out of bed, lifting patient into wheelchair • Support patient to undress and dress again • Support patient in washing face • Washing the patient's upper body, back and lower body • Support patient in hair care, combing • Support to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) • Application of new sanitary pads, removal and disposal of used ones • Cleaning of care area **Bathing and dressing** 45 minutes, once a week • Transfer out of bed, lifting patient into wheelchair • Support patient to undress and dress again • Lifting patient in bathtub • Support patient in washing face • Washing the patient's upper body, back and lower body • Support patient in hair care, combing • Support to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) • Application of new sanitary pads, removal and disposal of used ones • Cleaning of care area **Help with feeding** 50 minutes daily, three times a day • Cutting of food to mouth pieces • Supervise food intake • Moving patient to table • Providing drinks • Disposal of material • Cleaning of work space **Going to bed** 30 minutes daily • Support patient to undress and dress again • Helping patient to transfer into bed and positioning of person in bed • Support to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) • Application of new sanitary pads, removal and disposal of used ones *24 hours 45 minutes per week*
IADL needs	**Laundry** 1 hour, once a week **Cleaning** 1 hour, once a week **Shopping** 1 hour, twice a week **Prepare meals** 1 hour 30 minutes per day in total *14 hours 30 minutes per week*
Social needs	**Social activity** 2 hours per week (e.g. being taken out for a walk twice a week)

Typical case 4
Informal care for moderate needs

This person has the same needs as typical case 2, but they are met by an informal carer rather than a professional career.

Description of needs	
ADL needs	**Mobility** • Can get in and out of bed independently. • Has limited movement of the torso and problems bending down. • Can walk around the home only with the use of a mobility aid, but is unable to climb stairs unaided. • Can transfer independently in and out of bed, chairs and toilets using grab rails, which are installed in the home (the cost of these adaptations should not be considered for this questionnaire). • Can leave the house and go for short walks only with assistance and the use of a walking frame. Needs a wheelchair to travel longer distances or remain out of the house for a long time. • Can travel to see a doctor if accompanied by caregiver. **Hygiene** • Requires assistance to dress and undress. • Needs help to get in and out of the bathtub. • Can wash face with assistance, but back and upper and lower parts of the body need to be washed by caregiver. • Can comb hair and brush teeth under supervision. • Has bowel control, can use toilet independently using grab rails which are installed, and can clean self after defaecation. • Has limited bladder control and wears pads which need to be changed twice a day. **Food intake** • Can cut food into pieces and independently consume food and drinks. *Barthel Index score: 11/20*
IADL needs	• **Shopping:** can go to local shops with assistance but cannot carry shopping bags. • **Cooking:** cannot prepare food. • **Cleaning:** cannot do any housework or cleaning. • **Laundry:** cannot do any laundry. *Lawton IADL score: 4/8*
Social needs	Unable to maintain any social activities without assistance.
Other details	None of the above needs can be met through informal care. All necessary home adaptations have been installed and the cost of these adaptations is not in scope for this project.
Description of services that would be required if needs were met professionally – the informal caregiver meets all of the person's needs, either by providing these services or in another way *Except where support or supervise is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 20 minutes, six times a week • Support patient to undress and dress again

	• Support patient in washing face • Supervise hair care, combing • Washing the patient's upper body, back and lower body • Application of new sanitary pads, removal and disposal of used ones • Cleaning of care area **Bathing and dressing** 30 minutes, once a week • Support patient to undress and dress again • Support patient to get into the bathtub • Support patient in washing face • Washing the patient's upper body, back and lower body • Supervise hair care, combing • Application of new sanitary pads, removal and disposal of used ones • Cleaning of care area **Incontinence management** 15 minutes twice a day • Application of new sanitary pads, removal and disposal of used ones *6 hours per week*
IADL needs	**Laundry** 1 hour, once a week **Cleaning** 1 hour, once a week **Shopping** 1 hour, twice a week **Prepare meals** 1 hour 30 minutes per day in total *14 hours 30 minutes per week*
Social needs	**Social activity** 2 hours per week (e.g. being taken out for a walk twice a week)

Typical case 5
Institutional care for severe needs

This person has the same needs as typical case 3, but they are met in an institution instead of in the community.

Description of needs	
ADL needs	**Mobility** • Cannot get up or go to bed independently. Needs to be lifted manually into/out of the bed and positioned in bed. • Can sit independently and has limited use of arms. • Can stand when holding onto a person or object only for short periods of time before losing balance and falling. • Can only make one or two steps before losing balance even when holding on to a person or object, so is put in a wheelchair for most time of the day. Cannot move the wheelchair but needs to be moved everywhere within the apartment or outside the apartment by a caregiver. • Can travel as a passenger when lifted into car/ taxi when accompanied by a caregiver. • Cannot travel regularly to see a doctor, so requires home visits (the cost of these is out of scope of this questionnaire).

	Hygiene • Cannot dress and undress independently. This needs to be completely done by the caregiver with the patient sitting on the bed or bathtub. • Needs to be lifted in and out of the bathtub which is done manually. • Can only wash face with some difficulties and some assistance. Upper part, back and lower part of the body need to be washed by the caregiver. • Needs support when combing hair or brushing teeth. • Has bowel control but needs to be lifted from wheelchair to toilet and cleaned after defaecation; has limited bladder control and wears pads which need to be changed twice a day. **Food intake** • Cannot cut food into pieces but can move food and drink (with straw) to own mouth under supervision. *Barthel Index score: 4/20*
IADL needs	• **Shopping:** cannot do any shopping. • **Cooking:** cannot prepare food. • **Cleaning:** cannot do any housework or cleaning. • **Laundry:** cannot do any laundry. • **Other:** unable to use the telephone or manage money without assistance. *Lawton IADL score: 0/8*
Social needs	Unable to maintain any social activities without assistance.
Other details	Also requires significant healthcare, but this is outside the scope of the project. Has advanced dementia and displays hoarding behaviours and agitated or aggressive behaviours, such as shouting or hitting out. Requires 24-hour supervision.
Description of services provided within the institution and approximate timings where relevant *Except where support or supervise is specified, the caregiver must completely take over the activity*	
ADL needs	**Washing and dressing** 30 minutes, six days a week • Transfer out of bed, lifting patient into wheelchair • Support patient to undress and dress again • Support patient in washing face • Washing the patient's upper body, back and lower body • Support patient in hair care, combing • Support to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) • Application of new sanitary pads, removal and disposal of used ones • Cleaning of care area **Bathing and dressing** 45 minutes, once a week • Transfer out of bed, lifting patient into wheelchair • Support patient to undress and dress again • Lifting patient in bathtub • Support patient in washing face • Washing the patient's upper body, back and lower body • Support patient in hair care, combing • Support to use toilet (lifting patient from wheelchair to toilet and cleaning after

	defaecation) • Application of new sanitary pads, removal and disposal of used ones • Cleaning of care area **Help with feeding** 50 minutes daily, three times a day • Cutting of food to mouth pieces • Supervise food intake • Moving patient to table • Providing drinks • Disposal of material • Cleaning of work space **Going to bed** 30 minutes daily • Support patient to undress and dress again • Helping patient to transfer into bed and positioning of person in bed • Support to use toilet (lifting patient from wheelchair to toilet and cleaning after defaecation) • Application of new sanitary pads, removal and disposal of used ones *24 hours 45 minutes per week*
IADL needs	*The following services are provided by the institution to all residents, so it is not possible to assign an amount of professional carer time for a single person.* **Laundry** **Cleaning** **Preparing and serving all meals** *The following services are provided directly to the individual on a one-to-one-basis.* **Finances** 20 minutes, once a week **Help taking medications** 15 minutes daily
Social needs	The institution organises regular social activities for residents.

ANNEX B. SOURCES OF DATA AND COMPARABILITY

The analysis presented in this report is based on a hypothetical exercise that tries to assess the level of social protection that the same person would get in different countries. A questionnaire was sent to representatives of all OECD and EU countries asking them to carry out this exercise and return the results to the OECD for analysis. To make this assessment, countries need a variety of pieces of information about the person's needs, income, assets and various other things. Detailed descriptions of the "typical cases" were provided to countries, along with further guidance of the assumptions that they should make. However, the wide range of rules and criteria that exist in different countries mean that inevitably some further assumptions have been necessary.

Ensuring that these assumptions are made in a consistent way is crucial to the comparability of the results used in this report. The OECD has worked with country representatives to clarify methodological issues and ensure, as far as possible, consistency and comparability. In some cases, modelling of country systems has been carried out by the OECD, or jointly developed with country experts. Although responses were received from a larger number of countries, only those countries where results are thought to be comparable are included in this report. Nonetheless, there are a number of country-specific caveats and methodological points that should be considered when interpreting the results. These are summarised in the table below.

	Source of estimates	Notes on comparability
Belgium	Modelling carried out by country expert	Results refer only to Flanders. Different benefits may be available in other regions of Belgium, leading to different levels of coverage.
Canada	Nova Scotia Estimates supplied by country representative Informal care compensation rates were recalculated by the OECD based on further information provided by country representative Ontario Modelling carried out by the OECD, based on information provided by country representative	Social protection in Canada varies by province and so far it has only been possible to develop estimates for two provinces: Nova Scotia and Ontario. While social protection in these provinces shares some common features, there are also significant differences, suggesting that developing estimates for other provinces could be valuable.
Croatia	Modelling carried out by the OECD, based on information provided by country representative	
Czech Republic	Modelling carried out by the OECD, based on information provided by country representative	
England	Modelling carried out by the OECD, based on information provided by country representative	Eligibility thresholds for social care vary between regions of England. This analysis assumes that people with low needs are not eligible but those with moderate needs are – although either assumption may be untrue in some parts of the country.
France	Modelling carried out by the OECD, based on information provided by country representative	Estimates include the main care benefit (*allocation personnalisée d'autonomie*, or APA), tax reductions based on levels of disability and the benefit covering accommodation costs in institutional care (*aide sociale à l'hébergement*, or ASH). However, some people in France may get LTC reimbursed through their health insurance. For these people, coverage will be more comprehensive. Future work will aim to understand this issue in more detail.
Iceland	Estimates supplied by country expert	
Israel	Estimates supplied by country expert	
Japan	Modelling carried out by country expert, revised by OECD	Additional assumptions had to be made to determine the ceiling on food and accommodation costs in institutional care.
Korea	Modelling carried out by country expert, revised by OECD	
Netherlands	Estimates supplied by country expert	
Slovenia	Estimates supplied by country expert	
Sweden	Estimates supplied by country expert	Country representatives did not carry out a detailed assessment of eligibility based on level of need. It is possible that the low needs case would not be eligible for home care.
United States	Modelling carried out by the OECD, based on information provided by country representative	Medicaid rules and thresholds vary by state. Estimates have been calculated for California and Illinois. These were chosen as examples of relatively high and low coverage respectively. However, they do not represent the full range of coverage levels present in the United States.

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