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The effectiveness of social protection for long-term care in old age: Is social protection reducing the risk of poverty associated with care needs?

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THE EFFECTIVENESS OF SOCIAL PROTECTION FOR LONG-TERM CARE IN OLD AGE

Is social protection reducing the risk of poverty associated with care needs?

Tiago Cravo Oliveira Hashiguchi* and Ana Llena-Nozal*.

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Abstract

As people grow old and their health deteriorates, they are likely to require help with everyday activities that were once second nature; they need what is commonly termed long-term care (LTC). With demand for LTC in old age expected to grow, OECD countries face significant challenges in balancing financial sustainability with the provision of effective social protection against the financial risks associated with developing LTC needs – the cost of care can far exceed median incomes and its duration can be many years. This report provides a novel set of comprehensive and internationally comparable estimates of the adequacy, equity and efficiency of public social protection systems for LTC in old age in OECD countries and EU Member States. Using a set of "typical cases" of LTC need to ensure comparability, including different levels of severity and different ways in which needs can be met, this report shows cross-country and regional variations in the total costs of LTC services, the degree of public coverage, the out-of-pocket costs that care recipients face, and the associated poverty risks. The quantitative results are discussed in the context of how different countries design LTC benefits and schemes, including cost-sharing mechanisms. Finally, to illustrate the policy relevance of the analyses, the distributive effects of actual and hypothetical policy scenarios are simulated, including an international free personal care policy, and possible reforms in Ireland and England.

Résumé

Au fur et à mesure que les personnes viellissent et leur santé empire, ils sont plus enclins à avoir besoin d'aide pour les activités de la vie quotidienne: ces besoins constituent ce que l'on définit par les soins de longue durée (SLD). Les pays de l'OCDE vont faire face à des défis importants pour trouver un équilibre entre la viabilité des finances publiques et la provision optimale de la protection sociale contre les risques financiers associés aux besoins de longue durée étant donné la demande croissante des besoins due au vieillissement de la population et les coûts importants des soins, excédant les revenus medians et s'étalant sur plusieurs années. Cette étude contient les premières estimations comparatives de l'adéquation, l'équité et l'efficacité des systèmes de protection sociale des soins de longue durée pour les personnes âgées dans les pays de l'OCDE et l'UE. L'étude montre les variations entre les pays et les régions concernant les coûts des services des SLD, le montant de la couverture sociale publique, le reste-à-charge et les risques de pauvreté associés en utilisant des « cas typiques » des besoins de SLD afin d'établir une comparabilité internationale et se basant sur différents niveaux de sévérité des besoins et de la provision des soins. Les résultats quantitatifs illustrent également l'organisation des différentes prestations dans les pays, notamment les mécanismes de répartition des coûts. L'étude contient également des simulations des impacts distributifs de certains scénarios comme l'introduction de la gratuité des soins incluant des soins personnels et certaines réformes en Irlande et en Angleterre.

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1 Introduction

1. Populations in countries of the Organisation for Economic Co-operation and Development (OECD) are ageing rapidly due to improvements in life expectancy and declines in fertility rates. As people grow older their physical and mental health deteriorate, and they may struggle with everyday activities that were once second nature, such as getting dressed, shopping, or going out for a walk. The range of personal care and assistance services that these older people require is commonly referred to as long-term care or LTC (a definition is given in Box 1.1). Global demand for LTC in old age is becoming increasingly important due to population ageing, changing family characteristics, projected shortages of formal and informal carers, and rising expectations of the availability, affordability and quality of LTC services.

Box 1.1. Long-term care in old age: personal care, assistance services and social activities

As people grow older, they are increasingly likely to need help from other people to carry out the activities that make up their daily lives. These activities include washing and getting dressed – grouped under what is referred to as personal care, or Activities of Daily Living (ADLs) – as well as housekeeping tasks, like cleaning and shopping – grouped under what 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 participate in their community. They may need help with social activities, for example attending a community club or going out for a walk. Finally, people who are dependent on others often need ongoing medical care to manage often multiple chronic conditions and ensure that they remain as healthy as possible.

LTC consists of a range of medical/nursing care services, personal care services and assistance services that are consumed with the primary goals of alleviating pain and suffering, or reducing or managing the deterioration in health status in patients with a degree of long-term dependency (OECD, Eurostat and World Health Organisation, 2017[1]). As the emphasis is on long-term dependency, this report focuses on LTC needs and use that last at least six months. Furthermore, as most OECD countries and EU Member States provide universal or quasi-universal health coverage, this work excludes medical nursing care services. Throughout this report, the term LTC is used to encompass personal care (help with ADLs), assistance services (help with IADLs) and social activities, for periods of over six months (or until end of life).

Although people of any age can become dependent on others through illness or disability, this report focuses on older people who are over 65 years old. Whenever the report refers to people of retirement age, it means that they are 65 or above.

2. Many older people who struggle with everyday activities often find support in their spouses, children, friends and neighbours. Commonly termed informal care, this is generally the first line of support for older people, and in some places it may be the most prevalent form of support (Colombo et al., 2011[2]). While often unpaid, informal care is not without costs. Families and friends that provide support for the dependent elderly may suffer physical and mental stress, and are more likely to drop out of the labour market or reduce working hours. Income levels of family carers are also likely to decline as a result. Furthermore, population ageing coupled with changing social norms and structures (e.g. household

composition and female labour market participation) limit the pool of potential informal carers available to older people today and in the coming years. Older people with limitations in everyday activities may not have access to social networks from which to seek informal support. They may also suffer from more severe limitations that require support that is more intensive. Formal care – provided by paid professionals such as nurses, personal carers and personal assistants – may be a better, if not the only, option for such individuals.

3. As with health care, older people may also seek support from local public institutions and services. In doing so, they – and often the relatives and friends that advocate for them – may find the available public benefits, schemes and services difficult to navigate. Faced with multiple eligibility criteria, numerous stakeholders and intricate rules, they may find it difficult to predict how much care will cost them (i.e. their out-of-pocket costs). They may find there is limited formal support in their community, due to shortages in skilled workers and insufficient public funding. Where older people who struggle with everyday activities do not have access to, or cannot afford, formal care, and where their families and friends cannot or will not support them, LTC needs will go unmet. Besides the personal toll this can take on the wellbeing and quality of life of older people, it can also lead to avoidable high-cost admissions into acute care, should their health further deteriorate (e.g. through falls and poor hygiene).

4. 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 or cognitive impairments, and may require intensive support or even institutional care. Moreover, LTC needs can persist over many years, with lifetime costs running into potentially catastrophic sums. 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[2]). There are a number of possible explanations for the lack of private insurance for LTC. Market failures may be important, such as adverse selection. People may not plan sufficiently due to hyperbolic discounting (i.e. valuing immediate smaller rewards much more than larger long-term gains), or a myopic view of risk. It is common for governments to try to address this gap through public schemes (either funded through general taxation or earmarked contributions) or by incentivising or mandating private provision.

5. As populations grow older and care needs expand, public LTC expenditures are projected to rise in the coming decades in OECD countries. Over half of all users of LTC are over the age of 80, and the proportion of people over 80 years old in the OECD is expected to double from 5% today to 10% in 2050 (OECD, 2017[3]). With the risk of cognitive impairments increasing significantly with age, the prevalence of dementia in OECD countries could rise from 19 million to 41 million in 2050 (OECD, 2018[4]). Demand for LTC is thus expected to increase in the coming years and decades. According to the latest estimates for EU countries (ECFIN/AWG, 2018[5]), LTC spending could almost double by 2070 across all EU Member States. Close to one in three people in the EU are now over the age of 65, and this number could go up to over one in two by 2050, at which point there will be only one person of working age for every one person over 65 years old. Other demographic changes, such as changes in family formation patterns, raise concerns about the availability of carers and the fiscal sustainability of existing public LTC arrangements.

6. A comprehensive measure of the societal costs associated with old age dependency is difficult to estimate. It is very likely that national government expenditures on LTC capture just a share of the total economic burden, given that they do not include the opportunity costs of informal care, nor all unplanned admissions associated with LTC needs. Even given information on total government spending on formal LTC services, it remains unclear how much of that spending is helping individuals meet the actual costs of the care they need. The purpose of this report is to provide comparable information on which to base an assessment of the effectiveness of public social protection systems for LTC in old age in OECD countries and EU Member States. The report measures and estimates social protection metrics for a number of scenarios of needs, income and net wealth. The analyses focus on the extent to which public social

protection systems provide effective coverage for the total costs of LTC across the older population, and especially for the least well off.

7. It is not only access to, and affordability of, LTC that matter to older people, policy makers and care providers. It is also the quality of the care being delivered. Specifically, whether care is responsive – and centred on older people's needs and the needs of their families – and whether it is safe. While an assessment of the quality of LTC has significant policy relevance, it is beyond the scope of the analyses in this report, and could be undertaken at a later stage.

1.1. Typical cases of LTC needs: the basis for cross-country comparisons

8. Because there is no single internationally accepted and standardised definition of what constitutes LTC needs, it is not possible to make meaningful comparisons across countries and subnational areas using administrative data on LTC recipients and out-of-pocket spending, as differences in eligibility, scope and depth will all be confounded. As such, this report defines a set of typical cases of LTC needs (see Box 1.2). The typical cases describe an older person in terms of the types and severity of their LTC needs, and the professional services they would require (Muir, 2017[6]). Information on household composition and social structures is also provided. This approach allows the level of public support in different countries and subnational areas to be determined for a defined level of LTC needs. The reasons behind differences in public support can then be pinpointed and analysed, and recommendations made.

9. The analyses focus on the extent to which public social protection systems provide effective coverage for the total costs of LTC across the older population, and especially for the least well off. The report covers 25 out of 41 OECD countries and EU Member States. . The report quantifies public social protection for LTC for a number of scenarios of needs, income and net wealth. In eight countries, the rules and benefits are decentralised, and municipal-, regional- or state-level information is shown instead of country-level[1]. Countries and subnational areas covered include: Austria (Vienna region), Belgium (Flanders), Canada (Ontario), Croatia, Czech Republic, England, Estonia (Tallinn), Finland, France, Germany, Hungary, Iceland (Reikjavik), Ireland, Italy (South Tyrol), Japan, Korea, Latvia, Lithuania, Luxembourg, Slovak Republic, Slovenia, Spain, Sweden, the Netherlands, the United States (Illinois and California). The years that the information refers to are documented in Annex D and span from 2016 to 2019.

10. Given the heterogeneity of LTC systems, it is necessary to make certain simplifying assumptions in order to ensure comparability across countries, regions and municipalities, as well as the feasibility of analyses (e.g. burden of data collection on countries and subnational areas, availability of data at the level needed, number and detail of cases analysed, etc.). Firstly, the focus of this report is on the LTC benefits, schemes and services that make up public social protection systems in OECD and EU countries (emphasis on *public*). Private LTC benefits, schemes and services are not considered if they are not mandatory or not supported, in part or in full, by public social protection systems (e.g. non-mandatory purely private LTC insurance policies are not considered).

11. Secondly, all findings and estimates are based on the typical cases of LTC needs described in Box 1.2. Consequently, statements on the adequacy and effectiveness of public LTC benefits and schemes apply to groups of older people that have those defined LTC needs. The national and subnational representativeness of the typical cases of LTC needs used in this report will vary from country to country, and region to region, based on how eligibility and levels of public support change as a function of LTC

[1] As an example, the Austrian long-term care system consists of three pillars. The first pillar is a long-term care benefit in cash, the second one consists of measures to support caregiving relatives, and the third pillar consists of long-term care services in-kind. The first two pillars are the responsabilitiy of the federal government, while the federal states are responsible for providing the third pillar (the services).

needs. However, it should be noted that the typical cases used in this report cover a wide range of LTC needs and situations. A sensitivity analysis is provided in Annex B to explore how changes to one of the typical cases could lead to differences in the findings and conclusions. Future work may extend analyses to more combinations of LTC needs.

Box 1.2. The typical cases of LTC needs used in this report

In order to make meaningful national and international comparisons of the level of financial protection afforded by LTC schemes and benefits in different jurisdictions, a set of typical cases of LTC needs was developed. The cases are based on activities described in number of hours of need for help with ADLs, IADLs, and social activities (see Annex A for detailed descriptions).

The typical cases span different levels of care severity (low, moderate and severe) and different ways in which these needs can be met (professional home care, informal care and institutional care). Eight cases are defined, as summarised in Table 1.1. Note that a number of countries have care for individuals with severe needs that encompass 24-hour care and are more generous than the severe cases modelled. The OECD has worked with countries and subnational areas to map their assessment systems to these different typical cases. To do so, detailed descriptions of the abilities and limitations of the person in question, the services they require, and any other relevant assumptions, were given.

Table 1.1. Typical cases of LTC needs defined for this report

Needs	How needs are met
Low	6.5 hours of professional home care per week
Moderate	22.5 hours of professional home care per week
Moderate	22.5 hours of informal care (spouse) per week
Moderate	22.5 hours of mixed professional/informal care (spouse) per week
Moderate	22.5 hours of informal care (adult child) per week
Moderate	22.5 hours of mixed professional/informal care (adult child) per week
Severe	41.25 hours of professional home care per week
Severe	Institutional care

Note: Detailed descriptions of all typical cases can be found in Annex A.
Source: OECD Analysis (Muir, 2017[6]).

The analysis relies on the construction of models of the social protection systems that exist in each jurisdiction. These models codify the rules that determine eligibility for, and levels of, social protection for LTC in each jurisdiction. The OECD uses information on the actual distributions of income and wealth for each country from the OECD Income Distribution Database and the OECD Wealth Distribution Database, although these are not joint distributions (due to lack of data). The models estimate the level of social protection for different illustrative combinations of income and net wealth, taking averages and medians from the OECD income and wealth databases whenever relevant.

Most public systems take into account an older person's financial means when determining the level of support and the affordability of a given level of out-of-pocket costs 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. For that reason, this report uses percentiles to characterise care recipients' income and net wealth.

12. Thirdly, the report considers two professional care settings: home and institutions. It does not take into account intermediate care or community care settings (e.g. day care). In some countries, regions and municipalities (e.g. in Reykjavik, in Iceland, and in Finland), intermediate care settings are important.

13. Fourth and finally, older people may be able to pay out-of-pocket contributions to the total costs of LTC from their incomes, assets or both. Throughout the working paper, the affordability and adequacy of public social protection for LTC in old age are discussed in the context of specific types of resources (e.g.

income alone, or income and wealth). The ways in which different jurisdictions take into account different types of wealth when determining the amount of public support are considered in this report.

1.2. Older people would face high LTC costs if not for public social protection

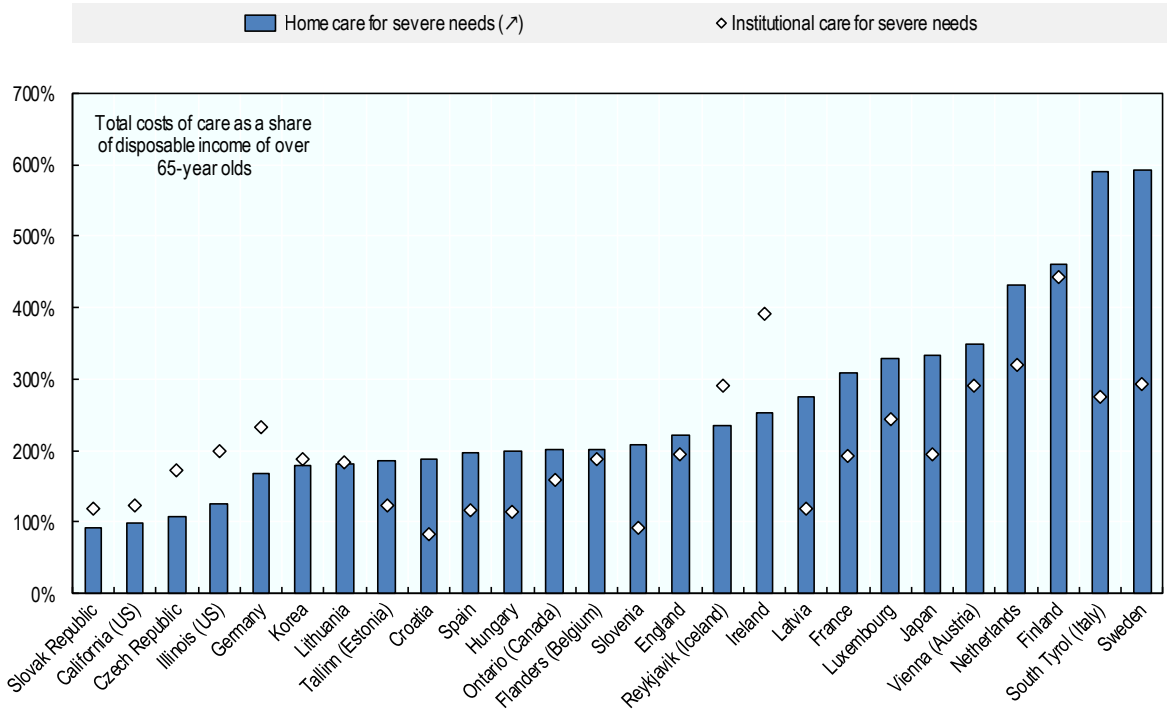
14. The financial challenges faced by older people with LTC needs who require professional care services can be quantified by looking at the total cost that an individual with defined LTC needs would face if they had to purchase professional care services to meet their needs, *in the absence of any public social protection*. Henceforth this concept is referred to simply as *total costs of LTC*. 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 associated with developing LTC needs. The total costs of care in this report have been collected directly from representatives of countries and subnational areas using a questionnaire. Costs consist of the monetary amount corresponding to all care, including the value of any in-kind services provided to help with limitations in terms of activities of daily living, instrumental activities of daily living and social needs.

1.2.1. The total costs of formal LTC are high, especially for care received at home

15. The total costs of receiving LTC can be very high and absorb a significant amount of an elderly person's income, *in the absence of public support*. For an individual with severe needs, totalling 41.25 hours of care per week (see Box 1.2), the total costs of LTC represents one to six times the median disposable income of individuals of retirement age or older (see Figure 1.1), depending on the country, region or municipality. Such costs are larger in Sweden, the region of South Tyrol in Italy, and Finland, compared to the Slovak Republic, the Czech Republic, and California and Illinois (in the United States). Differences in the costs of living across regions might also explain why some costs are high with respect to median national income, as is the case for South Tyrol in Italy.

Figure 1.1. Total costs of LTC are high compared to median disposable income in old age

Total costs as a proportion of national median disposable income for older people



Note: National median disposable incomes are for people of retirement age or older (e.g. the costs of LTC in South Tyrol are compared to the national median disposable incomes in Italy). Severe needs correspond to 41.25 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Older person with severe needs receiving LTC at home is assumed to live 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.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire and the OECD Income Distribution Database.

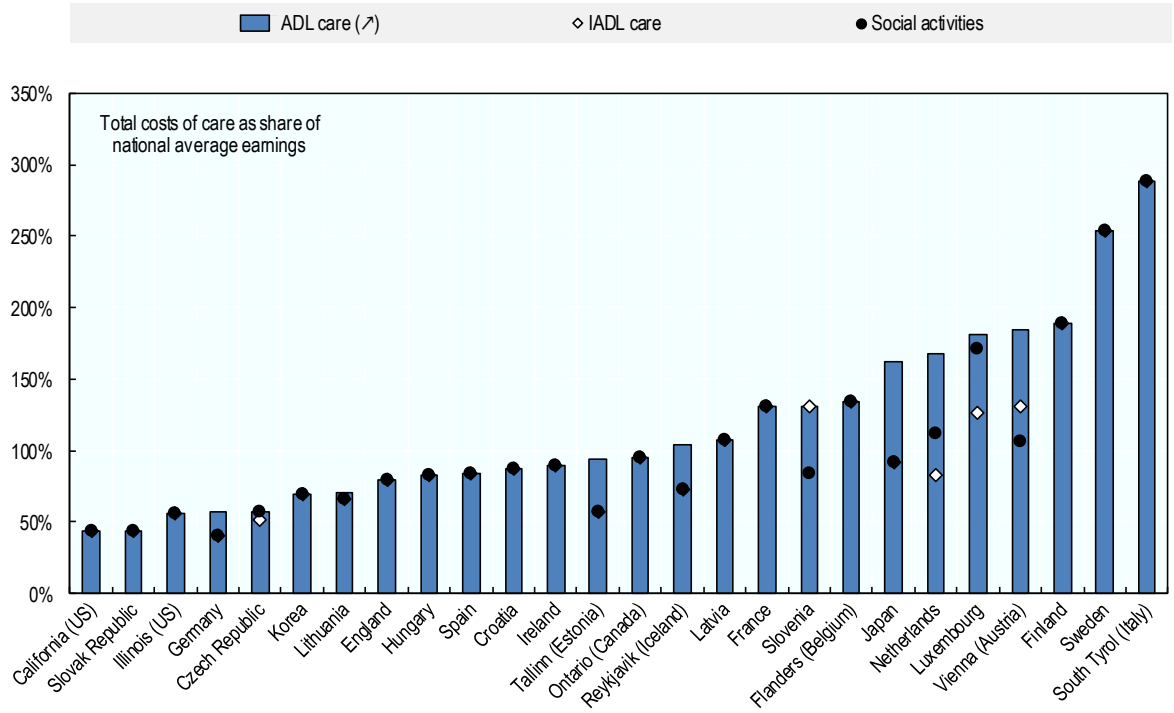
16. Formal home care can be a more expensive way of managing severe care needs, when professional carers[2] deliver all care. In certain jurisdictions (e.g. Croatia, Sweden, Latvia and Slovenia), the total costs of home care for individuals receiving 41.25 hours of care per week are twice as high as those of institutional care. Formal home care can thus be very expensive when needs are severe and involve many hours of care every week. Professional carers have to travel between care recipients' homes, which in some countries, regions and municipalities may take significant amounts of time, during which they are not providing care. This can limit the number of older people that they can care for at any given time. People living at home may receive some care from family and friends, thus reducing reliance on professional home care. In the absence of informal arrangements, though, institutional care may be the only option. Even including the costs of board and lodging, as well as 24-hour surveillance, Figure 1.1 illustrates that institutional care may be a less costly way to meet more severe LTC needs in old age.

17. Cross-country variation in the total costs of LTC is partly related to labour costs. The cost of one hour of home care varies widely between countries and subnational areas, compared with average earnings per hour actually worked (see Figure 1.2).

[2] Professional carers include a mix of professions with different levels of training such as nurses, nurse assistants, personal care workers and social workers, but exclude all unpaid caregivers. The roles and skills of professions vary between countries, even for professions with similar names. For instance, care is delivered mostly by social workers and personal carers in the Czech Republic, but is provided mostly by nurses in Flanders and in the Netherlands.

Figure 1.2. Total hourly costs of home care vary widely across countries and subnational areas

Total hourly costs as a proportion of national average earnings per hour actually worked in the economy



Note: Some countries, regions and municipalities were unable to provide hourly costs for home care that helps people to maintain social activities (like going for a walk or participating in their community); for these countries and subnational areas, it has been assumed that this type of care costs the same as the cost of help with IADLs in the respective country or subnational area.
Source: OECD analyses based on the Long-Term Care Social Protection questionnaire and the OECD Income Distribution Database..

18. The hourly cost of help with ADLs ranges from close to half of average earnings in the Slovak Republic and the United States (California and Illinois) to more than twice the average earnings in Sweden and the province of South Tyrol in Italy. It is important to note that, for some countries, regional or even municipal costs are being compared to national average wages. For example, according to the OECD Regional Demography Database, the average disposable income in the Italian province of South Tyrol is higher than the average disposable income in Italy as a whole. In these and other cases where regional costs are used, it is likely that differences between hourly costs of home care and national average earnings in the economy are partly driven by regional variation in average income.

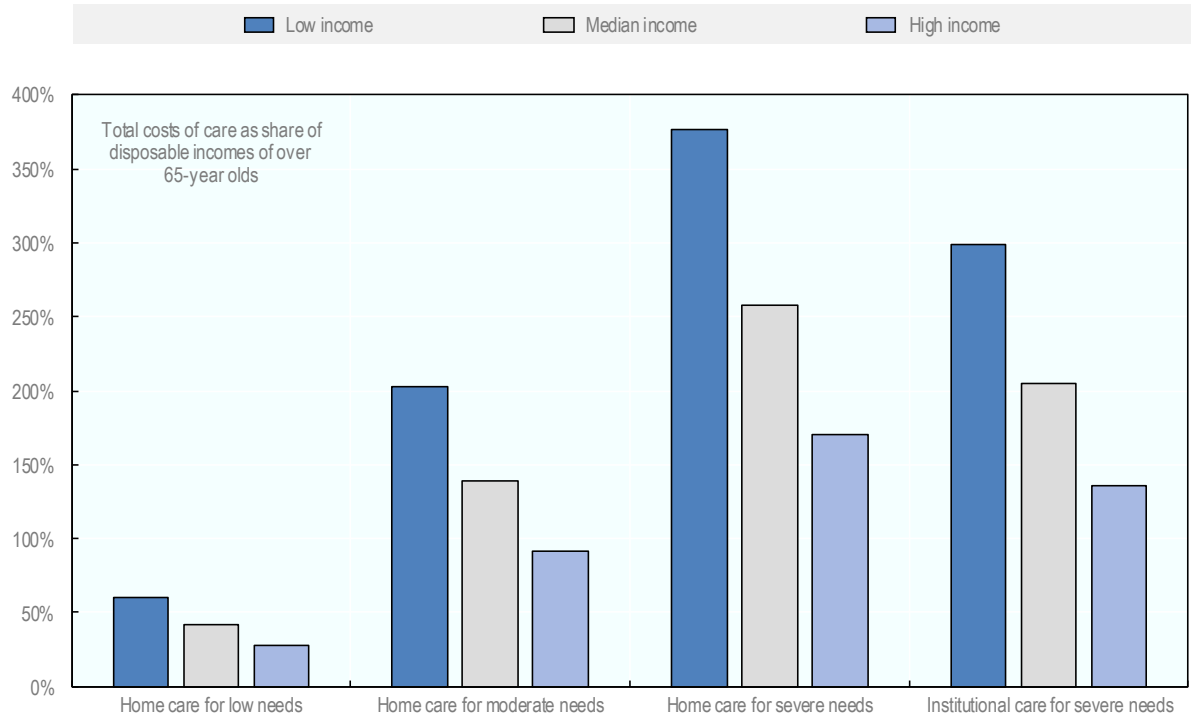
19. Relative differences in hourly costs of home care across countries and subnational areas are also associated with differences in the cost of labour and mean wages in the LTC sector. Cross-country differences in labour and mean wages in the LTC sector are likely due to differences in the training, qualifications, types and division of tasks, and the value that society in general attributes to LTC work. For example, in Ireland, LTC workers earn on average around 67% of the average earnings per hour actually worked in the general economy, and 38% of LTC workers have attained higher education levels. Conversely, in Germany, LTC workers earn close to 41% of the average earnings per hour actually worked in the economy with only 6% of LTC workers having completed higher education levels (OECD, 2020[7]).

1.2.2. Without effective social protection, even home care for low needs could be too costly for older people on lower incomes

20. In the absence of effective social protection, lower-income groups unsurprisingly face a higher risk of not being able to afford the total costs of LTC services from their incomes alone (see Figure 1.3). They are also more likely to need LTC compared to their richer counterparts. Even the total cost incurred by individuals with low needs could be high for those at the lower end of the income distribution. On average across countries and subnational areas, the total costs of 6.5 hours of formal home care per week represent 60% of the income of an older person on a low income, in the 20th percentile of the income distribution (among people of retirement age or older). The total costs of home care for individuals with moderate needs (22.5 hours of formal LTC per week) add up to more than twice the disposable income of someone in the lowest quintile of the old age income distribution. Without public social protection for moderate LTC needs, only the richest elderly would be able to cover the total costs of care by relying on their income alone. Care for severe needs would be unaffordable for all income categories without social protection, even those whose income is within the top quintile of income, on average across 26 OECD and EU countries, regions and municipalities.

Figure 1.3. Without social protection, the total costs of LTC would be unaffordable for older people on lower incomes, on average across the OECD/EU

Total costs of LTC as a share of over-65s' disposable income, in different settings and for different levels of needs, averaged across 26 jurisdictions in OECD countries and EU Member States



Note: Bars show unweighted averages for 26 OECD and EU countries, regions and municipalities. Low income refers to the upper boundary of the 20th percentile, and high income to the upper boundary of the 80th percentile. Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. The costs of institutional care include the provision of food and accommodation, so are overestimated relative to home care. Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on the Long-Term Care Social Protection questionnaire and the OECD Income Distribution Database.

21. Incomes of older people are, on average, lower than those of working age people, even when incomes are adjusted for differences in household size. The over-65s had average incomes of 88% of the total population incomes in 2014. On average, the incomes of people aged between 66 and 75 equalled 93% of the average income of the total population while the over-75s had an average income equal to 80% of that of the total population. In most OECD countries, public transfers provide the bulk of income in old age[3], with income from capital accounting for around 10% of older people's incomes (OECD, 2017[8]).

22. Relative income poverty risks have shifted towards the young in the past decades (see Box 1.3 for definition of relative income poverty). Still, at 23%, older people are more likely to be at risk of relative income poverty than the overall population (18%). In 25 out of 35 OECD countries, older people are more likely to be at risk of relative income poverty than the population as a whole. Moreover, while the elderly tend to have higher wealth levels than the young, some countries have high levels of asset-based poverty in terms of liquid financial wealth (see Box 1.3 below for detailed definition) among the elderly. For these asset-poor older people, even small out-of-pocket payments can represent a large proportion of their incomes and savings.

[3] Incomes for those 65+ exclude lump-sum payments which are frequent in the retirement schemes of some countries (e.g. Australia, Switzerland).

Box 1.3. Definitions of, and data sources for, income, wealth and relative poverty

To benchmark and monitor income inequality and poverty across countries, the OECD relies on a database – the OECD Income Distribution Database (IDD) – built on national sources (household surveys and administrative records) and on common definitions. Indicators are based on the concept of "equivalised household disposable income", i.e. the total market income received by all household members (gross earnings, self-employment income, capital income), plus the current cash transfers they receive (including transfers from social security, transfers from employment related social insurance and transfers from non-profit institutions and other households), less income and wealth taxes, social security contributions and current transfers that they pay to other households and to non-profit institutions. Household income is adjusted with an equivalence scale that divides household disposable income by the square root of household size. Standard concepts and definitions of household incomes are provided in the Canberra Group Handbook on Household Income Statistics (United Nations, 2011[9]) and in (OECD, 2013[10]).

For international comparisons, the EU and the OECD treat income poverty as a "relative" concept. The income poverty threshold depends on the median household income in a particular country at a particular point in time. This report uses both the OECD poverty threshold, set at 50% of the national median equivalised household disposable income. The equivalence scale used in this report is the square root scale,.

The OECD Wealth Distribution Database (WDD) is based on national sources, and estimates are currently available for 28 OECD countries. Concepts of wealth refer to the distribution of financial and non-financial assets and liabilities across households (rather than across persons or adults), with no adjustment made to reflect differences in household size. The data refer to the assets and liabilities held by private households residing in the country. Non-financial assets include the principal residence, other real estate property, vehicles and valuables. Financial assets include deposits, bonds, mutual funds, net equity in own unincorporated enterprises, stocks, unlisted shares, non-pension financial assets, individual life insurance and private pension funds.

Liquid financial assets (i.e. cash, quoted shares, mutual funds and bonds net of liabilities of own unincorporated enterprises) are used to capture asset-based poverty, as this represents the assets, which are relatively accessible to households if needed urgently. When net worth is used, measures of asset-based poverty are around 2/3 lower than those based on the liquid financial wealth concept. Individuals are identified as being at risk of asset-based poverty if they belong to a household with liquid financial wealth insufficient to support them at 50% of the national median equivalised disposable income (after social transfers have been taken into account) for at least three months (see Balestra and Tonkin (2018[11]) for more details).

2 Public support for and out-of-pocket costs of long-term care in old age

23. This chapter estimates, for 26 jurisdictions (countries, regions and municipalities) across the OECD and the EU, the level of public support for LTC and the out-of-pocket costs (the share of the total costs that remains after subtracting public support) for care recipients, for different typical cases of LTC needs, and for different levels of care recipient income and net total wealth (including primary residence and other assets). The following section quantifies the level of public support for LTC, as a share of the total costs of care for defined levels of need (the typical cases of LTC need described previously) and for different levels of care recipient income and net total wealth. Section 2.2 measures the out-of-pocket costs to care recipients, for different levels of income and net wealth, as well as different levels of need, including a discussion of the alignment of public support with broader LTC policy (e.g. ageing-in-place).

2.1. What is covered by public schemes: public support for the costs of LTC

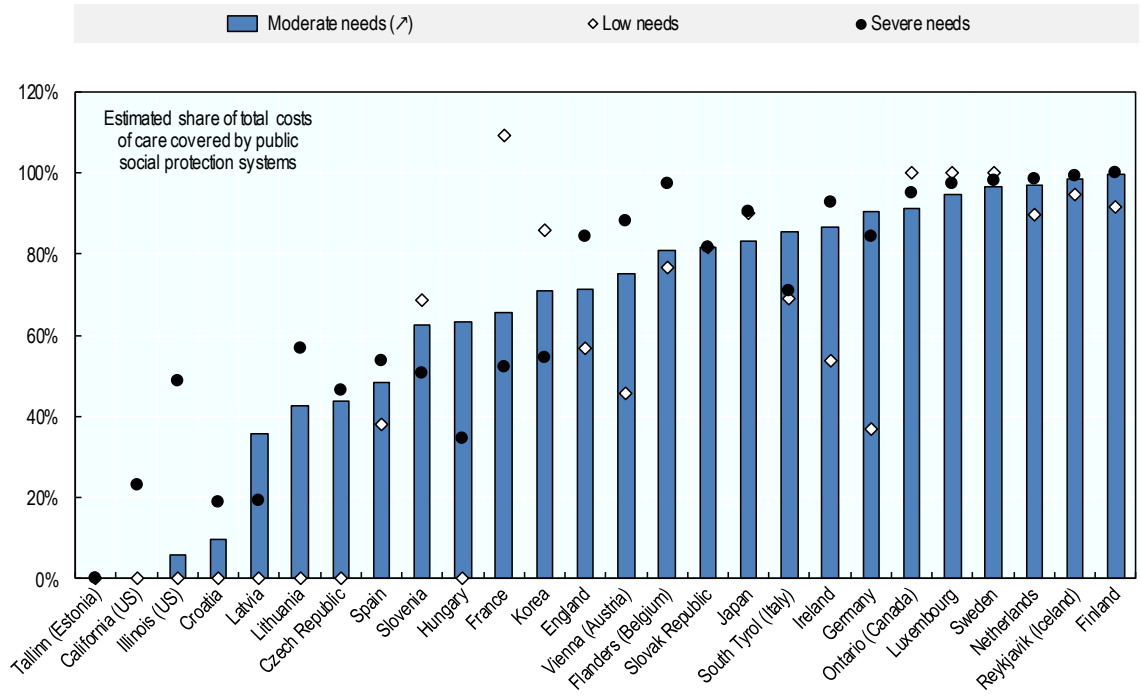
24. Without social protection, the total costs of LTC for older people are unaffordable in a large majority of OECD and EU countries and subnational areas, not only for those earning a median income but also, in many cases, for those at the higher end of income distributions. To protect older people against these potentially catastrophic costs, public social protection systems may subsidise a share of the total costs. The proportion of the total costs of LTC that public systems cover varies both between and within countries and subnational areas, across levels of care recipient need, income and net total wealth.

2.1.1. Public support tends to be greater for older people with more severe needs except in six jurisdictions where support is higher for people with low needs

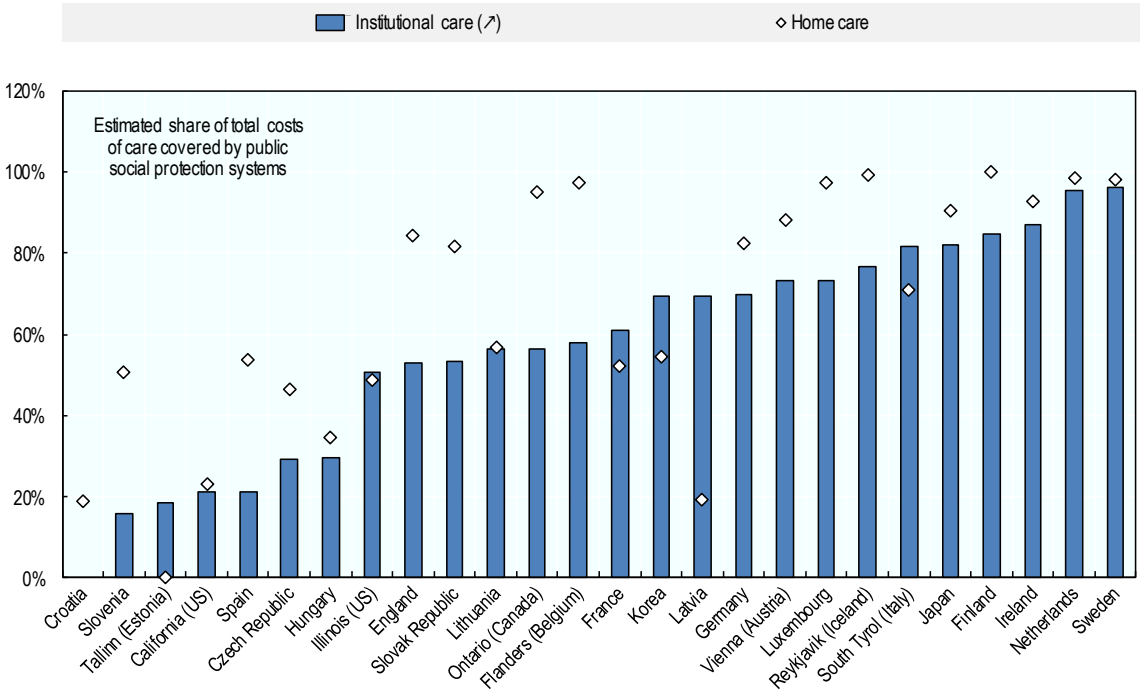
25. The shares of total costs of LTC for different severities and care settings that would be covered by public social protection systems according to the level of need – *for a person with a median income among the elderly and no net wealth* – are shown in Figure 2.1. There is wide variation in public cost shares (share of total costs covered by public social protection systems) across different levels of LTC needs, and different countries and subnational areas. In six jurisdictions, the share of total costs met by public social protection would be below 50% for moderate needs while ranging between 60% and 90% in 12 countries and subnational areas, and above 90% in six countries and subnational areas. For severe needs, public coverage would be below 50% in fewer countries and subnational areas (four), and over 90% in eight countries and subnational areas.

Figure 2.1. Share of total LTC costs that would be covered by public social protection, for care recipients earning a median income and holding no net wealth, by severity and care setting

Panel A – Home care for low, moderate and severe needs



Panel B – Institutional care and home care for severe needs



Note: Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A.

Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

26. In a majority of the 26 countries and subnational areas modelled here, as a share of the total costs of LTC, public support for home care for an older person with a median income, no net wealth and severe needs is as high as, or higher than, public support for institutional care (see Panel B in Figure 2.1). In Tallinn (Estonia), Latvia, Germany, Korea, Illinois (United States), South Tyrol (Italy) and France, the share of the total costs of care that are covered by public social protection systems would be higher for institutional care than for home care. Public support could exceed the total costs of LTC due to the combination of multiple benefits, but this is only the case in France, where older people with low needs receiving care at home may receive benefits that slightly exceed the costs of care (109% of the total costs) due to tax reductions on salaries paid to carers.

27. A majority of countries and subnational areas would cover a greater share of the total costs of home care for severe needs compared to moderate and, especially, low needs. In fact, eight countries and subnational areas (California and Illinois in the United States, Tallinn in Estonia, the Czech Republic, Latvia, Croatia, Lithuania and Hungary) out of 26 do not cover any of the costs of home care for those old people with median income, no net wealth andlow care needs. In the Czech Republic, Hungary and Illinois, low needs (equivalent to 6.5 hours of care per week) do not qualify for public support, while in the other countries and subnational areas, older people on lower incomes may receive some public support, but those earning the median income (as is the case in Figure 2.1) do not receive any financial support. Countries and subnational areas that adjust the level of public support to the income and net wealth of care recipients apply what is commonly referred to as means-testing (discussed more extensively in the next section and in chapter 3).

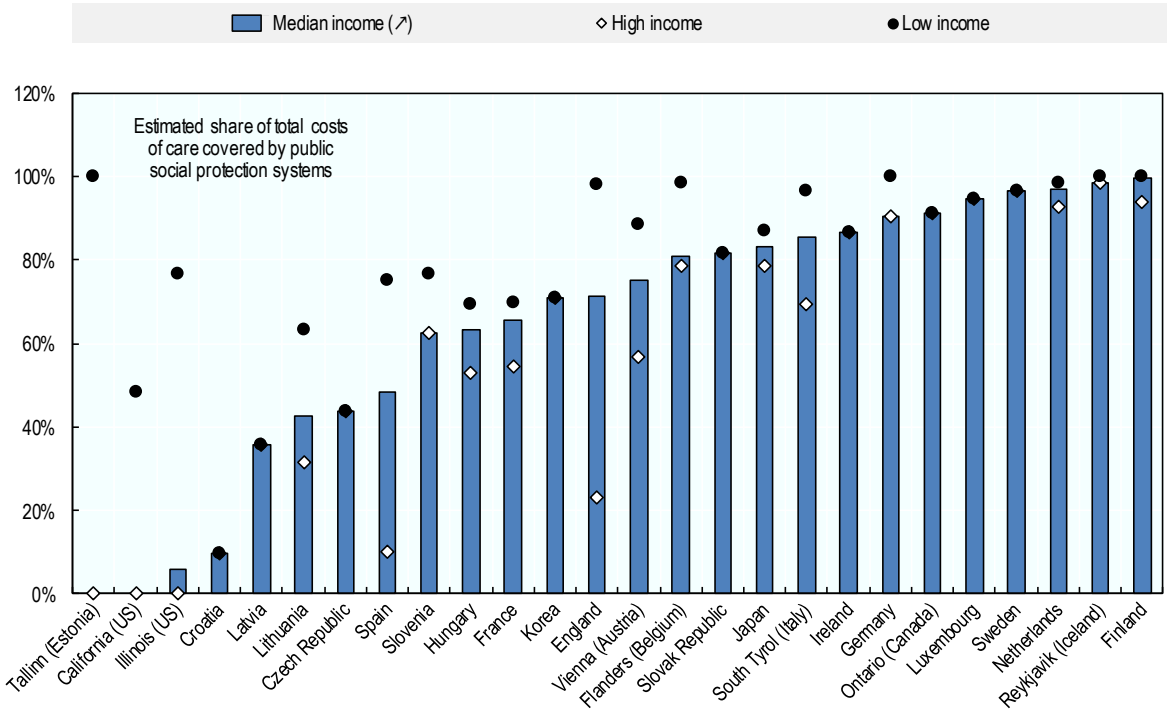
28. While the majority of jurisdictions would provide greater public support to care recipients with more severe LTC needs, there are a few exceptions. In Latvia, France, Slovenia, Hungary, South Tyrol in Italy, and Germany, the share of total costs of care that would be covered by the public social protection system for an older person earning a median income and holding no net wealth is higher for moderate needs than for severe needs. In France and Slovenia, there is actually an inverse relationship between public support and severity of LTC needs for those on a median income and no net wealth, with older people with lower levels of need receiving more support than those with moderate needs, and those with moderate needs receiving more support than those with severe needs. This pattern is due to both countries setting limits to the number of hours of care that can be covered through public LTC benefits and schemes.

2.1.2. Public support is generally lower for older people with higher income and wealth

29. Public social protection systems in a number of countries and subnational areas apply means-tests: the share of the total costs that public systems cover depends on the care recipient's income and/or net wealth (including primary residence and other financial and non-financial assets). Figure 2.2 shows the shares of the total costs of *home care for moderate needs* that would be covered by public social protection systems for different levels of care recipient income and *no net wealth*. Most countries and subnational areas do adjust the level of public support for home care to the income of the care recipient. Generally, care recipients with higher incomes receive less public support, while users on lower incomes are typically entitled to greater public support (this pattern is also observed in institutional care – data not shown here). The motivation for income-testing is that people earning more are expected to be able to afford to pay more towards the total costs of care, and thus have less need for public financial support.

Figure 2.2. Share of total home care costs met by public social protection, by income

For an older person receiving home care for moderate needs and with no net wealth



Note: Low income is the upper boundary of the 20th percentile of income and high income is the upper boundary of the 80th percentile of income, both among people of retirement age or older. Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

30. In a majority of countries, older people on lower incomes would receive a greater degree of public support for the total costs of home care. This extra support ranges from 65 to 75 percentage points more in Spain and England respectively, but amounts to less than 10 percentage points in Japan and Germany[4]. However, in nine jurisdictions, older people with low and high income[5] would receive the same level of public support for home care for moderate needs. In Latvia and Croatia, older people earning below the upper boundary of the 20th percentile of income (not shown in Figure 2.2) would be entitled to greater public support.

31. Out of the 26 jurisdictions modelled in this paper, 14 apply assets-tests when determining the share of the total costs of institutional care that public social protection systems cover, as shown in Figure 2.3 (while Slovenia also uses assets-tests in institutional care, these do not lead to differences in public support for care recipients earning the national median income). Flanders, in Belgium, excludes the care recipient's primary residence from assets-tests, as does Ireland but only after three years in institutional care. Whereas for home care, Croatia, Spain and England do not include primary residence in assets-tests, these countries do so for institutional care, since the care recipient (who is considered single in this analysis) is no longer living at home. More countries apply assets-tests in institutional care than in

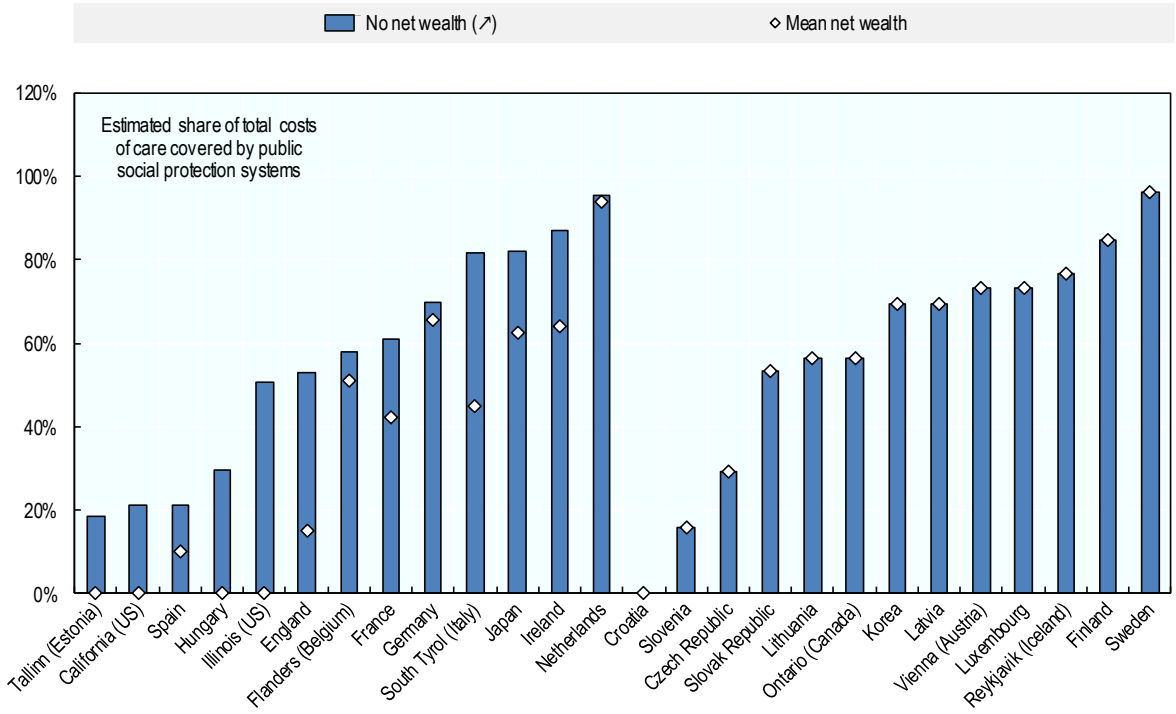
[4] In Germany, there is nonetheless public support for the lowest income quintile, which is separate from LTC benefits, and will cover close to 100% of home care costs.

[5] Low income is the upper boundary of the 20th percentile of income while high income is the upper boundary of the 80th percentile of income, in both cases among people of retirement age or older.

home care, since older people are no longer living in their own homes (and for many older people, their primary residence is their main asset). Moreover, as the total costs of institutional care are high compared to the total costs of home care for less severe needs (i.e. low and moderate care needs); assets-tests may provide a way to limit public spending on institutional care.

Figure 2.3. Share of total institutional care costs met by public social protection, by net wealth

For an older person with severe needs earning the national median income



Note: Care recipients earn the national median income (among people of retirement age or older). Mean net total wealth is for over 65 year olds. For countries with no net wealth data (Czech Republic, Iceland, Croatia, Lithuania and Sweden) it is assumed mean net wealth is 17 times the national median income (based on the average ratio between mean net wealth and national median income across OECD countries for which both data are available). It is assumed 52% of mean net wealth is primary residence and 48% is other assets (based on average percentages across OECD countries for which data are available). Detailed descriptions of care recipients' needs are available in Annex A. Countries, regions and municipalities are first sorted based on whether they apply assets-tests to public support for institutional care for severe needs.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

2.1.3. Public support for formal care is almost universally higher than for informal care

32. Balancing adequate public social protection for the total costs of formal LTC services with an appreciation and recognition of the contributions of informal carers is not straightforward, especially as it may create incentives for older people and their families to choose formal instead of informal care, and vice versa. On the one hand, many older people prefer to be cared for in their own homes by their relatives and friends. On the other hand, informal carers tend to suffer physical and mental stress, and are more likely to drop out of the labour market or reduce working hours, leading to lower income and reduced social contributions (Colombo et al., 2011[2]). Caring for an elderly relative can thus become a burden. Providing adequate support and meeting the preferences of all involved (care recipient as well as formal and informal carers) can be challenging.

33. There are reasons why public social protection systems would limit the generosity of public support for informal care, provided by either a spouse or an adult child. While public social protection systems can use cash benefits to incentivise the supply of informal care, they are reluctant to make it too attractive as often care would have been provided even without compensation. It is difficult to strike a good balance between adequately compensating informal carers, and disincentivising labour market participation and resulting gaps in employee contributions.

34. Public support for informal care rarely constitutes a remuneration in line with the average wage that an adult child might be able to receive in the economy. In twelve countries and subnational areas, an adult child providing 22.5 hours of care to an elderly parent with moderate needs would receive no public support (either directed to the care recipient or the caregiver), despite the fact that the adult child would have to reduce working hours – or even stop working altogether – to provide care. Public support for informal care is most generous in the Netherlands and Flanders (Belgium) where it would represent around 84% and 74%, respectively, of a median hourly income, adjusted for hours actually worked[6] (data not shown here). In Germany, support towards informal carers is not meant to replace wages but is a considered a form of family support. While the large majority of countries and subnational areas do not provide any direct financial support to informal caregivers, a number of countries, regions and municipalities do give care recipients cash benefits that can be used to compensate informal caregivers (however, often, there is no obligation to use these cash benefits to pay caregivers and care recipients are free to use the cash as they wish). Public social protection systems in Tallinn (Estonia) and Flanders (Belgium) support the caregiver directly, while Finland combines both benefits to the care recipient and benefits to the adult child.

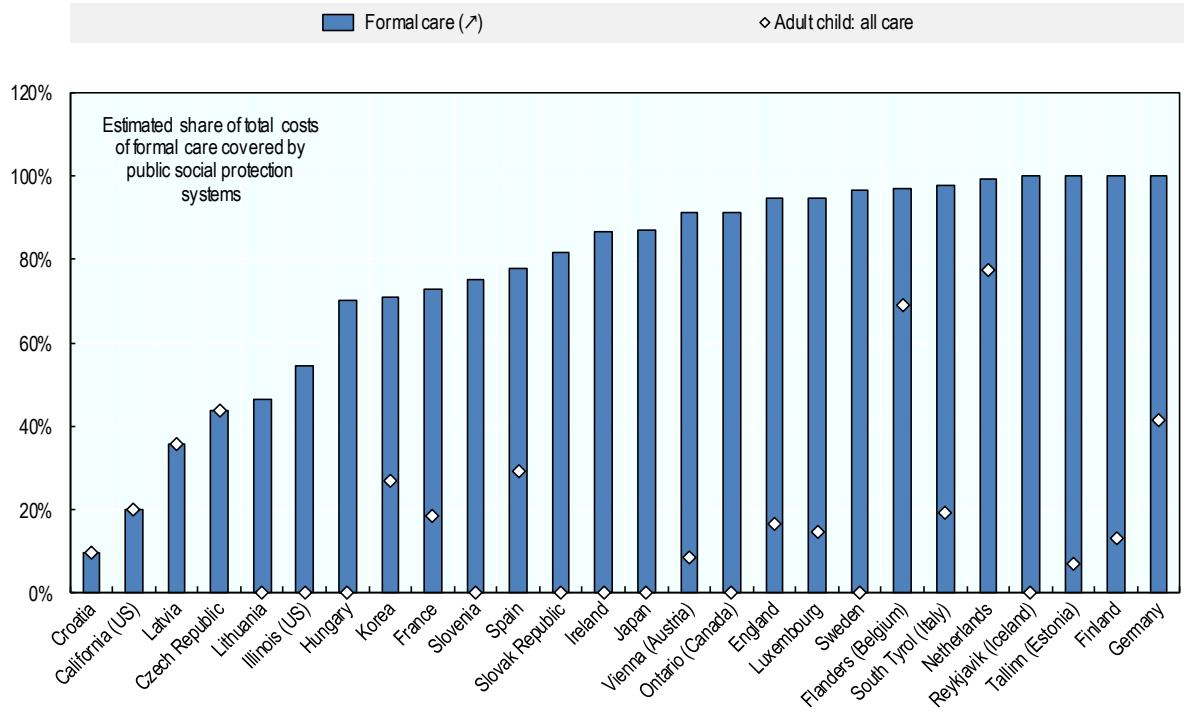
35. In the absence of sufficient public support for informal carers, older people and their relatives and friends might have to rely fully on formal care when they might have preferred that the older person be cared for by relatives and friends. Informal carers, such as adult children, might find it impossible to provide support for their elderly parents without incurring significant opportunity costs from reduced labour market participation. Figure 2.4 shows the extent of public support for moderate care *for an older person earning just above the relative income poverty line*[7] provided by either a formal carer or an adult child, as a share of the total costs of formal care (to facilitate interpretation). In ten jurisdictions (Slovenia, Lithuania, Hungary, Ireland, Japan, Ontario in Canada, Sweden, Slovak Republic, Illinois in the United States, and Reykjavik in Iceland), an adult child would not receive any public support whatsoever, while between 40% and 100% of the total costs of formal home care would be covered. In certain countries, regions and municipalities, there is thus a strong financial incentive to choose formal care over informal care, when considering the out-of-pocket costs of home care for moderate needs to care recipients, and the opportunity costs to informal caregivers.

[6] For the Netherlands, rules regarding the use of personal budget schemes differ from one municipality to another and some municipalities make less use of the personal budget scheme to pay informal carers.

[7] The relative income poverty threshold (50% of the national median disposable income among the whole population) is used here to illustrate a scenario in which public support is most needed, and thus is likely to be close to 100% of the total costs of care.

Figure 2.4. Public support for formal and informal home care for moderate needs, as a share of total formal home care costs

Care recipients earn just above the relative income poverty threshold and have no net wealth



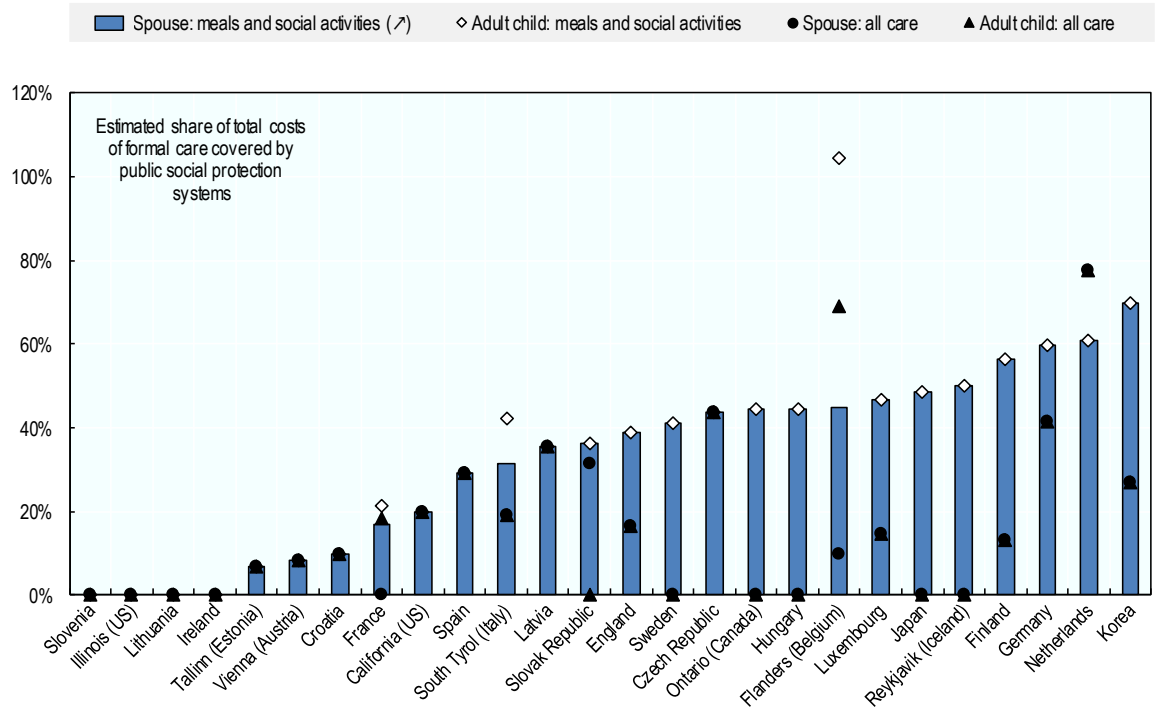
Note: Moderate needs correspond to 22.5 hours of care per week. Care recipient earns the relative poverty income (50% of the national median disposable income among the whole population). Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

2.1.4. Different combinations of formal and informal care are associated with large differences in the level of public support

36. Countries, regions and municipalities provide very heterogeneous levels of public support for different combinations of formal and informal care, and depending on whether the informal carer is the care recipient's spouse or their adult child. The levels of public support for an older person with *moderate needs, at risk of income poverty and with no net wealth*, for different combinations of formal and informal care, are shown in Figure 2.5, as a share of the total costs of formal home care for moderate needs (for easier interpretation). In Spain, for example, there would be the same level of public support for any combination of formal and informal care, as well as any choice of informal carer. However, in Flanders (Belgium), public support would differ significantly depending on whether the informal carer is an adult child or a spouse, and how much and what type of care they provide. Across all countries and subnational areas, public support for mixed formal and informal care (with formal carers helping with ADLs, shopping, laundry and cleaning, and informal carers helping with meals and social activities) tends to be higher than for fully-informal care (when informal carers perform all caring activities).

Figure 2.5. Public support for different types of informal care, as a share of total formal care costs

Care recipients have moderate needs, just above the relative income poverty threshold and have no net wealth



Note: Moderate needs correspond to 22.5 hours of care per week. Care recipient earns the relative poverty income (50% of the national median disposable income among the whole population). Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

2.2. What is not covered by public schemes: out-of-pocket costs of LTC for older people, after public support

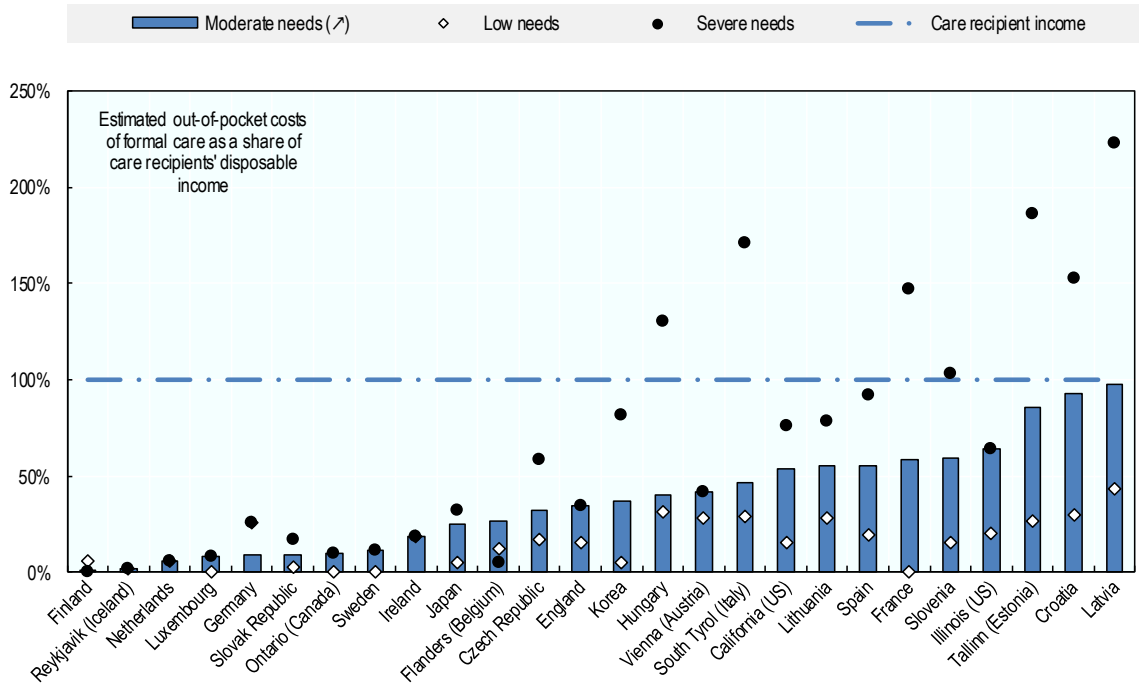
37. As discussed in the previous section, the proportion of the total costs of LTC that public systems would cover varies widely between and within countries and subnational areas, and across levels of care recipient need, income and assets. Depending on the country, region or municipality, and the characteristics of the care recipient, some older people could have to cover the total costs of care in full. Moreover, while public social protection systems would tend to provide greater support to those with fewer means (income and net wealth); even small out-of-pocket payments can represent a large proportion of the incomes of older people with limited financial resources. This section shows how the out-of-pocket costs of LTC (the share of the total LTC costs that is left for older people to pay, after taking into account public support) compare to older people's disposable incomes.

2.2.1. Even after public support, care for severe needs may be too costly for the elderly

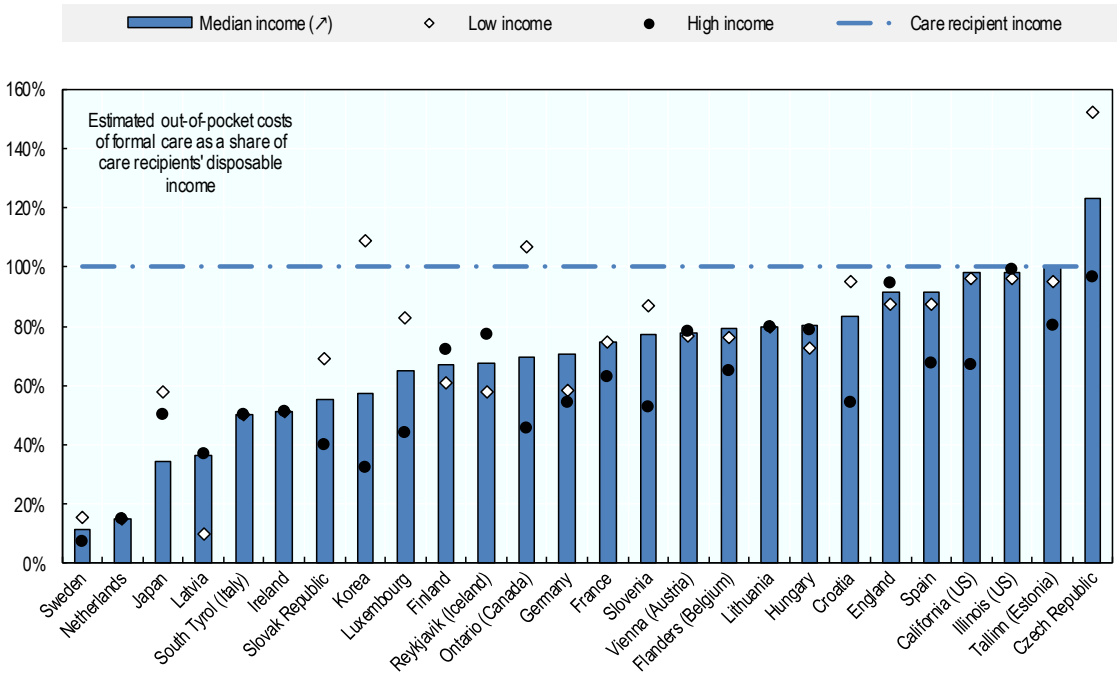
38. The estimated out-of-pocket costs of home care for different LTC needs, after receiving public support, for *an older person with a median income and no net wealth*, and as a percentage of their disposable income are shown in Figure 2.6 below. Also shown are the estimated out-of-pocket costs of institutional care, after receiving public support, *for an older person with no net wealth and for different levels of income*, as a percentage of their disposable income.

Figure 2.6. Out-of-pocket costs of care as a share of old age income after public support, for home care by severity of needs (Panel A) and for institutional care by level of income (Panel B)

Panel A – home care for older people earning a national median income and no net wealth, by severity



Panel B – institutional care for older people with severe needs and no net total wealth, by level of income



Note: Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Low income is the upper boundary of the 20th percentile of income and high income is the upper boundary of the 80th percentile of income, both among people of retirement age or older. Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

39. Across countries and subnational areas, out-of-pocket spending would be lowest for low needs and highest for severe needs. The out-of-pocket costs of home care for low and moderate needs would be lower than the median income among older people in all 26 countries and subnational areas modelled here. Out-of-pocket spending on home care would generally represent less than 50% of the median income among older people with low needs. In seven jurisdictions (Hungary, South Tyrol in Italy, France, Slovenia, Tallinn in Estonia, Latvia and Croatia) the out-of-pocket costs of home care for severe needs would be unaffordable for an older person earning a median income (see Panel A in Figure 2.6).

40. High out-of-pocket costs, even with public support, can become unaffordable when adding the basic costs of living at home, such as food and accommodation, (such costs can amount in some cases to 50% of income). In these cases, care recipients can turn to family members, friends and others for financial support or informal care, as a way to prevent them from going without care. In Croatia and Latvia, older people would have less than 10% of their incomes left after paying for home care for moderate needs and might not be able to afford basic living expenses.

41. With respect to institutional care, in Germany, older people on low incomes would face no out-of-pocket costs for LTC received in an institution. Conversely, older people in the Czech Republic on low and median incomes, and those on low incomes in Ontario (Canada) and Korea would not be able to cover the out-of-pocket costs of institutional care from their incomes alone[8], even with public support.

42. Out-of-pocket costs for institutional care would represent less than an older person's median income in all countries and subnational areas except in the Czech Republic and in Tallinn, Estonia (in Tallinn they would represent 100% of a median earner's income). In all other jurisdictions, the out-of-pocket costs of institutional care would represent only a small share of the median income among people of retirement age or older (see Panel B in Figure 2.6). As institutional care costs include board and lodging, older people living in LTC institutions might be able to spend all of their income on the out-of-pocket costs of care. However, if people are left with very limited financial resources, they lose some of their independence to spend their income on other things they might like. Several countries, such as England, France, Luxembourg and the Czech Republic, include rules that explicitly ensure that people in residential care are left with at least a certain amount of income (around 9%-15% of the median pensioner's income).

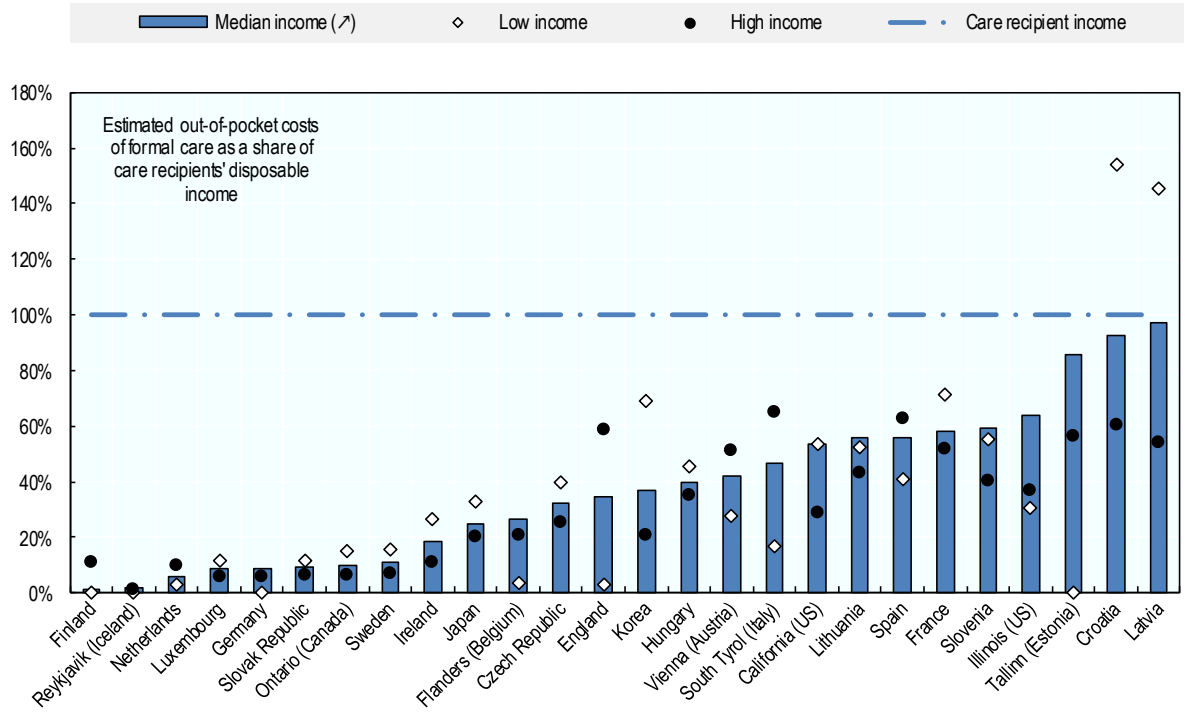
2.2.2. Income-tests may not limit out-of-pocket costs for older people on low incomes

43. The estimated out-of-pocket costs of *home care* after receiving public support, for different levels of income, as a percentage of disposable income, are shown in Figure 2.7. In four countries and subnational areas (Finland, Germany, Tallinn in Estonia, and Reykjavik in Iceland) older people earning a low income would have no out-of-pocket expenses after receiving public support. Conversely, in eight countries or subnational areas, an older person earning a low income would have to devote over half of their income to pay for care, leaving less than half of their already low income to cover basic living expenses. In Croatia and Latvia, older people on low incomes would not be able to afford the out-of-pocket costs of home care for moderate needs, as these costs would exceed their incomes, even after receiving public support.

[8] Note that Korea has a scheme for older people with LTC needs and low income who are financially supported by public systems through discounting legal out-of-pocket costs of LTC up to 100%.

Figure 2.7. Out-of-pocket costs of home care as a share of old age income, by income level, after public support

For an older person receiving home care for moderate needs and no net wealth



Note: Low income is the 20th percentile of income and high income is the 80th percentile of income, both among people of retirement age or older. Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

44. Public social protection systems in Slovenia, Japan, Hungary, France and Lithuania would provide greater support to older people on low incomes than they would for those on high incomes. Yet, the out-of-pocket costs of care, as a percentage of income in these countries, would be higher for older people on low incomes than for those on high incomes. In effect, older people on high incomes would pay a lower proportion of their income towards the costs of care than would those on low incomes, despite the latter receiving greater public support. In countries and subnational areas that do not adjust public support for home care for moderate needs to care recipients' incomes (Croatia, Latvia, Ontario in Canada, Luxembourg, Sweden, Slovak Republic, Ireland, the Czech Republic and Korea), older people with high incomes would also spend a lower share of their income on care compared to those on low incomes.

2.2.3. Older people with average net wealth may face very high out-of-pocket costs in nine jurisdictions, especially in institutional care

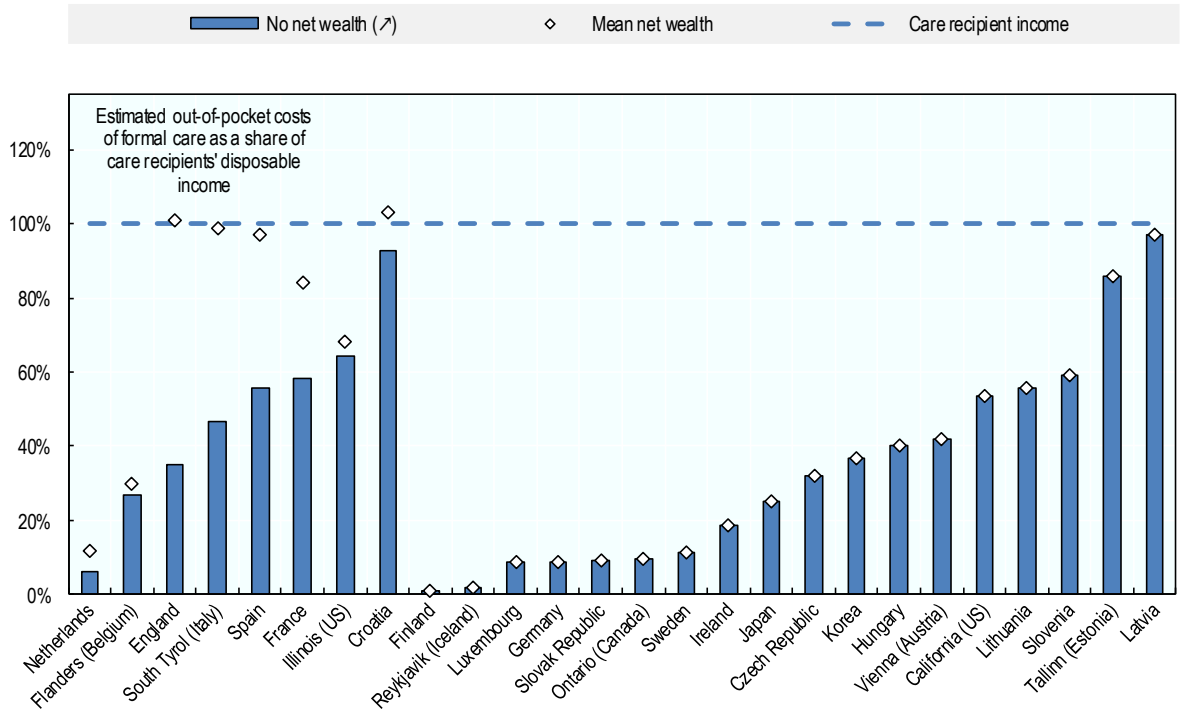
45. The estimated out-of-pocket costs of *home care for moderate needs* after receiving public support, for *an older person with median income (among people of retirement age or older)*, and for different levels of net wealth[9], as a percentage of income, are shown in Figure 2.8. In seven out of ten jurisdictions, there are no asset-tests for home care and thus no difference in the out-of-pocket costs for different levels of

[9] Only two levels of net wealth (no net wealth and mean net wealth) are presented here because means-testing in all jurisdictions do not show differences for higher levels of wealth.

wealth. Because of asset-tests, in ten jurisdictions (Croatia, Spain, France, England, the region of Flanders in Belgium, the region of South Tyrol in Italy, the states of Illinois and California, Germany and Netherlands), older people without any net wealth would face out-of-pocket costs that are lower than the median income among older people. Assets-tests in Germany and California do not alter the level of out-of-pocket costs for older people earning a median income, as seen in Figure 2.8.

Figure 2.8. Out-of-pocket costs of home care as a share of old age income, by net wealth, after public support

For an older person receiving home care for moderate needs and earning the national median income



Note: Mean net total wealth is for over 65 year olds. For countries with no net wealth data (Czech Republic, Iceland, Croatia, Lithuania and Sweden) it is assumed mean net wealth is 17 times the national median income (based on the average ratio between mean net wealth and national median income across OECD countries for which both data are available). It is assumed 52% of mean net wealth is primary residence and 48% is other assets (based on average percentages across OECD countries for which data are available). Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Countries, regions and municipalities are first sorted based on whether they apply assets-tests for home care for moderate needs.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database..

46. In Illinois, Flanders (Belgium) and the Netherlands, older people with mean net wealth would face higher out-of-pocket costs than those without net wealth, yet they would still be able to afford out-of-pocket costs from their incomes alone. In Croatia and England, the out-of-pocket costs for older people with mean net wealth would be higher than their incomes, and thus they might have to deplete their assets to cover the shortfall.

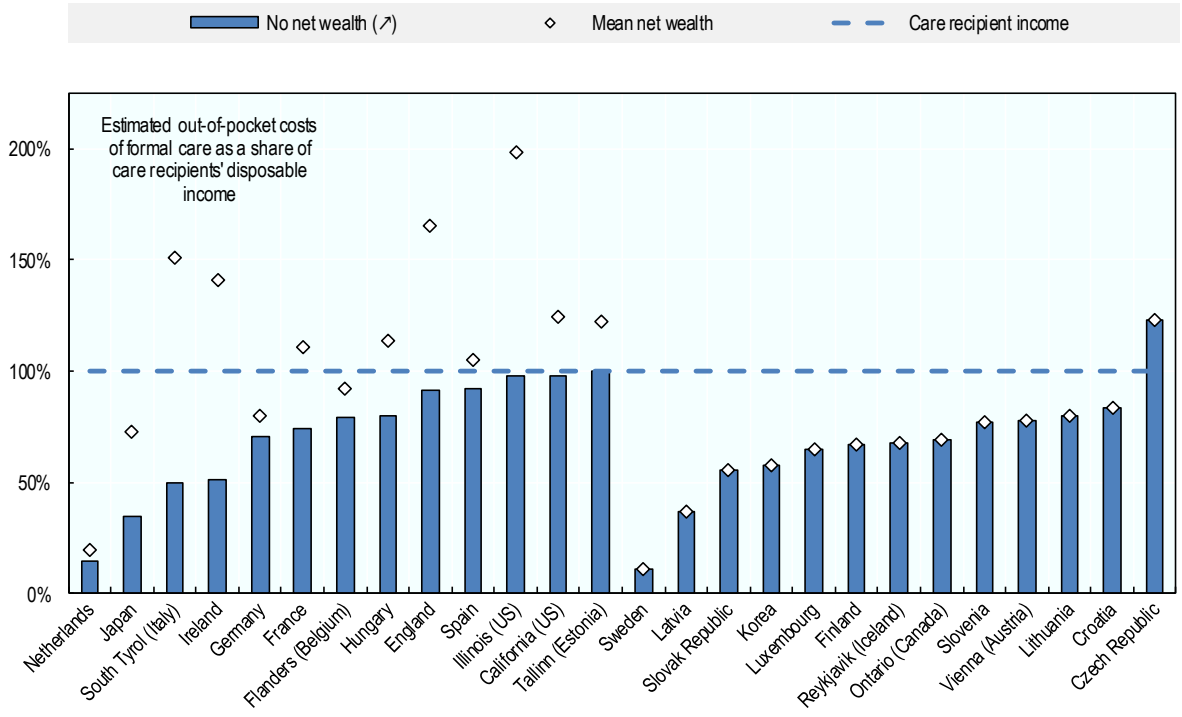
47. The estimated out-of-pocket costs of *institutional care* after receiving public support, for *an older person with median income (among people of retirement age or older)* and for different levels of net wealth, as a percentage of income, are shown in Figure 2.9. In the 14 jurisdictions that apply assets-tests for *institutional care*, older people with no assets would face out-of-pocket costs that are lower than their

incomes. Slovenia also applies assets-tests although these do not lead to a difference in public support for an older person with a median income (as shown in Figure 2.9).

48. In the Netherlands, Germany, Japan and Flanders (Belgium), older people with mean net wealth could face higher out-of-pocket costs, yet they would still be able to afford out-of-pocket costs from their incomes alone. However, in Spain, England, South Tyrol (Italy), Ireland, France, Tallinn (Estonia), Hungary, California and Illinois (United States), the out-of-pocket costs for older people with mean net wealth would be higher than their incomes, implying that care recipients should deplete their assets to pay for institutional care. In almost all jurisdictions that apply assets-tests in institutional care, the care recipient's primary residence would be taken into account (the exceptions are Flanders, in Belgium, and Ireland, and in the latter primary residence is excluded after the first three years).

Figure 2.9. Out-of-pocket costs of institutional care as a share of income, by net total wealth

For an older person with severe needs earning the national median income



Note: Mean net total wealth is for over 65 year olds. For countries with no net wealth data (Czech Republic, Iceland, Croatia, Lithuania and Sweden) it is assumed mean net wealth is 17 times the national median income (based on the average ratio between mean net wealth and national median income across OECD countries for which both data are available). It is assumed 52% of mean net wealth is primary residence and 48% is other assets (based on average percentages across OECD countries for which data are available). Detailed descriptions of care recipients' needs are available in Annex A. Countries, regions and municipalities are first sorted based on whether they apply assets-tests to institutional care for severe needs.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

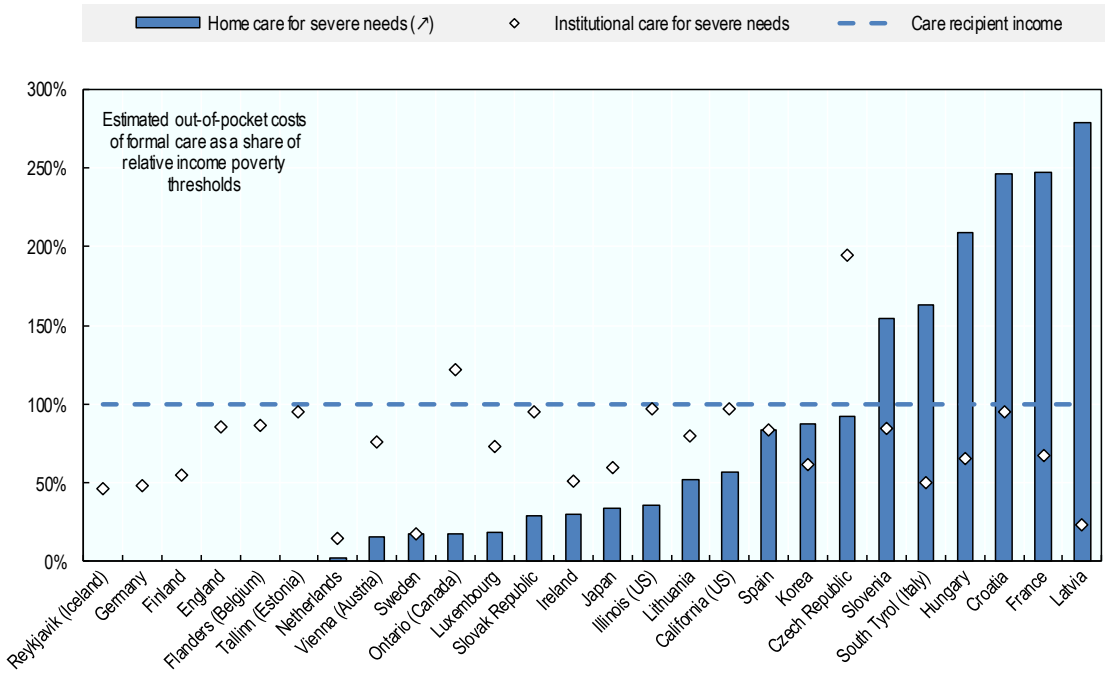
2.2.4. Public social protection is not necessarily aligned with ageing-in-place policies

49. Many OECD countries and EU Member States have policies or strategies to support home care (i.e. to age in-place), yet they are not always reflected in financial incentives. For example, Latvia approved in 1995 legislation to deinstitutionalise LTC (World Bank, 2010[12]), yet the level of public support for an older person with severe LTC needs earning a median income would be lower for home care than if that

person were to receive care in an institution (see Figure 2.1). In eight countries, older people could face higher out-of-pocket costs at home than if they were in an institution (see Figure 2.10). For example, Slovenia would cover 51% of the total costs of home care for an older person with severe needs, compared to 16% if the same person received care in an institution. However, because home care for someone with severe LTC needs in Slovenia costs (in total) more than institutional care, a home care recipient would face out-of-pocket costs that are unaffordable from income alone. If the older person in question is at risk of poverty (both income and asset-based poverty), they would not be able to afford to age in-place. Conversely, the out-of-pocket costs of institutional care would represent less than their income (even allowing care recipients to keep around 15% of their income) and their basic living costs would be fully covered (through board and lodging).

Figure 2.10. Out-of-pocket costs of home and institutional care, as a share of old age income

Care recipients have severe needs, earn at the relative income poverty threshold and have no net wealth



Note: Severe needs correspond to 41.25 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

50. Furthermore, jurisdictions promoting ageing-in-place should take into account that staying in the community requires covering basic living costs, in addition to care costs. Even in countries and subnational areas where public support for older people with severe LTC needs would be higher for home care than for institutional care, public systems may not be doing enough to prevent older people in the community from being at risk of poverty. Older people who are at risk of poverty cannot afford to make any out-of-pocket payments or they will fall below poverty lines (especially if they are also asset poor and thus cannot deplete their assets to pay for care). Yet, in the majority of countries and subnational areas in Figure 2.10, care recipients who are at risk of poverty would still need to contribute to the costs of home care, effectively pushing them below relative income poverty lines. This despite greater or equal public support for home care in many of these countries and subnational areas, and policies to promote ageing-in-place.

3 The design of benefits and schemes for long-term care in old age

51. The estimated level of public social protection against the total costs of LTC in old age varies widely both across and within countries and subnational areas in the OECD and the EU, as seen in the previous chapter. Older people with similar LTC needs could face significantly different out-of-pocket costs depending on which country or region they live in. Furthermore, even within the same country or region, the out-of-pocket costs might change considerably as the severity of LTC needs evolves. To some extent, this heterogeneity is due to the use of different needs assessments (as discussed in the introduction) which tend to provide greater support to older people with more severe LTC needs (as shown in the previous chapter). In large part, variation is also due to whether (and how) public social protection systems in different jurisdictions share the costs of care with older people and their families.

52. Cost-sharing can have both advantages and drawbacks. Out-of-pocket payments are a source of revenue for limited state budgets, they make users more aware of the total costs of the care they receive and could potentially disincentivise frivolous use (Kolasa and Kowalczyk, 2016[13]). This last point, though often considered important in health care, is likely to be less relevant in the context of LTC, since older people must undergo needs assessments before receiving public support. On the other hand, out-of-pocket payments can disproportionately affect those with lower incomes and fewer assets, and prevent them from affording the care they need. Safety nets and exemptions can help target out-of-pocket payments to those who can afford them, but they can also be difficult and expensive to administer and enforce (OECD, 2017[14]), and might make public support more opaque to users and their advocates.

53. This chapter details how public social protection systems implement cost-sharing. The following section discusses the different cost-sharing dimensions and rules in use in different countries and subnational areas. Means-testing (making the level of public support change as a function of the care recipient's income, assets or both) is described in section 3.2.

3.1. All countries and subnational areas apply some form of cost-sharing

54. In all jurisdictions analysed in this paper, at least some care recipients will have to contribute to the costs of care (i.e. they will face out-of-pocket payments). How these contributions are calculated differs widely across countries and subnational areas, and often in such ways that care recipients might have difficulty predicting their out-of-pocket costs when planning care. Table E.1 (in Annex E) lists the benefits and schemes available to older people with defined LTC needs in 26 jurisdictions (including two states in the United States) in the OECD and the EU, detailing whether they are provided in-kind or in cash, and if means-tests are applied. Most countries and subnational areas have multiple benefits and schemes (only the Czech Republic and Japan have one comprehensive scheme for all typical cases of LTC needs used here). Most countries and subnational areas combine both in-kind and in cash transfers although some systems rely exclusively on cash benefits or in-kind services.

55. Both forms have benefits and drawbacks but whether a country or region has in cash or in-kind LTC benefits and schemes does not seem to, in itself, determine its effectiveness. In-kind transfers

encourage consumption of particular goods and can induce those with less severe LTC needs to self-select out of the scheme or benefit. However, when there is a means-test or other barrier to participation, unless means-tests are well designed (i.e. target the right group of older people), providing services in-kind does not dramatically increase targeting efficiency (Currie and Gahvari, 2008[15]). Cash transfers, on the other hand, are a less appropriate means of targeting: providing transfers in cash is attractive for everyone, even the wealthiest. Some cash benefits may also be used to buy anything (Harvey, Slater and Farrington, 2005[16]). This issue can be avoided by earmarking cash transfer (e.g. vouchers). However, pure cash transfers have the benefit of affording beneficiaries greater purchasing power and freedom over their consumption. They also have lower administrative and logistical costs, and are very quick to implement (Oxfam, 2006[17]).

3.1.1. Most jurisdictions require user contributions in home care, but their form varies

56. A number of countries and subnational areas have LTC benefits and schemes with fixed user contributions (user contributions do not depend on the care recipient's income and net wealth). For example, in Flanders (Belgium), service vouchers have been introduced to make household work cheaper for consumers, in order to increase employment in this sector, and to reduce undeclared work. Service vouchers can be purchased by elderly people at a discounted price (due to a tax rebate) and used to pay for assistance services (help with IADLs). The price does not depend on the care recipient's income or assets. In Hungary and Slovenia, care recipients must pay 100% of the total costs of care above a certain threshold (any care above four hours per day in Hungary, and 20 or 25 hours per week in Slovenia depending on the LTC needs of the care recipient). Some services may have to be paid in full by care recipients, such as in Ireland (help with laundry and shopping) and in Luxembourg (meals-on-wheels).

57. Beyond these limited cases of fixed contributions, the large majority of LTC benefits and schemes, across multiple countries and subnational areas, have means-tested contributions from care recipients. The exact form of means-testing varies widely, as discussed below in the next section. In some cases, contributions are fixed as a share of the care recipient's income and/or net wealth. In other cases, contributions can change either continuously or non-linearly (e.g. discrete steps using income or asset thresholds), ranging from 0% to 100% of the total costs of care depending on the care recipient's means.

User contributions can depend on the types of long-term care received

58. In nine jurisdictions (Vienna in Austria, Flanders in Belgium, Ontario in Canada, France, Ireland, Japan, Lithuania, Luxembourg and the Netherlands), public support for help with ADLs is higher than for help with IADLs or social activities (as a share of the total costs). In Vienna (Austria), public support for help with ADLs is slightly higher than for help with IADLs, although assistance with laundry has the lowest user contribution of any type of LTC support. There is no public support for the costs of help with social activities in Japan and Ontario (Canada). In the Netherlands, contributions from care recipients for help with IADLs and social activities can go up to 100% of the costs depending on the care recipient's income and net wealth. In Lithuania, older people on higher incomes have higher user contributions to the costs of help with IADLs.

59. In seven countries and subnational areas, public social protection systems provide at least one LTC benefit or scheme that requires no contributions from care recipients (these are summarised in Table 3.1). However, not all types of care services are covered by these benefits and schemes. In Ontario (Canada), for example, care recipients do not have to contribute towards the costs of home care, but they are only entitled to up to 120 hours of care for every 30 days (there are exemptions for older people with complex care needs, but these exemptions are rare). In the Netherlands, home care provided under the health insurance act (Zvw) does not require any user contributions but covers only help with ADLs.

Table 3.1. Home LTC benefits and schemes that require no user contributions

Countries and subnational areas	Home care benefits and schemes	Types of services covered and excluded
Ontario (Canada)	Home and community care	Help with ADLs and IADLs, within certain monthly time limits
Germany	Pflegesachleistungen	Care in-kind is covered
Reykjavik (Iceland)	Home nursing (Heimahjúkrun)	Care in-kind is covered
Ireland	Home support service	Help with laundry and shopping is not covered
South Tyrol (Italy)	Care allowance	Care paid with cash benefit or vouchers is covered
Luxembourg	Long-term care insurance	Help with ADL and IADLs, although there are limits on provision of meals-on-wheels
Netherlands	Zorgverzekeringswet (Zvw)	Help with ADLs only

Note: Countries and subnational areas are sorted top to bottom alphabetically by the name of the country.
Source: OECD compilation based on the Long-Term Care Social Protection questionnaire.

Contributions from care recipients may be capped in some countries and subnational areas

60. In seven jurisdictions (Vienna in Austria, Flanders in Belgium, Japan, Korea, the Netherlands, Spain and Sweden), there are LTC benefits and schemes that cap or limit the annual or monthly amount of user contributions to the costs of home care. In Reykjavik in Iceland, there is also a cap on user contributions to the total costs of care, but only in institutional care. In Vienna, Flanders and Japan, the cap depends on the care recipient's income, while in Korea, the Netherlands, Spain and Sweden, the ceiling on user contributions does not depend on the care recipient's means. In Vienna (Austria), the maximum user contribution increases almost continuously as the care recipient's income increases[10]. In Japan, ceilings on monthly user contributions depend on household income and composition, and do not take into account user contributions towards the costs of help with IADLs and social activities. In Spain, at least 10% of the costs of care must be covered by the public social protection system so that no care recipient will ever cover more than 90% of the costs of care. In Sweden, user contributions are capped at the equivalent of EUR 190 per month for all care recipients.

61. The use of caps or ceilings on user contributions does not necessarily guarantee effective social protection for older people with LTC needs, as illustrated in the previous chapter. Despite the caps on user contributions in Japan, Korea, Spain and Sweden, some older people could be at an increased risk of poverty due to the out-of-pocket costs of LTC, even after receiving public support.

3.1.2. All countries and subnational areas have user contributions in institutional care

62. In all 26 jurisdictions analysed in this report, care recipients are expected to contribute to the costs of institutional care. In all but the Czech Republic, the Slovak Republic and Korea, user contributions to the costs of institutional care are higher for older people on higher incomes and/or with greater net wealth. In spite of this cost-sharing, safety nets for institutional care are generally effective (see Figure 2.10), with public social protection systems covering the costs in their entirety if the care recipient does not have the means from which to make an out-of-pocket contribution. The only exceptions are Ontario (Canada), the Czech Republic and Korea, where some older people would not be able to afford the out-of-pocket contributions to the costs of care, from their incomes alone, without being at risk of relative income poverty. In the Czech Republic and Korea, this is because public support for institutional care does not depend on income and so there is no increased support for older people on lower income, while in Ontario even with added support for accommodation costs, care recipients still have to make out-of-pocket contributions to support services and food.

[10] Contributions range from no user contributions for care recipients earning below EUR 624 to a monthly maximum of EUR 2 039 for care recipients earning at least EUR 3 308.

Most countries and subnational areas apply steep means-tests to institutional care

63. In some countries and subnational areas, user contributions are set as a share of the care recipient's income while in others they are set as a share of the total costs of care (the proportion depends on care recipients' incomes). As previously stated, safety nets are used to protect those older people with fewer means, typically covering 100% of the total costs of institutional care for severe needs. On top of this, many countries and subnational areas set minimum guaranteed income levels for care recipients in institutional care. Often called allowances, they guarantee that care recipients are left with a minimum amount of income after paying for user contributions to the total costs of care. Table 3.2 lists the different LTC benefits and schemes that guarantee a minimum income to institutional care recipients.

Table 3.2. Institutional LTC benefits and schemes with minimum guaranteed allowances

Countries and subnational areas	Institutional care benefits and schemes	Values of minimum guaranteed allowances
Vienna (Austria)	Pflegegeld Fonds Soziales Wien	EUR 45.20 per month 20% of disposable income
Ontario (Canada)	Long-term care homes	Comfort allowance of CAD 31.85 per week
Croatia	Allowance for assistance and care	HRK 100 per month
England	Social care	Personal Expense Allowance of GBP 24.90 per week Assets worth GBP 14 250
Finland	Social care services	EUR 108 per month
France	Aide sociale à l'hébergement	Highest of a) 10% of income, or b) EUR 104 per month
Germany	Social assistance	EUR 832 per month plus housing deduction (home care) EUR 110 per month (institutional care) Assets worth up to EUR 5 000 (single household) Assets worth up to EUR 10 000 (couple)
Hungary	Homes for the elderly	20% of old age pension if care recipient has no assets 30% of old age pension if care recipient has assets
Reykjavik (Iceland)	Institutional care	ISK 92 228 per month
Ireland	Nursing home support scheme	Highest of a) 20% of income, or b) 20% of maximum rate non-contributory state pension (EUR 46.40 per week)
South Tyrol (Italy)	Residential services	50% of economic situation
Latvia	Institutional care	10% of disposable income
Lithuania	Institutional care	20% of disposable income Assets worth up to EUR 4 260
Luxembourg	Complément accueil gérontologique	EUR 101.96 per week
Netherlands	Wet langdurige zorg (Wlz)	Pocket money of EUR 3 654 per year Assets worth up to EUR 21 330
Slovak Republic	Institutional care	EUR 50 per month
Slovenia	Municipality-subsidised care	30% of national minimum income (EUR 89.20 per month) Assets worth up to EUR 2 500
Spain	Antención Residencial	19% of the IPREM (EUR 102.19 per month
Sweden	Institutional care	SEK 5 057 per month
California (United States)	Medi-Cal institutional care	USD 50 per month
Illinois (United States)	Medicaid institutional care	USD 60 per month

Note: The old age pension in Hungary was HUF 28 500 per week in 2014. The maximum rate of the State Pension (non-contributory) in Ireland was EUR 232 per week in 2018 (with an extra EUR 10 for those aged 80 years or over). The national minimum income in Slovenia was EUR 297.33 per month in 2017. The Spanish Indicador Público de Renta de Efectos Múltiples (IPREM) was EUR 537.83 per month in 2018. In South Tyrol, the economic situation is the sum of disposable income and a certain share of care recipients' assets (20% of any assets over EUR 5 500). Countries and subnational areas are sorted top to bottom alphabetically by the name of the country.
Source: OECD compilation based on the Long-Term Care Social Protection questionnaire.

64. A number of jurisdictions (Flanders in Belgium, England, Finland, South Tyrol in Italy, and Slovenia) also provide non-means-tested cash benefits to older people in institutional care. These can be independent of other cash or in-kind benefits (as in Flanders and Finland) or there may be dependencies. In England, older people in institutional care cannot simultaneously receive in-kind support from social care and the in cash attendance allowance, and in Slovenia the attendance allowance cash benefit is taken into account in means-tests for in-kind support. In South Tyrol (Italy), care recipients in institutional care are eligible for the care allowance but it is paid to the institution, not to the care recipient.

65. The Czech Republic, the Slovak Republic and Korea are the only countries where public support for institutional care does not depend on the care recipient's means (income and net wealth). As the value of the Czech care allowance falls short of the total costs of institutional care, care recipients must make an out-of-pocket contribution to the total costs of care. In Korea, care recipients pay a fixed proportion of the total costs. In all other countries and subnational areas, user contributions to the total costs of institutional care depend on the care recipient's income, assets or both.

There may be special contributions for board and lodging in institutional care

66. In six jurisdictions (Flanders in Belgium, Ontario in Canada, France, Japan, Luxembourg, and Sweden), care recipients must contribute more to the costs of board and lodging (i.e. meals and accommodation) than to the costs of nursing, personal care and assistance services. In these countries and subnational areas, board and lodging are considered a social/housing risk and are thus not included in public LTC coverage. In Flanders (Belgium), France, Germany, Japan, Luxembourg and Ontario (Canada), care recipients typically pay 100% of the costs of board and lodging, while in Sweden care recipients must pay 100% of the costs of food.

67. User contributions to the costs of board and lodging can result in high out-of-pocket expenses. There are, however, a number of extra protections (or safety nets) for older people who are not able to afford the out-of-pocket costs of board and lodging. In Ontario (Canada), care recipients may qualify for a reduced rate for accommodation depending on their disposable income. In Japan, care recipients could be entitled to a supplemental benefit and user contributions can be reduced from 100% down to the best-case scenario of 33% of the costs of board and lodging, if they satisfy certain conditions[11]. In Sweden, while care recipients must pay 100% of the costs of food, there is a ceiling on monthly expenses (SEK 2013 or EUR 190).

68. In two countries, help for board and lodging is available but under cost-recovery options. In France, older people who are not able to afford the costs of accommodation might be eligible for the *Aide sociale à l'hébergement* (ASH), a cash benefit. Recipients of the ASH must make a reduced contribution of either 90% of their disposable income or the maximum contribution that they can make while keeping EUR 104 per month (whichever is lowest). However, all amounts paid through the ASH can be recovered from the estate of the care recipient upon death. This is also the case in Luxembourg, where the *Complément accueil gérontologique* will cover board and lodging for older people with limited means but will recover the amounts from the inheritance within certain conditions (e.g. if the inheritors are not in financial hardship).

3.2. Means-tests can promote efficiency and equity but there are also challenges

69. As previously stated, countries and subnational areas have limited resources to guarantee that older people will not fall into poverty and hardship due to their LTC needs. Public social protection systems

[11] The supplemental benefit is available in case of exemption from local inhabitant taxes and savings below a certain threshold that depends on household composition.

must use those limited resources in ways that maximise *adequacy* (anyone can access and afford the care they need), *equity* (the most vulnerable are adequately protected) and *efficiency* (a given level of results is achieved at the lowest cost to the public purse). Means-testing – making the level of public support depend on the care recipient's income and assets – may help accomplish these objectives[12]. Means-tests can be designed to allow public support to be higher for care recipients with lower incomes and net wealth, while limiting – or even withholding – support from care recipients who can afford to pay more. Means-tests can thus promote equity at the same time that they promote efficiency. Furthermore, as is the case in many countries and subnational areas, means-tested benefits and schemes can be combined with non-means-tested benefits and schemes (as seen in Table 3.3). There are, nonetheless, challenges and risks in designing and administrating means-tests, and these are discussed below.

Table 3.3. Overview of the use of means-testing to determine level of public support for LTC

	Assets-tested	Not assets-tested
Income-tested	Flanders (Belgium), Croatia, England, Tallinn (Estonia), France, Germany, Hungary, Ireland, South Tyrol (Italy), Japan, Lithuania, Netherlands, Slovenia, Spain, California (United States), Illinois (United States)	Vienna (Austria), Flanders (Belgium), Ontario (Canada), Tallinn (Estonia), Finland, France, Hungary, Reykjavik (Iceland), Korea, Latvia, Lithuania, Luxembourg, Slovak Republic, Sweden
Not income-tested	Croatia	Vienna (Austria), Flanders (Belgium), Ontario (Canada), Czech Republic, England, Finland, Germany, Reykjavik (Iceland), Ireland, South Tyrol (Italy), Latvia, Lithuania, Luxembourg, Slovak Republic, Slovenia, Spain

Note: Countries and subnational areas can belong to more than one category if they have multiple LTC benefits and schemes.
Source: OECD compilation based on the Long-Term Care Social Protection questionnaire.

70. In home care, the preferred combination, in six jurisdictions (England, Germany, South Tyrol in Italy, Netherlands, Spain and Slovenia), is a mix of non-means-tested and both income- and assets-tested benefits and schemes (see Table E.3 in Annex E). Five countries and subnational areas (Vienna in Austria, Finland, Reykjavik in Iceland, Latvia and Lithuania) mix non-means-tested and income-tested only (not assets-tested) benefits and schemes. Another five countries and subnational areas (Ontario in Canada, the Czech Republic, Ireland, Luxembourg and the Slovak Republic) have only non-means-tested benefits and schemes for home care, while Tallinn (Estonia), Hungary, Japan, Korea and Sweden provide only income-tested only (not assets-tested) benefits and schemes. No jurisdiction combines all four categories of means-testing and non-means-testing. Across all four categories, assets-testing only (not income-tested) is the least preferred option (only Croatia has this kind of benefit or scheme in home care). Similarly, for institutional care, no country or region combines all four categories of means-testing and non-means-testing. The preferred option in institutional care, in seven jurisdictions (Hungary, Ireland, Japan, Netherlands, Spain, and California and Illinois in the United States), is the provision of both income- and assets-tested benefits and schemes (see Table E.4 in Annex E).

3.2.1. Means-tests are widely used to target public support

71. All countries and subnational areas with the exception of the Czech Republic have some form of means-tested LTC benefits and schemes for home and institutional care (either income-testing only,

[12] Means-tests can be used both to determine eligibility for LTC benefits and schemes, and to determine the level of support for those who are eligible. This report focusses only on the latter: if a LTC benefit or scheme is categorised as means-tested (i.e. income-tested, assets-tested or both), then that means that the level of public support, and thus the out-of-pocket user contributions, are dependent on the care recipient's means. This categorisation should not be interpreted as pertaining to eligibility (e.g. the Korean LTC insurance scheme is a universal benefit with respect to eligibility but it is income-tested with respect to the level of public support).

assets-testing only, or both income- and assets-testing). The exact form of means-testing varies widely, although assets-tests are usually employed alongside income-tests in all but Croatia (for home care). Income-testing is the most widely used option, often combined with assets-tests, for institutional care in 24 countries and subnational areas, and in home care in 21 jurisdictions.

The most common forms of means-testing involve thresholds and proportions

72. Income-tests may be defined in such a way that a defined percentage of the care recipient's income must be devoted to paying for care services. This is typically the case in institutional care, even across different countries and subnational areas. Recipients of the *Fonds Soziales Wien* in Vienna (Austria) or in-kind institutional care in Lithuania, for example, must contribute up to 80% of their income towards the costs of institutional care. In Hungary, care recipients must contribute up to 25% of their income towards paying for the first four hours of home care. It is important to clarify that user contributions can never go above the costs of care[13]. Furthermore, as previously discussed (see Table 3.2), many countries and subnational areas insulate portions of the care recipients' income and assets from income- and assets-tests in institutional care.

73. Some income-tests involve a combination of a binary rule and a share of income. In Latvia, care recipients must contribute any income (up to 100%) above EUR 53 per month to the costs of home care. In Finland, single older people are required to pay up to 35% of any income above EUR 576 per month. In Lithuania, care recipients that earn more than three times the state-supported income[14] must contribute up to 50% of their income towards the total costs of social assistance (help with IADLs and social activities), or 20% of their income if they earn below that threshold. In Japan and Korea, thresholds are also used but user contributions are defined in terms of shares of total costs and not shares of incomes[15].

74. Another form of income-testing in home care involves the use of simple binary rules (e.g. Croatia, Tallinn in Estonia, Reykjavik in Iceland). If care recipients' incomes fall below a certain threshold then they receive a certain level of public support, otherwise they receive a different level of public support. Such binary rules can lead to a *cliff effect* (Roll and East, 2014[18]): just a small increment in care recipients' income may result in a complete loss of public support. This is the case in Tallinn (Estonia), where home care recipients earning less than the minimum wage[16] are eligible for full public support (i.e. the public social protection system covers 100% of the costs of home care) while those earning just EUR 1 above the minimum wage pay 100% of the costs out-of-pocket.

75. In some countries and subnational areas, means-tests applied in LTC benefits and schemes may be quite intricate, involving deductions and exclusions, minimum and maximum contributions, different thresholds and shares, often for multiple benefits and schemes within the same country, region or municipality. In a number of countries and subnational areas, certain forms of income are deducted from the income taken into account for means-testing, which can lead to greater public support. In Flanders

[13] If the costs of care are lower than 80% of the care recipient's income, the user pays the costs of care and not 80% of their income.

[14] The state-supported income in Lithuania was EUR 102 per month in 2017.

[15] In Japan, care recipients who earn less than JPY 2 800 000 per year have to pay 10% of the costs of help with ADLs and IADLs, those who earn less than JPY 3 400 000 per year have to pay 20%, and those who earn above JPY 3 400 000 per year have to pay 30%. In Korea, care recipients with incomes below or equal to 30% of the government-defined median income (KRW 1 672 105 per month), the user contribution is zero. For those with incomes above 30%, but below or equal to 40%, of the government-defined median income, the user contribution is 7.5% of the costs of care. Finally, for older people with incomes above 40% of the government-defined median income, the user contribution is 15% of the costs of care.

[16] The national minimum wage in Estonia was EUR 500 per month in 2018.

(Belgium), Germany (only social assistance or Sozialhilfe) and Sweden, income-tests for some home care benefits and schemes do not take into account rental payments made by older people. Means-tests that combine income and assets tend to be more intricate. As seen in Table E.3 and Table E.4, 10 countries and subnational areas have benefits and schemes for home care that are both income- and assets-tested, and 14 countries and subnational areas have benefits and schemes for institutional care that combine income- and assets-tests. These means-tests tend to combine different types of rules (deductions and exclusions, minimum and maximum contributions, different thresholds and shares), making them the most intricate of means-tests, and thus potentially opaque to care recipients and their families. In France, Ireland and the Netherlands, for instance, user contributions depend on the total monetary value of the sum of income and assets, and there are a number of deductions (see Annex E for more details).

3.2.2. Assets-tests must be well-designed to avoid distorting saving behaviour

76. Assets-tests are used to target public support to those who can least afford the potentially high out-of-pocket costs of care. Countries and subnational areas that apply assets-tests cover a lower share of the total costs of care for older people with higher net wealth, under the assumption that, even if they cannot afford out-of-pocket costs from their incomes alone, people with greater net wealth can afford to cover the shortfall from their assets. Consequently, older people in these countries and subnational areas may have to deplete their assets to reach a threshold that qualifies them for increased public support.

77. As seen in Table E.3 and Table E.4 (in Annex E), 11 countries and subnational areas have home care benefits and schemes that apply assets-tests and 14 countries and subnational areas have assets-tested institutional care benefits and schemes. Across these different benefits and schemes, there are a set of common features that assets-tests tend to have (see Table 3.4). First, assets below a certain value are often excluded from assets-tests. However, these thresholds tend to be low compared to the national mean net wealth (e.g. equivalent to 2% of the national mean net wealth in England and Germany), and if public support is not effective below these asset thresholds, then care recipients may still end up using their assets to pay for care. Second, often only a share of all assets above the threshold are considered in assets-tests (although some countries and subnational areas do consider all assets). Third, assets-tests may include or exclude different types of assets. For example, the care recipient's primary residence is often excluded from assets-tests while the older person or their dependents are living there (e.g. as in home care). Fourth, deferred payment agreements may be used to allow care recipients to postpone user contributions to their care. In such schemes, care recipients agree to use their assets (including their primary residence) to repay the public social protection system for any postponed user contributions. This happens if they sell their house (e.g. when moving to institutional care) or when they die.

78. Assets-tests can help target limited public social protection budgets to those older people who most need it, but they can also act as a form of taxation on wealth and savings. Assets-tests thus have the potential to introduce distortions in saving behaviours (OECD, 2018[19]), influencing the allocation of savings across different types of assets and the allocation of savings over the lifecycle. In the context of LTC, decisions concerning the allocation of savings can take place both before and after retirement age. However, given a prevalent myopic behaviour in saving for LTC, the distortionary potential in terms of allocation across different types of assets is likely more important than in terms of allocation over the lifecycle, although both are likely relevant.

Table 3.4. Treatment of assets in LTC benefits and schemes that apply assets-tests

Countries and subnational areas	Benefits and schemes	Setting	Simplified description of rule	Types of assets	Deferred payment?
Flanders (Belgium)	Allowance for the assistance of the elderly	Both	6% of assets	Primary residence excluded	No
Croatia	Allowance for assistance and care	Institution	None	All	Yes
		Home	Not given out if care recipient has assets	All	No
England	Social care	Institution	No user contribution for assets below GBP 14 250, full contribution for assets above GBP 23 250	All	Yes
		Home		Primary residence excluded	Yes
Tallinn (Estonia)	Institutional care	Institution	Full user contribution if care recipient has assets	All	No
France	Allocation Personnalisée d'Autonomie	Both	100% of assets can be used for contributions	Primary residence excluded	No
	Aide sociale à l'hébergement	Institution	None	All	Yes
Germany	Assistance for care (Hilfe zur Pflege)	Both	EUR5,000.00 excluded	All	No
Hungary	Homes for the elderly	Institution	Full user contribution if care recipient has assets; higher income allowance for care recipients that have assets	All	No
Japan	Long-term care insurance	Institution	To qualify for reduced board and lodging fees care recipients must have assets worth below JPY 10 000 000	Excludes life insurance, cars, watches	No
Lithuania	Institutional care	Institution	1% of assets over EUR 4 260[1]	All	No
Luxembourg	Complément accueil gérontologique	Institution	None	All	Yes
Netherlands	Wet langdurige zorg (Wlz)	Both	8% of assets over EUR 21 330	All	No
	Wet Maatschappelijke Ondersteuning (Wmo)				
Slovenia	Municipality-subsidized care	Institution	100% of assets over EUR 2 500	All	No
		Home		Primary residence excluded	No
Spain	Ayuda al domicilio	Home	5% of assets	Primary residence excluded	No
	Prestación económica vinculada al servicio	Home		All	No
	Antención Residencial	Institution		All	No
California (United States)	In home support services	Home	Full user contribution if care recipient has assets worth over USD 2 000	Primary residence excluded	No
	Medi-Cal institutional care	Institution		Primary residence excluded only if worth less than USD 585 000	No
Illinois (United States)	Home and Community Based Services	Home	Full user contribution if care recipient has assets worth over USD 2 000	Primary residence excluded	No
	Medicaid institutional care	Institution		Primary residence excluded only if worth less than USD 585 000	No

Note: [1]based on a value of EUR 355 per square meter for a property with 12 square meters. Countries and subnational areas are sorted top to bottom alphabetically by the name of the country.
Source: OECD compilation based on Long-Term Care Social Protection questionnaire.

79. With respect to the potential distortionary impact of assets-tests on the allocation of savings across different assets (i.e. portfolio composition), public social protection systems may impose certain restrictions on care recipients in order to qualify for public support. Older Croatians with LTC needs may be eligible for fully funded home care in-kind if they earn below 350% of the minimum wage, but to qualify they must not have sold any property in the year before their application to the scheme. In England, local authorities are responsible for organising LTC for older people and subsidising care for those with assets worth under GBP 23 250. If local authorities believe that care recipients have transferred or otherwise reduced their assets in order to be eligible for increased public support (what is referred to as deprivation of assets), then the local authority may charge the care recipient as if they still possessed the deprived assets, or even seek charges from the new asset holder. In Ireland, the financial assessment undertaken as part of an application to the nursing home support scheme also considers the deprivation of assets since applying for support or in the previous five years.

80. Another way in which assets-tests may distort the allocation of savings across assets is in the differential treatment of the care recipient's primary residence. As seen in Table 3.4, a number of countries and subnational areas exclude primary residence from assets-tests. This creates an implicit incentive to change the allocation of savings across assets. If the care recipient moves into institutional care however, then most countries and subnational areas will consider all types of assets (including primary residence), somewhat weakening the distortionary potential. It is important to stress there is no evidence to suggest that older people shift their savings into primary residence wealth because of developing LTC needs.

81. The potential distortionary impact of assets-tests on the allocation of savings across the lifecycle is difficult to characterise, and depends on how each country and region organises their assets-tests. Croatia, Tallinn (Estonia) and Hungary all have LTC benefits and schemes that completely withdraw support if the care recipient has any assets. The incentive for care recipients to save is minimal in these extreme cases. However, even in other countries and subnational areas, assets-tests may have a distortionary impact. In England, the Institute and Faculty of Actuaries or IFoA (2018[20]) suggests that older people with between GBP 20 000 and GBP 40 000 who decide to save an extra GBP 10 000 would see their LTC out-of-pocket spending increase by roughly the same amount (for the exact same level of care), effectively disincentivising any extra savings. The IFoA proposes two solutions to this problem: changing the thresholds used in the assets-tests to incentivise savings among less wealthy older people, and introducing new financial products that allow savings to be exempt from assets-tests within certain limits.

3.2.3. Thresholds used to target public support may miss the most vulnerable

82. Many countries and subnational areas have LTC benefits and schemes that set income thresholds below which care recipients are eligible for greater public support. These thresholds can help ensure that more economically vulnerable individuals (e.g. those at risk of poverty or even below the relative income poverty line) do not have to make any user contributions to the costs of care, which would further push recipients into poverty. As Table 3.5 illustrates, the thresholds set by public social protection systems in some countries and subnational areas may fall short of the thresholds used internationally to characterise relative income poverty (the OECD relative income poverty of 50% of the national median income across the whole population, and the EU at risk-of-poverty or AROP threshold of 60% of the national median income). Consequently, older people who are income poor under OECD and EU definitions, may be above the threshold, and thus not be eligible for increased public support. Without increase public support, these economically vulnerable care recipients may have to make out-of-pocket contributions to the costs of care that they cannot afford to make without going further into poverty.

Table 3.5. Income thresholds used in LTC benefits and schemes to target vulnerable users

Countries and subnational areas	Benefits and schemes	Threshold	Relative poverty threshold	AROP threshold	Public support
Vienna (Austria)	Fonds Soziales Wien	EUR 626	EUR 1 085.75	EUR 1 302.89	91%
Flanders (Belgium)	NIHDI Home care organisations	EUR 1 441.98 EUR 248	EUR 1 048.74	EUR 1 258.48	101%
Croatia	Subsidised home care for low income	HRK 1 750	HRK 2 163.40	HRK 2 596.08	10%
Tallinn (Estonia)	Domestic care service	EUR 500	EUR 406.28	EUR 487.73	100%
France	Allocation Personnalisée d'Autonomie Aide sociale à l'hébergement	EUR 187.14 EUR 193	EUR 915.43	EUR 1 098.50	65%
Reykjavik (Iceland)	Social home service	ISK 52 380.08	ISK 172 695.62	ISK 207 234.75	100%
South Tyrol (Italy)	Home care services	EUR 489.60	EUR 760.38	EUR 912.45	100%
Japan	Long-term care insurance	JPY 66 666.67	JPY 101 750	JPY 122 100	87%
Korea	Long-term Care Insurance for Older People	KRW 501 631.50	KRW 967 651.80	KRW 1 161 182	71%
Latvia	Home care services / care allowance	EUR 128.06	EUR 317.89	EUR 381.47	35%
Lithuania	Social assistance	EUR 306	EUR 264.11	EUR 316.93	63%
Spain	Ayuda al domicilio Prestación económica vinculada al servicio Antención Residencial	EUR 537.84	EUR 635.19	EUR 762.22	86%
Illinois (United States)	Home and Community Based Services	USD 1 011.67	USD 1 438.08	USD 1 725.70	71%

Note: the at risk of poverty (AROP) income is 60% of the population-wide median income; the relative poverty income is 50% of the population-wide median income. The column public support represents the share of total costs that are covered by the public social protection system for an older person at risk of income and asset-based poverty with moderate needs receiving care at home, taking into account all LTC benefits and schemes available in each country and region. Countries and subnational areas are sorted top to bottom alphabetically by the name of the country.
Source: OECD analyses based on Long-Term Care Social Protection questionnaire.

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83. It is important to note that, in some countries, the benefits and schemes in Table 3.5 may not be the only ones available to economically vulnerable care recipients. In Vienna (Austria), for example, the *Fonds Soziales Wien* is complemented by the *Pflegegeld* (a cash benefit) and furthermore allows rent to be deducted. This is why Table 3.5 also includes a column showing, for illustrative purposes, the share of the costs that would be covered by the public social protection system for *older person at risk of income and asset-based poverty with moderate needs receiving care at home*. A value lower than 100% indicates that care recipients would have to make out-of-pocket payments that would put them at an increased risk of income and asset-based poverty. There are also other non-LTC benefits and schemes that can be used to support income-poor and asset-poor older people. For example, in Austria measures to relieve the financial burden of low-income persons who also need care include the exemption from various fees such as the Compulsory Licence Fee (broadcasting), prescription fees and heating subsidies. For other examples from other countries, please refer to the OECD Social Benefit Recipients Database[17].

[17] Available from http://www.oecd.org/els/soc/recipients.htm

4 Effectiveness of social protection for long-term care in old age

84. Social protection is effective when it is adequate, equitable and efficient (OECD, 2018[21]). A system is adequate when those who need LTC can both access and afford it. Public social protection systems should provide coverage for the entire population at risk (to ensure access), and provide sufficient financial support to limit out-of-pocket spending (to ensure affordability). Social protection is equitable when it contributes to reducing the risks of poverty and addressing inequities across socio-economic groups. Older people who are poor, or vulnerable to poverty, are more likely to need care and least likely to be able to afford it (see section 4.2.1). As such, an assessment of the effectiveness of social protection for LTC must consider the distribution of costs and benefits. Finally, public social protection is efficient when gains in wellbeing and reductions in poverty and vulnerability are achieved at minimum cost to the public purse.

85. This chapter assesses estimates of the effectiveness of public social protection for LTC in old age, in a number of OECD and EU countries and subnational areas, focusing mostly on affordability and equity, and very briefly on efficiency. The next section assesses the adequacy of LTC benefits, estimating net incomes of care recipients (after public support and LTC costs) and gaps in social protection. Section 4.2 considers equity, appraising the impact of public support for LTC costs on vulnerable groups. The final section briefly considers how efficiency could be gauged.

86. The chapter contains a significant number of figures to illustrate the estimated impact of public social protection on the risk of poverty associated with needing LTC for different combinations of needs, settings, carers, periods, incomes, wealth and types of wealth. To help navigate the results, Table 4.1 provides an overview of all the figures in this chapter.

Table 4.1. Overview of figures on the effectiveness of social protection for LTC used in this chapter

Estimates			Care characteristics				Care recipient		
Figure	Numerator	Denominator	Needs	Setting	Carer(s)	Time unit	Income	Wealth	Type of wealth
Figure 4.1	Population at risk of poverty	Older population	Low, moderate & severe	Institution & Home	Formal	1 week	Entire distribution	Zero	Total
Figure 4.2	Population at risk of poverty	Older population	Low, Moderate & Severe	Home	Formal	1 week	Entire distribution	Zero	Total
Figure 4.3	Income	AROP	Low, Moderate & Severe	Home	Formal	1 week	Median	Zero	Total
Figure 4.4	Financial wealth	Financial wealth	Severe	Institution & Home	Formal	9 years	Median	Mean	Financial
Figure 4.5	Public support	Costs	Low, Moderate & Severe	Home	Formal	1 week	AROP	Zero	Total
Figure 4.6	Financial wealth	Financial wealth	Low, Moderate & Severe	Home	Formal	1 year	Median	Poverty	Financial
Figure 4.7	Financial wealth	Financial wealth	Severe	Institution & Home	Formal	9 years	AROP	Mean	Financial
Figure 4.8	Income	AROP	Low, Moderate & Severe	Home	Formal	1 week	Mean (men/women)	Zero	Total

Note: In both institutional and home care, countries, regions and municipalities that apply assets-tests set relatively low wealth thresholds above which care recipients receive more limited public support. This is why there are no estimates for high net wealth. In all countries and subnational areas, the level of public support is the same whether the care recipient has mean or high net wealth.

4.1. Adequacy of social protection for LTC in old age

87. Across the countries and subnational areas surveyed here, public social protection systems tend to provide greater support to older people with more severe LTC needs and fewer means (income and net wealth). While greater public support for more vulnerable groups can lead to lower out-of-pocket costs, this is not always the case, as illustrated in Chapter 2. It is not only out-of-pocket costs that matter to care recipients, but also how much of their income is left after making out-of-pocket payments, and whether this net income – plus any savings and other assets they may have – are enough to afford them an independent and dignified life.

88. Adequate public social protection for LTC in old age should provide sufficient financial support to protect older people from the risk of poverty associated with the out-of-pocket costs of LTC. A successful public social protection system is thus one that guarantees that no older person has to choose between paying for care that could puts them at risk of poverty and going without care. The adequacy of public social protection for LTC is then a function of old age income and wealth, public support (see section 2.1) and out-of-pocket costs (see section 2.2). This section brings these three elements together to assess the adequacy of social protection for LTC in old age, analysing as well how the way different systems are set up (see chapter 3) is related to their effectiveness.

4.1.1. Even with public support, home care costs might push older people into poverty

89. If there were no public social protection for LTC in old age, the majority of older people would not be able to pay the out-of-pocket costs of care from their incomes alone without being pushed into relative income poverty (disposable income after paying out-of-pocket costs below 50% of the population-wide median income[18]). Figure 4.1 shows the proportions of older people that would be in relative income

[18] Sensitivity of results to different relative income poverty thresholds is analysed in Annex B.

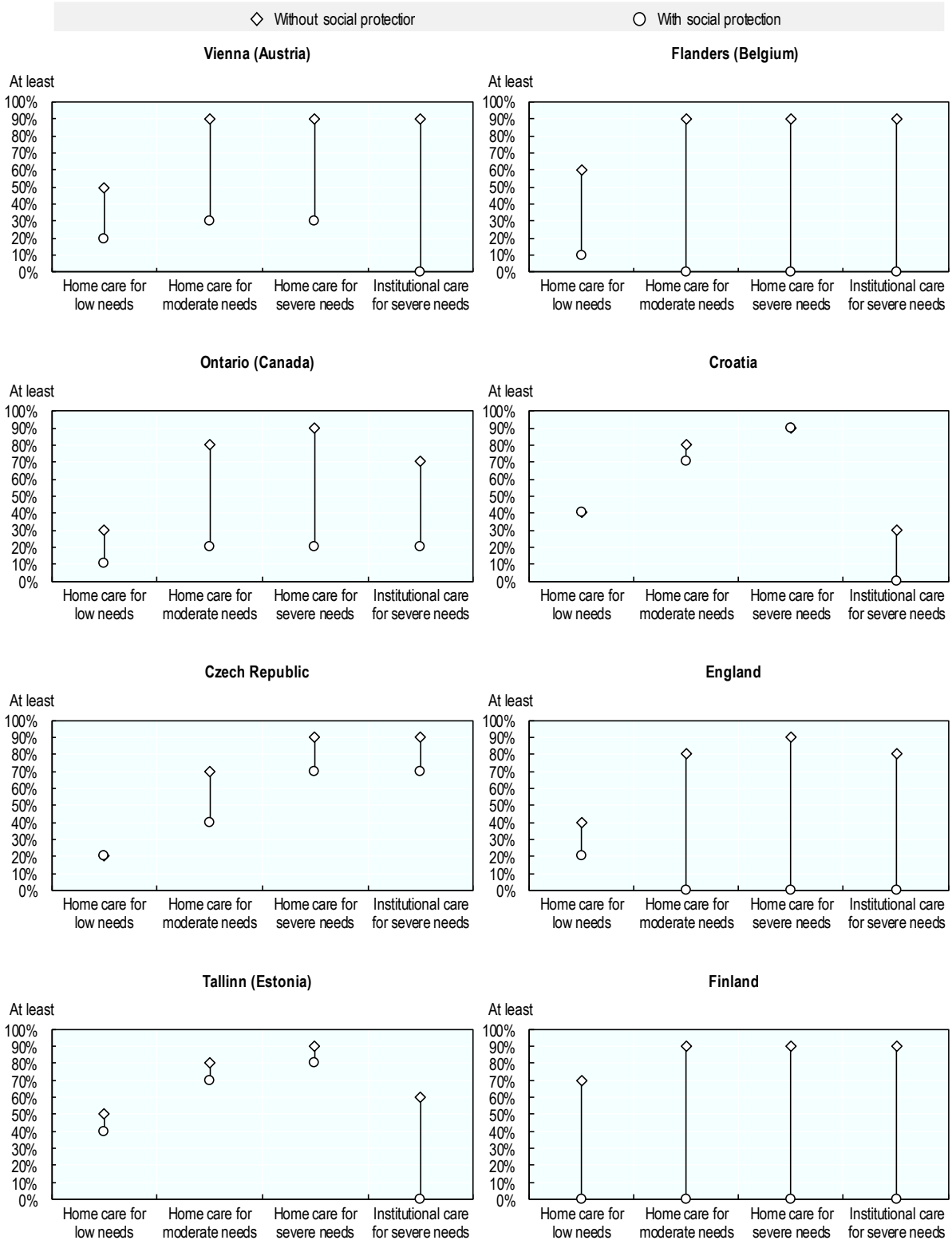
poverty after paying the out-of-pocket costs of *home care for low, moderate and severe needs, and institutional care for severe needs*, assuming they have *no net total wealth* (the most favourable case in countries that apply assets-tests). Jurisdictions are sorted alphabetically by the name of the country.

90. In most countries and subnational areas, public social protection systems have a considerable and positive impact on the affordability of home care for low needs, bringing down out-of-pocket costs for care recipients. If it were not for public social protection systems in 14 countries and subnational areas, around 50% of older people would be in relative income poverty after paying the out-of-pocket costs of just 6.5 hours of home care per week. In France, Luxembourg, the Netherlands, Finland, Germany, Reykjavik in Iceland, and the Slovak Republic, public social protection systems guarantee that no older person would be pushed into relative income poverty after paying for the out-of-pocket costs of home care for low needs (care recipients have no net total wealth in Figure 4.1). Public social protection systems in the Czech Republic, Illinois and California (United States), Hungary, Croatia, Lithuania, Tallinn (Estonia) and Latvia do not cover any of the costs of home care for older people earning a median income and with low needs. As such, public systems in these eight countries and subnational areas would not reduce the risk of income poverty that is associated with paying for home care for low needs. In Latvia particularly, around 60% of older people would not be able to afford home care for low needs without being pushed below the income poverty line.

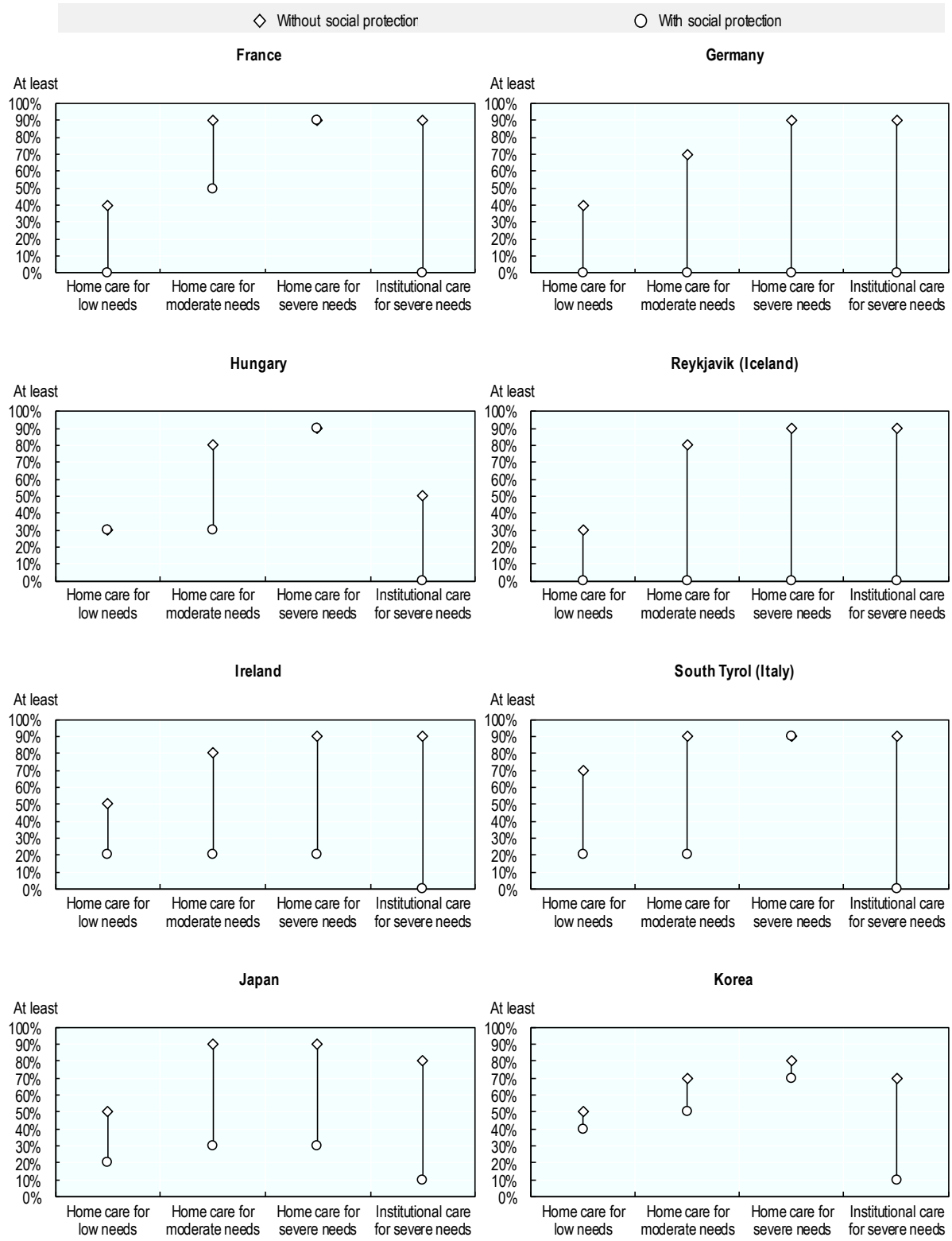
91. Older people with moderate LTC needs are at a much higher financial risk compared to those with low needs. In all but three countries and subnational areas (the Slovak Republic, and Illinois and California in the United States), if it were not for public social protection, around 70% of older people would not be able to afford the out-of-pocket costs of care without falling below the relative income poverty line. In six countries and subnational areas, public social protection systems guarantee that any older person who needs home care for moderate needs (and has no net total wealth) would be able to afford it without being pushed into relative income poverty. Conversely, in ten countries and subnational areas older people earning the national median income would not be able to afford to pay for care without being at risk of poverty, even after accounting for public support. In California and Illinois (United States), it is estimated that public social protections systems have no impact on the risk of income poverty that is associated with paying for home care for moderate needs. While both states have safety nets for the poorest care recipients (guaranteeing free care), the Federal Poverty Level in the United States is set at a lower value than the OECD relative income poverty threshold (50% of the national median equivalised disposable income).

Figure 4.1. Proportion of the old age population that would be in relative income poverty after paying for the out-of-pocket costs of LTC, for different severities of needs and settings

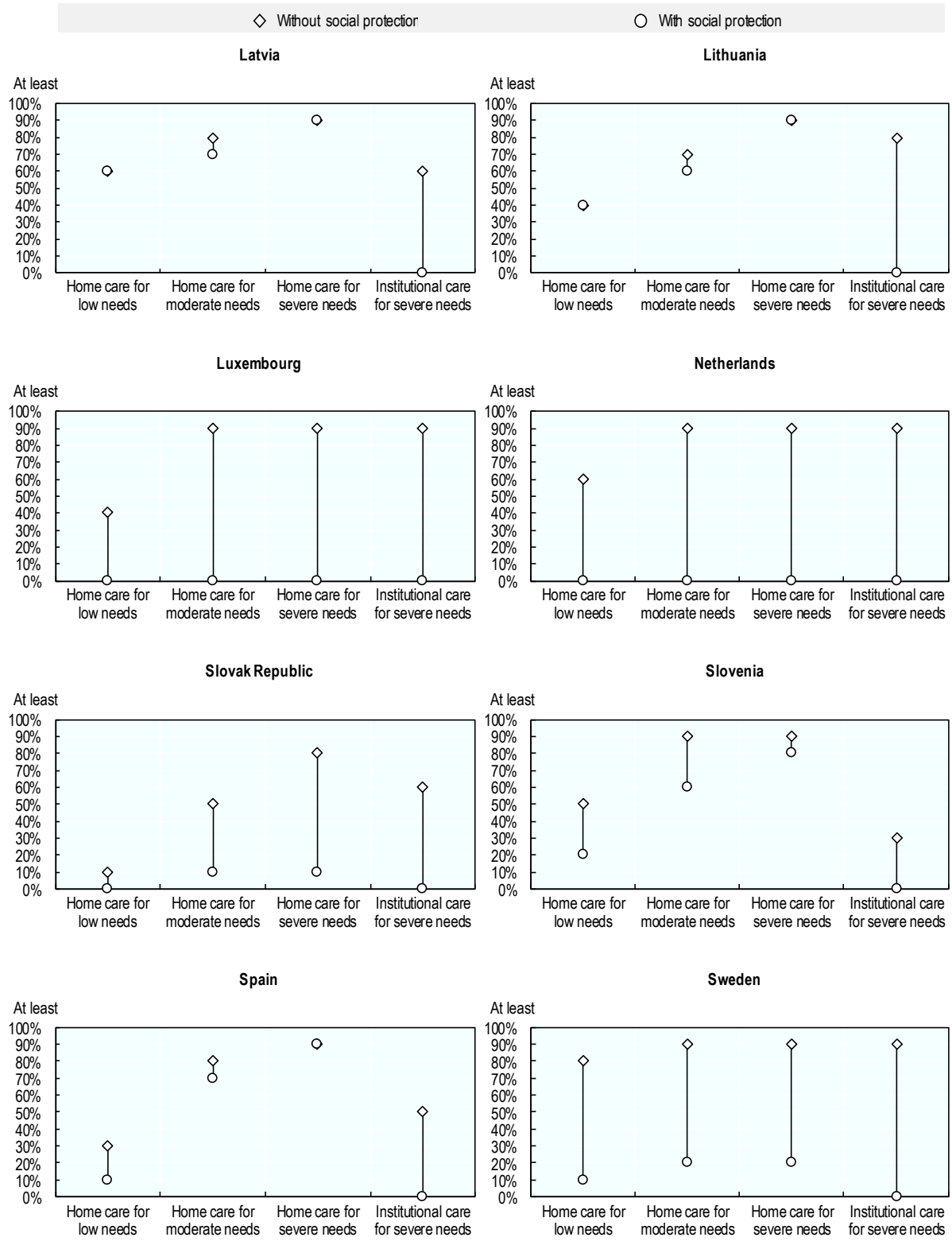
Assuming no net total wealth (the most favourable case in countries that apply assets-tests)



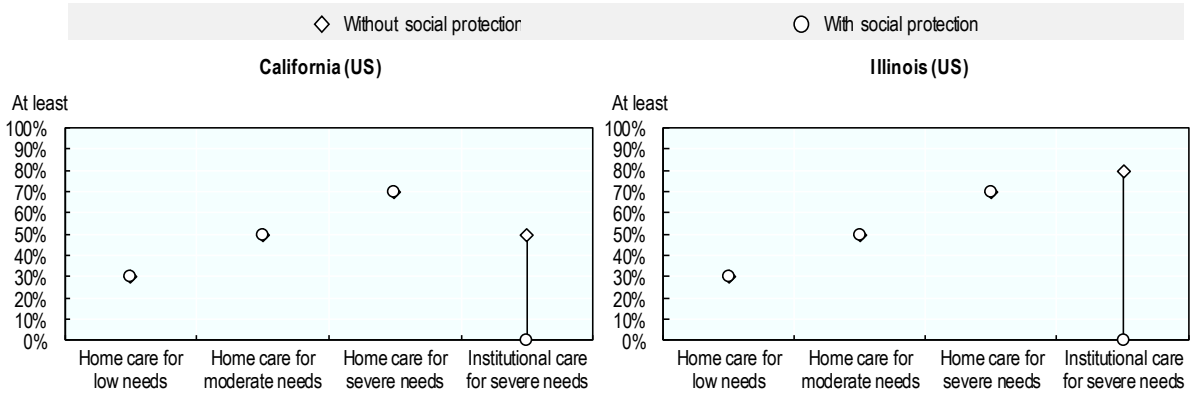
Assuming <u>no net total wealth</u> (the most favourable case in countries that apply assets-tests) – continued



Assuming no net total wealth (the most favourable case in countries that apply assets-tests) – continued



Assuming no net total wealth (the most favourable case in countries that apply assets-tests) – continued



Note: Jurisdictions are sorted alphabetically by name of the country. Income deciles are derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Care recipients have no net total wealth. Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

92. Without public social protection, in all countries and subnational areas except Korea, the Slovak Republic and the states of California and Illinois in the United States, around 90% of older people would be pushed into relative income poverty after paying for out-of-pocket costs of home care for severe needs. The out-of-pocket costs are so significant that only the richest 10% of older people would be able to afford them without falling below the income poverty line. Public social protection is estimated to reduce poverty risks in 17 countries and subnational areas (very significantly in most cases) but not in all. In six countries and subnational areas, the risk of poverty is estimated to decline from 90% of the population to less than 10%. In others, reductions are still substantial but less pronounced. On the other hand, in Slovenia, Tallinn (Estonia) and Korea, estimated poverty risks are reduced by 10 percentage points only, while in nine countries and subnational areas there is no change in poverty risks. While it is clear that public social protection is essential to guarantee the affordability of home care for severe needs, in nine countries and subnational areas, public support would not reduce the risk of relative income poverty associated with the out-of-pocket costs of care. In 13 countries and subnational areas, at least 70% of older people would be in relative income poverty after paying for home care for severe needs, even after receiving public support.

93. In all countries and subnational areas with the exception of Ontario (Canada), Korea, Japan and the Czech Republic, public social protection systems guarantee that any older person would be able to afford the out-of-pocket costs of institutional care. In the Czech Republic, around 70% of older people would not be able to afford the costs of institutional care, even after receiving public support (assuming they have no net total wealth). The results from the above mentioned countries highlight the stark contrast between policies in many OECD and EU countries to allow older people to age in place and the reality of how the out-of-pocket costs of home care could force older people to move to institutional care (as previously discussed in section 2.2.4).

4.1.2. Public support generally reduces poverty risks but not always sufficiently

94. As mentioned, adequate public social protection for LTC should guarantee that no older person is at an increased risk of poverty due to developing LTC needs. No older person should have to choose between paying out-of-pocket costs that push them into poverty and going without care. This section shows how public social protection systems in different countries and subnational areas perform against this

measure of success, by combining two metrics. The first metric is the share of the old age population (retirement age or older) that is in relative income poverty (regardless of whether or not they have LTC needs). The second figure is the share of the old age population that would be in relative income poverty if they needed LTC and had access to public social protection. This second figure was already presented in the previous section to illustrate the impact of public support on the affordability of LTC, for older people with LTC needs. This section assesses whether social protection for LTC is reducing the risk of poverty associated with LTC compared to overall poverty risks among older populations.

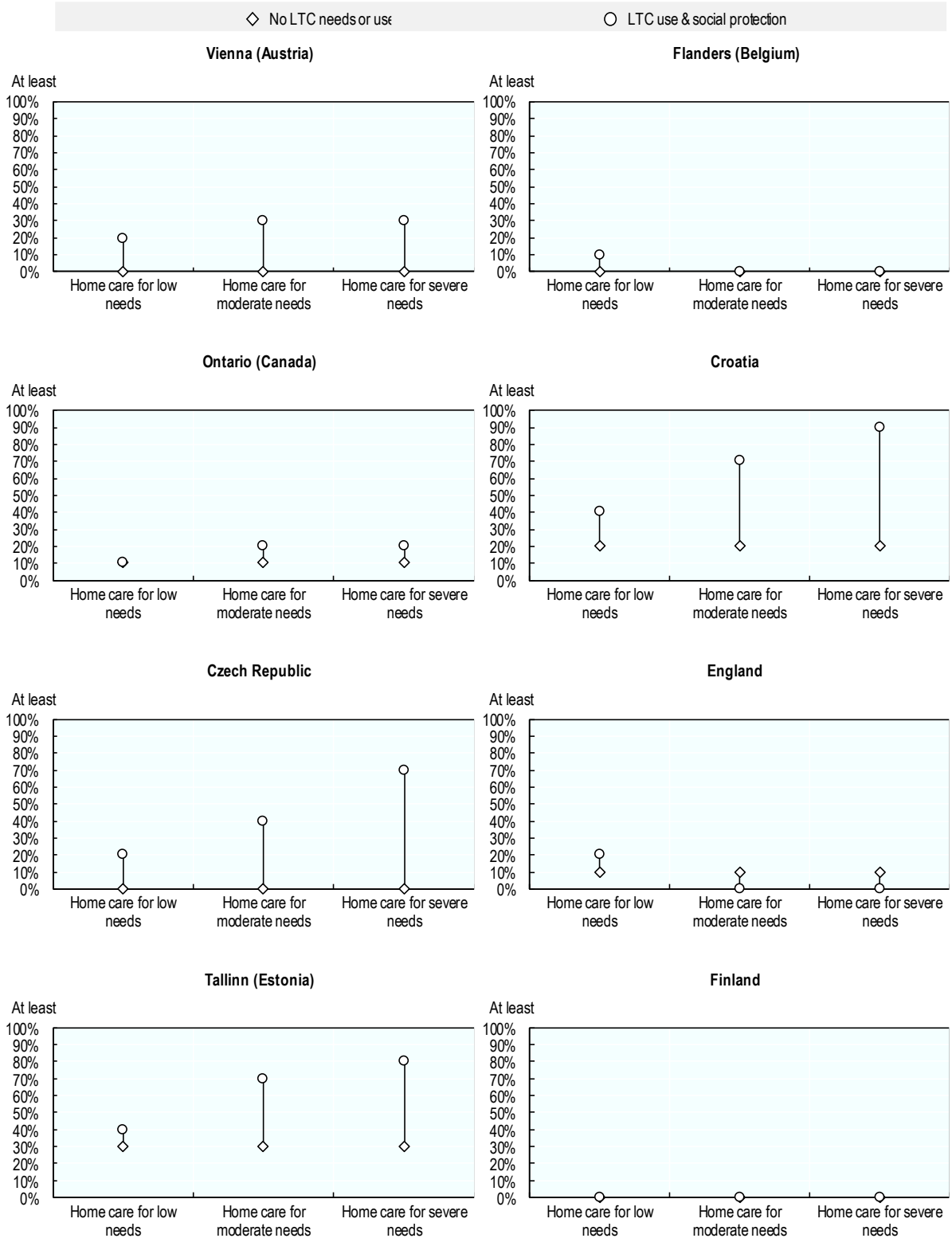
95. The estimated shares of old age populations in relative income poverty in two different situations (no LTC needs or use, and use of LTC and access to social protection) are shown in Figure 4.2, for different severities of LTC need and different care settings. As illustrated in the previous section, public social protection systems in most countries and subnational areas are estimated to have a demonstrably positive impact on reducing the risk of poverty associated with the out-of-pocket costs of care. However, in 16 countries and subnational areas, public support for home care for low needs would not bring relative income poverty levels back to pre-LTC levels (this is noticeable in the differences between the circles and the diamonds in Figure 4.2). In other words, in these 16 countries and subnational areas public social protection does not seem to adequately protect older people with low needs from the added risk of poverty that is associated with the out-of-pocket costs of care. The risks can be estimated. For example, less than 10% of all older Hungarians earn below the relative income poverty line but around 30% could be in relative income poverty if they needed to pay for 6.5 hours of home care per week, even after receiving public support.

96. While most public systems would reduce the risk of poverty associated with paying for home care for moderate needs (as seen in Figure 4.2), it is estimated that in 20 countries and subnational areas public support does not bring relative income poverty levels back to pre-LTC levels. In 10 countries and subnational areas, 50% of the old age population in these 10 countries and subnational areas would not be able to afford home care for moderate needs from income alone, should they need it, without being at risk of relative income poverty. Moreover, this is likely to be a conservative estimate as it does not take into account that older people with lower incomes are more likely to develop LTC needs.

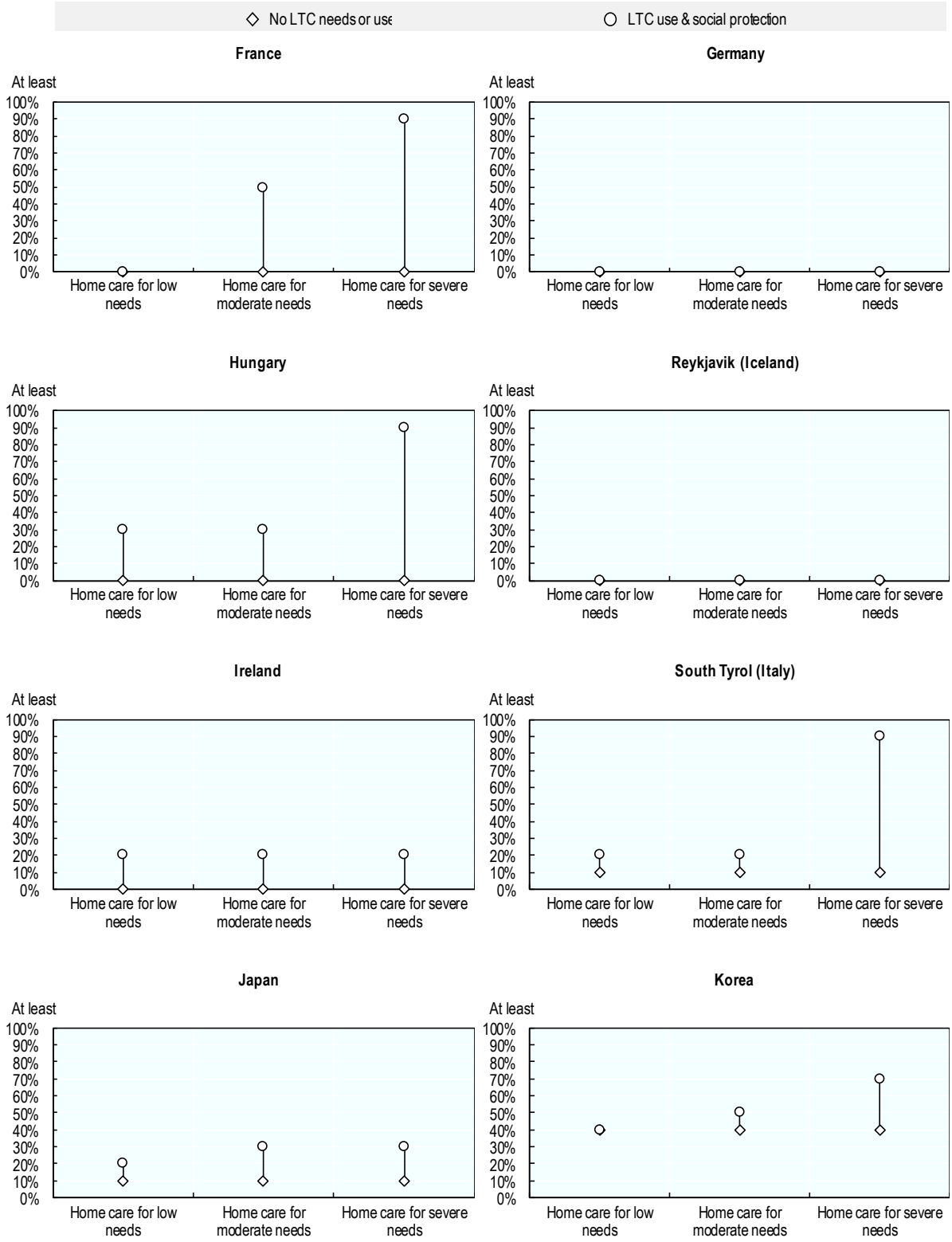
97. In England, while 10% of older people are in relative income poverty, public social protection would guarantee that fewer than 10% would be pushed into relative income poverty after paying for home care. In effect, the poorest 10% of English would actually be at a lower risk of poverty if they received public support for home care for severe needs. In 20 other countries and subnational areas, public support for home care for severe needs would not bring relative income poverty levels back to pre-LTC levels. In nine countries and subnational areas, 80% of older people would not be able to afford home care for severe needs, should they need it, without being in relative income poverty, even after receiving public support. As shown in the previous section, older people in countries and subnational areas with inadequate support for home care for severe needs would be able to afford institutional care.

Figure 4.2. Proportion of older people in relative income poverty in two situations: no LTC needs or use, and use of LTC and access to social protection, for different severities of needs and settings

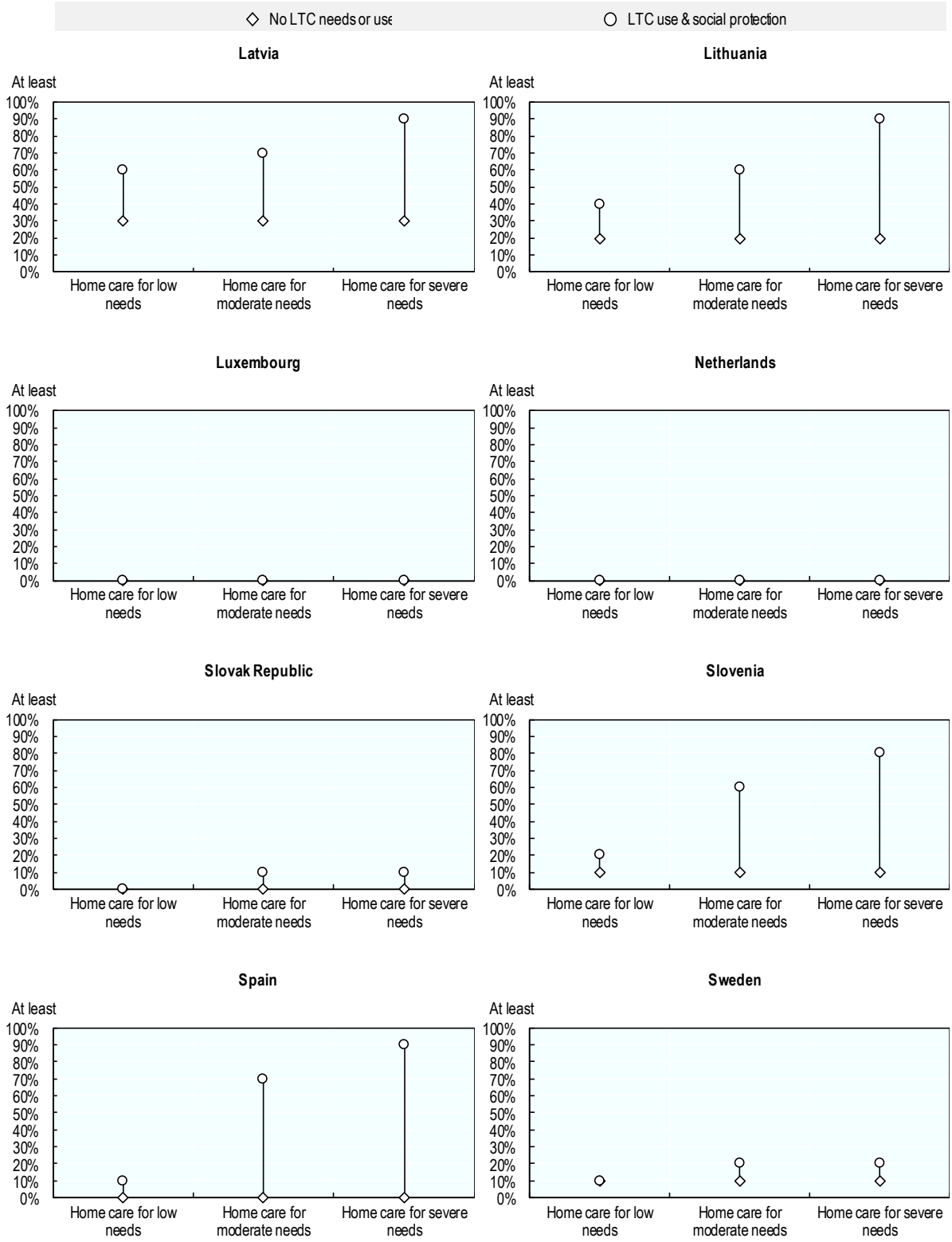
Assuming no net total wealth (the most favourable case in countries that apply assets-tests)



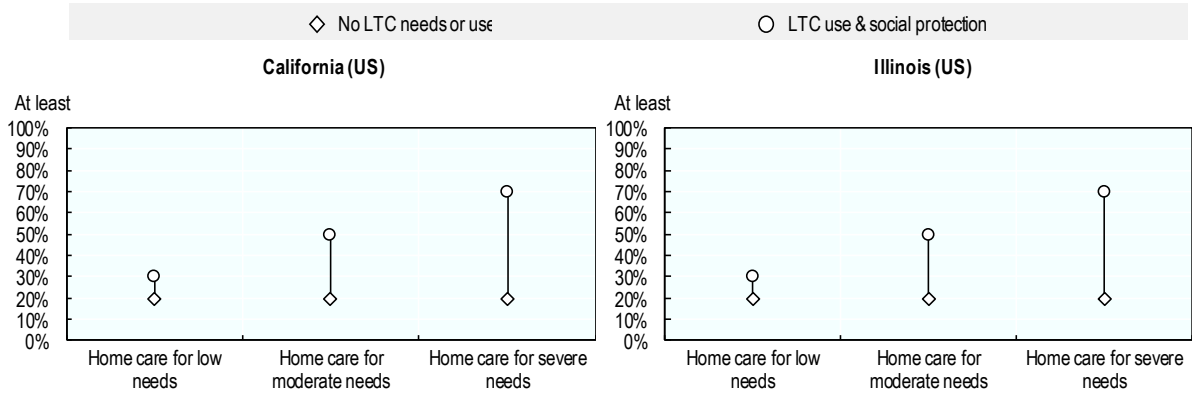
Assuming no net total wealth (the most favourable case in countries that apply assets-tests) – continued



Assuming no net total wealth (the most favourable case in countries that apply assets-tests) – continued



Assuming no net total wealth (the most favourable case in countries that apply assets-tests) – continued



Note: Jurisdictions are sorted alphabetically by name of the country. Income deciles are derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Care recipients have no net total wealth. Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

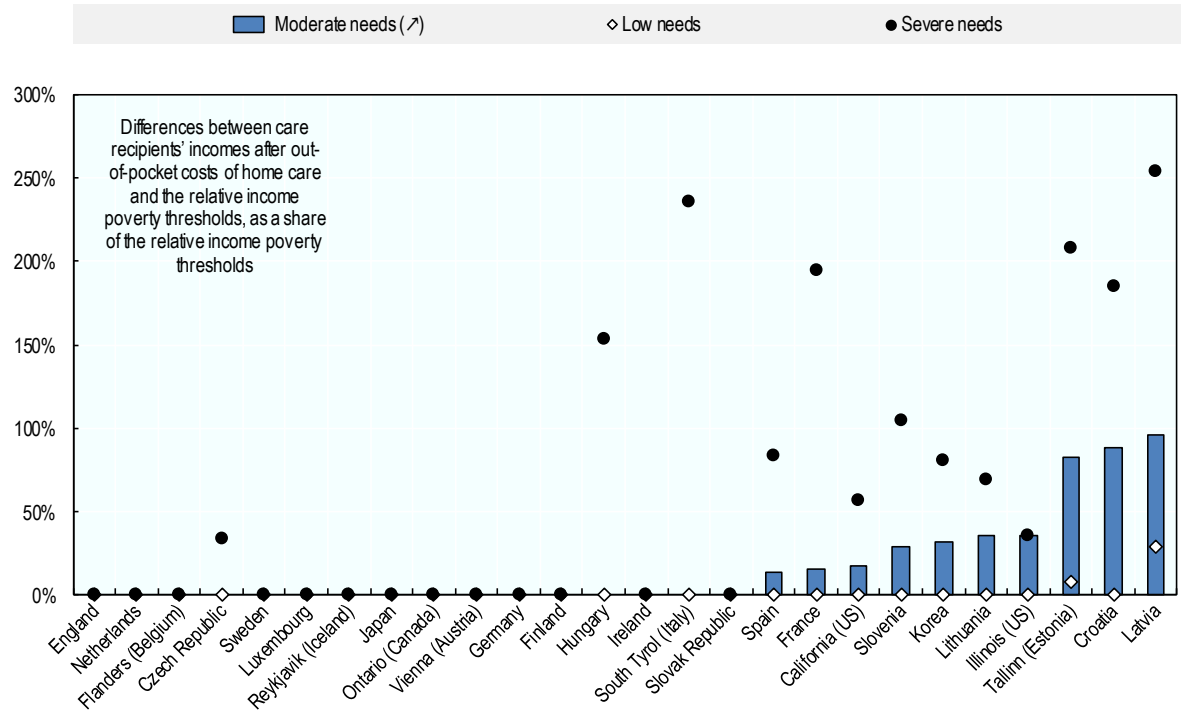
4.1.3. Older people with severe needs face gaps in public support in many countries

98. In a number of countries and subnational areas, public social protection systems might not provide sufficient financial support to protect older people from the risk of poverty associated with paying out-of-pocket costs of LTC. These estimated gaps in adequacy mean that older people are left with incomes – after accounting for public support and out-of-pocket costs – that put them at risk of income poverty. Public social protection systems could bring these older people up to non-poverty levels by increasing public support to cover the difference between their incomes (after LTC costs and social protection) and the relative income poverty line. Doing so would guarantee that no older person is at an increased risk of poverty due to the out-of-pocket costs of LTC.

99. The differences between an older person's income after paying for *home care for different needs* and relative income poverty thresholds, for a care recipient *earning a median income* and with *no net total wealth*, as a share of relative income poverty thresholds, are shown in Figure 4.3.

Figure 4.3. Differences between care recipients' incomes after out-of-pocket costs of home care and the relative income poverty thresholds, as a share of the relative income poverty thresholds

Care recipients earn a median income (among people of retirement age or older) and have no net total wealth



Note: Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

100. An older person earning a median income, with no net total wealth and receiving home care for low needs would fall around 8% (close to EUR 8 per week) and 29% (around EUR 21 per week per person) short of the OECD relative income poverty thresholds in Estonia (Tallinn) and Latvia respectively, after accounting for public support and out-of-pocket costs of home care for low needs. In 10 countries and subnational areas, an older person earning a median income and with no net total wealth would not be able to cover the out-of-pocket costs of home care for moderate needs without falling below the income poverty line. Bringing these older people up to non-poverty incomes would require between around 14% of the relative poverty income in Spain and around 96% of the relative poverty income in Latvia. Gaps in the adequacy of public social protection for home care for severe needs would be the most significant. In 13 countries and subnational areas, older people earning a median income and with no net total wealth would not be able to cover the out-of-pocket costs without being pushed into relative income poverty. Increasing public support by between 33% of the relative poverty income in the Czech Republic to 254% of the relative poverty income in Latvia would guarantee no older person is at risk of poverty after paying for the out-of-pocket costs of LTC.

4.1.4. Older people might have to spend down assets to offset gaps in public support

101. Faced with gaps in the adequacy of public social protection for LTC, older people may have to use their net wealth to cover the difference between their incomes (after out-of-pocket costs) and relative

poverty incomes. In other words, they may deplete their assets to guarantee they are not at risk of income poverty after receiving public support and making out-of-pocket payments. This is an option for older people regardless of whether this is a deliberate policy choice by public social protection systems (as in England) or not. Older people earning a median income may also deplete their assets to ensure their income remains constant at the same level as before out-of-pocket costs of LTC. This will necessarily lead to higher asset depletion rates than the ones presented in this section.

102. Figure 4.4 shows the shares of an older person's financial net wealth that are depleted over a simulation period of nine years. The older person starts the simulation with *mean net financial wealth*[19] and earns *a median income* that remains constant throughout the simulation. In those nine years, the care recipient spends six years in home care for low needs, one year in home care for moderate needs, and two years in either home care for severe needs or in institutional care (these durations are based on averages of actual observed durations for men and women derived from Kingston et al (2017[22])).

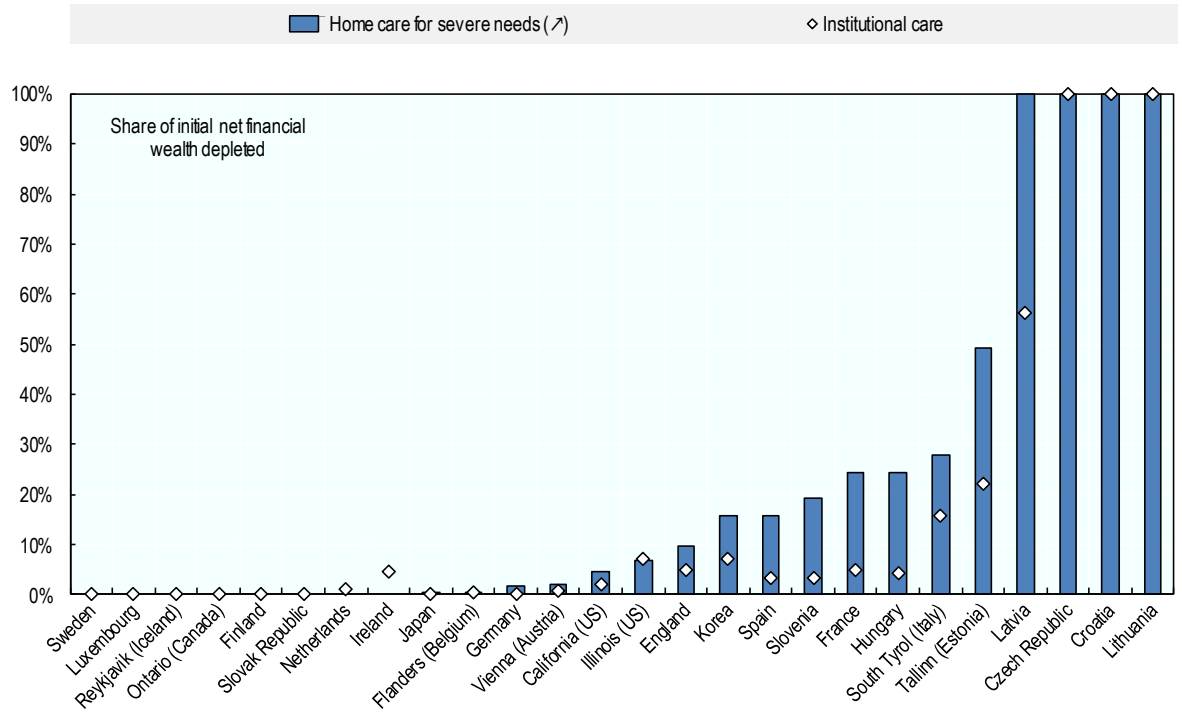
103. In 20 countries and subnational areas, an older person earning a median income, with mean net financial wealth at the start of a nine-year period of LTC would need to use less than 25% of their net financial wealth to avoid being at risk of poverty after receiving public support and making out-of-pocket payments (regardless of whether the last years in severe needs are spent at home or in an institution). In eight of these countries and subnational areas, care recipients would not be at risk of poverty to begin with and would thus keep 100% of their net wealth. In none of these countries and subnational areas would care recipients need to use their primary residence wealth to avoid being at risk of poverty.

104. Conversely, in the Czech Republic, Croatia and Lithuania, in order to avoid being at risk of poverty, older people would need to deplete 100% of their net financial wealth, regardless of whether they spend the last two years of the simulation at home or in institutional care (in Latvia this true only for home care). With their net financial wealth gone, they would need to consider selling their home to pay for care or, if possible, move to potentially cheaper institutional care. While in many countries and subnational areas there is no difference in asset depletion between care for severe needs at home or in an institution, in a number of countries and subnational areas care recipients would face smaller gaps in institutional care, and would thus deplete less of their net financial wealth to avoid falling into relative income poverty.

[19] The focus is on mean net financial wealth so as to show more clearly the impact of gaps in social protection for LTC on asset-based poverty (see Box 1.3 for detailed definitions of asset-based poverty).

Figure 4.4. Share of initial net financial wealth depleted at the end of nine years of LTC

Care recipient spends six years in home care for low needs, one year in home care for moderate needs, and two years in either home care for severe needs or institutional care, and earns a median income throughout.



Note: Care recipients earn a median income (among people of retirement age or older) and have mean net financial wealth at the start of the simulation. National-level mean net financial wealth is for over 65 year olds. For countries with no net wealth data (Czech Republic, Iceland, Croatia, Lithuania and Sweden) it is assumed mean net wealth is 17 times the national median income (based on the average ratio between mean net wealth and national median income across OECD countries for which both data are available). It is assumed 48% of mean net wealth is composed of financial wealth (based on average percentages across OECD countries for which data are available). Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

4.1.5. Purely means-tested LTC systems seem less successful at tackling poverty risks

105. As illustrated in chapter 3, public social protection systems use a myriad ways to organise their LTC benefits and schemes, mixing different forms of means-testing (including different types of rules) with non-means-tested benefits and schemes. For home care, countries and subnational areas can be grouped into five different types of systems, characterised in terms of how they combine means-testing and non-means-testing. Table 4.2 shows the estimated impact of different types of systems on the risk of poverty associated with the out-of-pocket costs of home care for different severities of LTC needs.

Table 4.2. Effect of means-testing options on estimated poverty risks associated with home care

Countries and subnational areas	Type of system	Reductions in risk of poverty associated with home care (* indicates higher poverty risk despite public support)			
		Low needs	Moderate needs	Severe needs	Average
Germany	Income- and assets-tested plus non-means-tested	0.4	0.7	0.9	
Netherlands		0.6	0.9	0.9	
Flanders (Belgium)		0.5*	0.9	0.9	
England		0.2*	0.8	0.9	
South Tyrol (Italy)		0.5*	0.7*	0*	
Slovenia		0.3*	0.3*	0.1*	
Spain		0.2*	0.1*	0*	0.51
Slovak Republic	Non-means-tested	0.1	0.4*	0.7*	
Luxembourg		0.4	0.9	0.9	
Ontario (Canada)		0.2	0.6*	0.7*	
Ireland		0.3*	0.6*	0.7*	
Czech Republic		0*	0.3*	0.2*	0.47
Finland	Income-tested only plus non-means-tested	0.7	0.9	0.9	
Reykjavik (Iceland)		0.3	0.8	0.9	
Vienna (Austria)		0.3*	0.6*	0.6*	
Latvia		0*	0.1*	0*	
Lithuania		0*	0.1*	0*	0.41
Sweden	Only income-tested	0.7	0.7*	0.7*	
Korea		0.1	0.2*	0.1*	
Japan		0.3*	0.6*	0.6*	
Tallinn (Estonia)		0.1*	0.1*	0.1*	
Hungary		0*	0.5*	0*	0.32
France	Income- and assets-tested	0.4	0.4*	0*	
Croatia		0*	0.1*	0*	
California (United States)		0*	0*	0*	
Illinois (United States)		0*	0*	0*	0.09

Note: The reduction in the proportion of old age population in relative income poverty is defined as the difference between the proportion of old age population in relative income poverty when using LTC without access to social protection, and the proportion of old age population in relative income poverty when using LTC with access to social protection. Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on Long-Term Care Social Protection questionnaire.

106. While there are no silver bullets for how to organise LTC benefits and schemes to reduce poverty risks associated with LTC needs, systems that are purely means-tested, whether income-tested only (as in Japan or Hungary) or both income- and assets-tested (as in the United States and France), would seem less effective at reducing the risk of poverty associated with the costs of receiving LTC. The best performing systems either rely only on non-means-tested benefits and schemes (such as Luxembourg or Ontario in Canada) or combine some form of income-testing (income-testing only or both income- and assets-testing) with non-means-tested benefits and schemes (like in Finland or in Germany).

107. However, overall, whether a country, region or municipality has means-tested and/or non-means-tested benefits and schemes does not seem, in itself, to determine its adequacy in a significant way. Across all types of systems, there is at least one country or region where older people would be at a significantly increased risk of poverty if they were to develop LTC needs, even after receiving public support. Beyond merely combining different types of benefits, it is important to combine them appropriately. Means-tests must be well-designed (e.g. with thresholds that target the most vulnerable) and non-means-tested benefits and schemes should cover all relevant costs (e.g. help with IADLs).

108. Another key question concerning social transfers is whether they should be provided in-kind or in the form of cash. Most countries and subnational areas usually combine provision of benefits both in-kind

and in cash whereas some public social protection systems rely exclusively on cash benefits or purely on in-kind services. Countries and subnational areas with in-kind only benefits and schemes seem to have a considerable and positive impact on the affordability of home care (see Table 4.3). However, as with means-testing and non-means-testing, combining cash benefits and in-kind services can also be an effective way to reduce the risk of poverty associated with receiving LTC services back to pre-LTC levels, as illustrated in Table 4.3 by the number of cases where poverty risk is not higher across different levels of severity (indicated by the absence of asterisks).

Table 4.3. Effect of forms of benefits on estimated poverty risk associated with home care

Countries and subnational areas	Type of system	Reductions in risk of poverty associated with home care (* indicates higher poverty risk despite public support)			
		Low needs	Moderate needs	Severe needs	Average
Finland	Has benefits that are both in cash and in-kind	0.7	0.9	0.9	
Germany		0.4	0.7	0.9	
Netherlands		0.6	0.9	0.9	
Korea		0.1	0.2*	0.1*	
Flanders (Belgium)		0.5*	0.9	0.9	
England		0.2*	0.8	0.9	
South Tyrol (Italy)		0.5*	0.7*	0*	
Luxembourg		0.4	0.9	0.9	
Latvia		0*	0.1*	0*	
Vienna (Austria)		0.3*	0.6*	0.6*	
Croatia		0*	0.1*	0*	
Spain		0.2*	0.1*	0*	
Slovenia		0.3*	0.3*	0.1*	
Lithuania		0*	0.1*	0*	
Hungary		0*	0.5*	0*	
California (United States)		0*	0*	0*	0.38
Slovak Republic	Has benefits that are in cash only	0.1	0.4*	0.7*	
France		0.4	0.4*	0*	
Czech Republic		0*	0.3*	0.2*	0.28
Reykjavik (Iceland)	Has benefits that are in-kind only	0.3	0.8	0.9	
Ontario (Canada)		0.2	0.6*	0.7*	
Sweden		0.7	0.7*	0.7*	
Japan		0.3*	0.6*	0.6*	
Tallin (Estonia)		0.1*	0.1*	0.1*	
Ireland		0.3*	0.6*	0.7*	
Illinois (United Stated)		0*	0*	0*	0.43

Note: The reduction in the proportion of old age population in relative income poverty is defined as the difference between the proportion of old age population in relative income poverty when using LTC without access to social protection, and the proportion of old age population in relative income poverty when using LTC with access to social protection. Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on Long-Term Care Social Protection questionnaire.

4.2. Equity of social protection for long-term care in old age

4.2.1. There are clear demographic and socio-economic gradients in the need for care

109. Not only do lower-income groups face a higher risk of not being able to afford LTC services by relying on their incomes alone, they are also more likely to need LTC compared to their richer counterparts. There are clear demographic and socio-economic gradients in the number of self-reported difficulties with ADLs among over 65 year olds (Börsch-Supan, 2019[23]). According to responses to the Survey of Health, Ageing and Retirement in Europe (SHARE), women are consistently more likely to report difficulties with

ADLs than men are (an average of 35% of women across EU member states report difficulties with ADLs compared to 24% of men). This gradient along gender remains after adjusting for income. An average of 40% of older women in the bottom 20th percentile of income (among those surveyed) reported difficulties with one or more ADLs, compared to 27% of men in the bottom 20th percentile of income. Across both older men and women, 21% of those in the top quintile of income report difficulties with ADLs compared to 36% of those in the bottom quintile of income (a difference of 15 percentage points). Finally, older people in the bottom quintile of assets (among respondents in each country) are more likely to report difficulties with one or more ADLs than those in the top quintile are (34% compared to 23% respectively).

110. Social protection is equitable when it contributes to reducing poverty, economic vulnerability and inequities in financial risks associated with care needs. Public benefits and schemes should target those older people that face greater financial risks and support them proportionally to their risks. Consider an older person who is isolated, economically vulnerable, has experienced some cognitive decline, and has limited support from family, friends and neighbours. Not only is this person more likely to need some help with ADLs, but they are also more likely to be unable to access and afford help. This person's situation is worsened by developing LTC needs, compounding already existing inequities in health and wellbeing. Public social protection is equitable when support is proportional to financial risk so that older people who are more economically vulnerable are also more protected. The following sections assess how well public social protection for LTC in old age is supporting the most economically vulnerable groups of older people.

4.2.2. There are gaps in public support for the economically vulnerable elderly

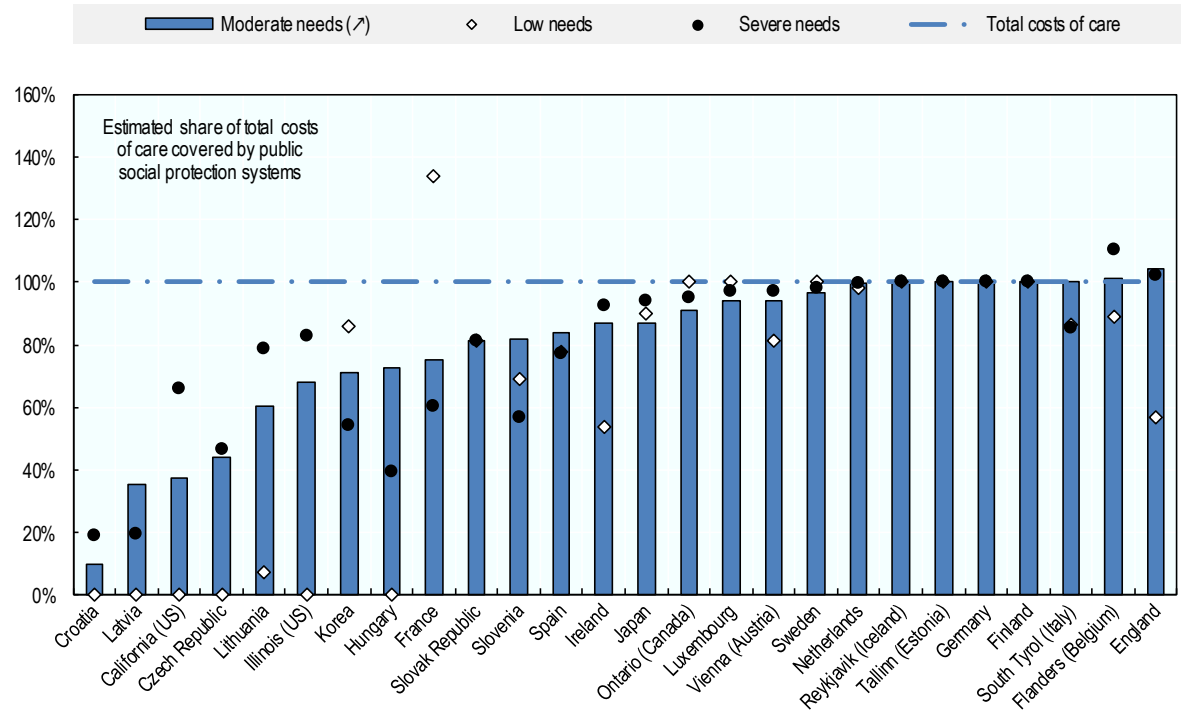
111. As shown in previous sections, public social protection systems tend to provide greater support to older people with fewer financial resources (income and net total wealth).

Safety nets for the income and asset poor are often missing or inadequate

112. Older people at risk of income and asset-based poverty (see Box 1.3 for detailed definitions) have no ability to pay the out-of-pocket costs of LTC without being pushed into poverty. To provide effective protection to the income and asset poor, public support should cover 100% of the total costs of care, essentially acting as a safety net for the most financially vulnerable older people. The estimated shares of the total costs of *home care* for different levels of LTC need that would be covered by public social protection systems – for older people *at risk of poverty and with no net wealth* – are shown in Figure 4.5.

Figure 4.5. Share of home care costs met by public social protection systems for older people earning the relative poverty income and with no net total wealth, by level of severity

Care recipients have no net total wealth (most favourable case in assets-tested systems)



Note: Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

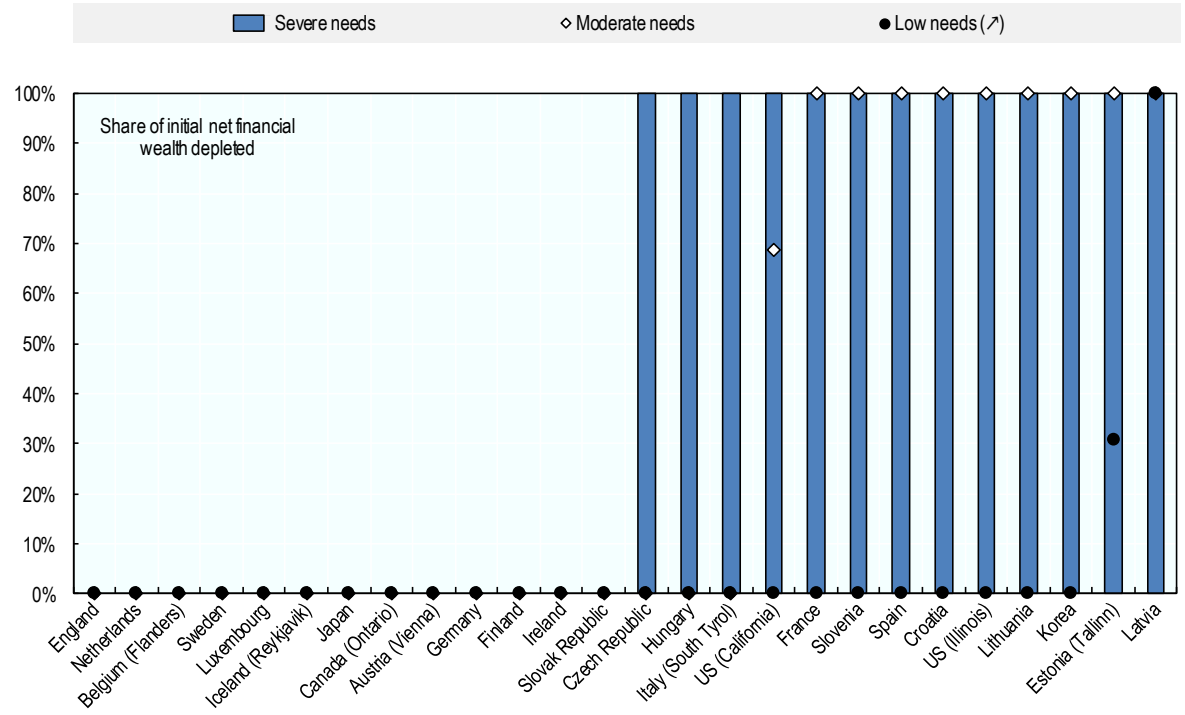
113. Across different levels of severity, and for different countries and subnational areas, public social protection systems might not be adequately protecting the most financially vulnerable older people in a majority of cases (in 57 out of 78 country/region/municipality-severity combinations for home care). Public social protection systems would cover the full cost of home care across all three levels of severity in only four countries and subnational areas (Reykjavik in Iceland, Tallinn in Estonia, Germany, and Finland). In 18 countries and subnational areas, public support for home care would be inadequate (i.e. would not cover 100% of the costs) for all three levels of severity. Even in systems that are often described as safety net systems (e.g. Illinois and California in the United States and England), and in systems that are considered universal (e.g. Sweden), there would be gaps in adequacy for at least one level of severity (although the magnitude of those gaps varies significantly across countries and subnational areas).

Gaps in public social protection may push older people into asset-based poverty

114. Economically vulnerable older people – those who are at risk of asset-based poverty but not income poverty – have no capacity to compensate for any gaps in public support for LTC by using their assets, as this would push them into asset-based poverty (see Box 1.3 for detailed definitions). Figure 4.6 shows the estimated shares of an older person's net financial wealth that would be depleted over 12 months of home care for different severities of LTC needs, for an older person *earning a median income (among people of retirement age or older) but at risk of asset-based poverty*.

Figure 4.6. Share of net financial wealth depleted after a year of home care, by severity

Care recipients are economically vulnerable: at risk of asset-based poverty but earning a median income



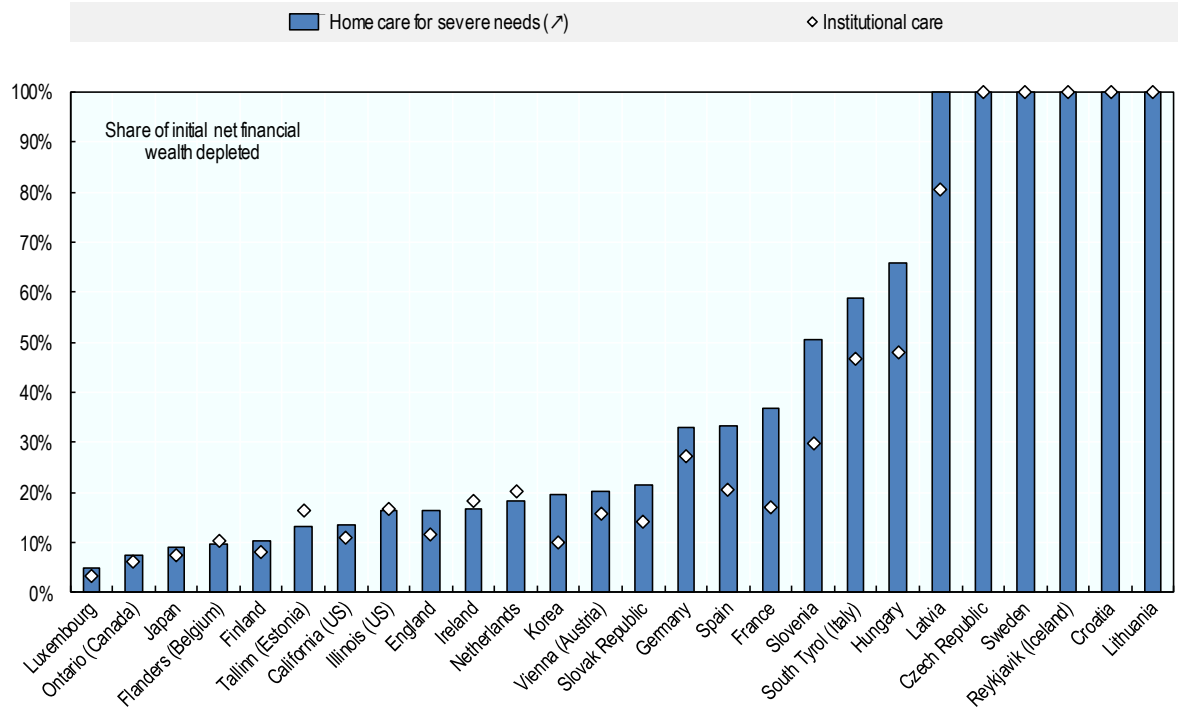
Note: Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account. Individuals are identified as being in asset-based poverty if they belong to a household with liquid financial wealth insufficient to support them at 50% of the median equivalised disposable income (after social transfers have been taken into account) for at least three months. Any means-tests are based on income and assets at start of the simulation.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

115. In 13 countries and subnational areas, an economically vulnerable older person would be able to avoid asset-based poverty after paying for home care across all three levels of LTC needs. In another 13 countries, regions and municipalities, paying the out-of-pocket costs of home care for moderate or severe needs would push the economically vulnerable further into asset-based poverty. In Latvia, the user contributions to 12 months of home care for low needs would be enough to wipe out the entire net financial wealth of an economically vulnerable older person, leaving them with only their income to pay for care, and thus no way to afford formal home care for low needs.

116. Older people that need care for more than 12 months are at a higher risk of asset-based poverty. Figure 4.7 shows the shares of an older person's net financial wealth that are depleted over a simulation period of nine years (durations are based on averages of actual observed durations for men and women derived from Kingston and colleagues (2017[22])). The older person *earns the relative poverty income and starts the simulation with mean net financial wealth*.

Figure 4.7. Share of initial net financial wealth depleted at the end of nine years of LTC

Care recipient spends six years in home care for low needs, one year in home care for moderate needs, and two years in either home care for severe needs or institutional care, and earns the relative poverty income throughout



Note: Care recipients earn the relative poverty income and have mean net financial wealth at the start of the simulation. National-level mean net financial wealth is for over 65 year olds. For countries with no net wealth data (Czech Republic, Iceland, Croatia, Lithuania and Sweden) it is assumed mean net wealth is 17 times the median income (based on the average ratio between mean net wealth and national median income across OECD countries for which both data are available). It is assumed 52% of mean net wealth is primary residence and 48% is other assets (based on average percentages across OECD countries for which data are available). Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

117. In seven countries and subnational areas, older people at risk of poverty would deplete more than half of their net financial wealth to cover the out-of-pocket costs of nine years of home care. Not only would they be at an increased risk of asset-based poverty but they might also have to use their housing wealth to pay for care. Despite rules that protect housing wealth by excluding an older person's primary residence from assets-tests for home care in England, France, Spain, and Hungary, care recipients in these countries would have lower out-of-pocket costs if they spent the last years of care in an institution, depleting less of their net financial wealth. It is likely that the shares of assets depleted to make up for gaps in public social protection for LTC may actually be larger since older people who are vulnerable to poverty could have even lower net financial wealth levels than the ones assumed here (mean net financial wealth).

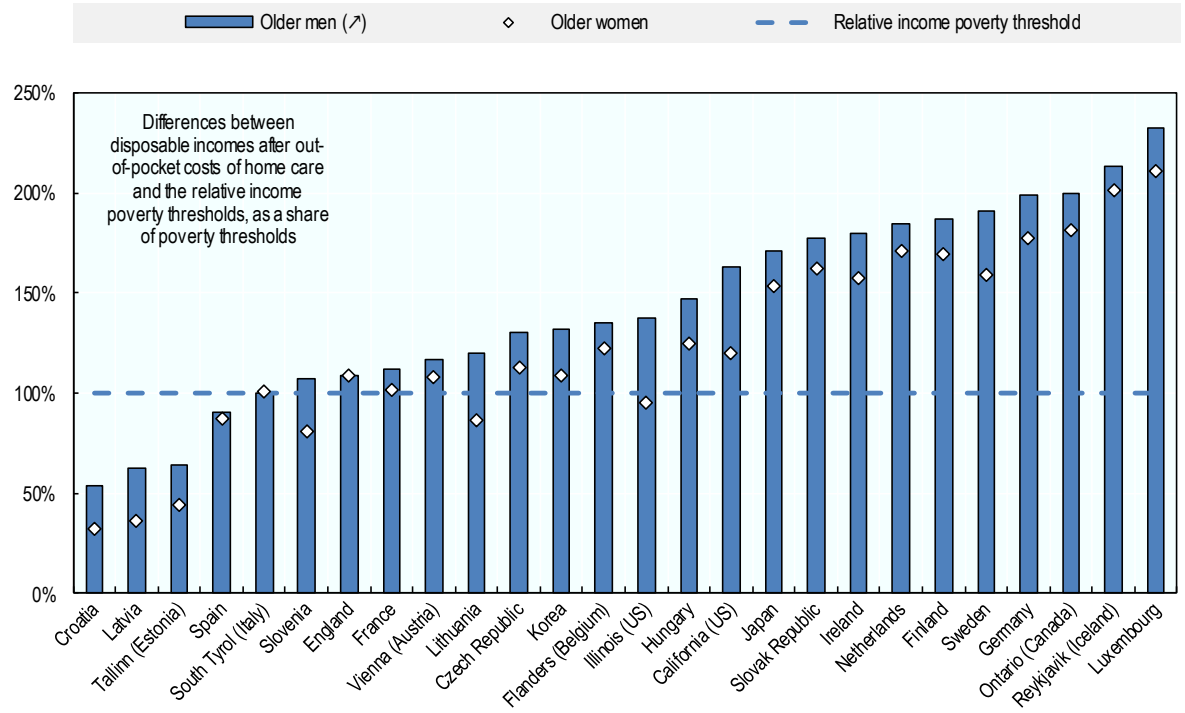
4.2.3. Public support for women may be inadequate due to higher economic vulnerability

118. Compared to older men, older women are more likely to need LTC, and need it for longer periods, while also being less likely to afford it, due to, among other reasons, lower labour market participation, lower lifetime earnings and lower pensions (OECD, 2017[24]). Older women are thus at a higher financial risk than older men, given a higher likelihood of needing care and lower likelihood of being able to afford it from their income and net total wealth. Given this heightened financial risk, it is important to assess how

well public social protection systems are supporting older men and women, across countries and subnational areas. The differences between older men and women's incomes after paying for *home care for moderate needs*, for a care recipient *earning an average income among people of retirement age or older of their gender* and with *no net wealth*, as a share of relative income poverty thresholds, are shown in Figure 4.8. Values below the 100% threshold indicate care recipients' incomes – after public support and out-of-pocket costs – fall below the relative income poverty threshold.

Figure 4.8. Differences between older men and older women's incomes after out-of-pocket costs of home care and the relative income poverty thresholds, as a share of poverty thresholds

Men/women earn an average income (among those of retirement age or older) and have no net total wealth



Note: Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

119. In Lithuania, Illinois (US) and Slovenia, older women earning an average income would fall below the relative income poverty threshold, even after receiving public support for home care for moderate needs, while older men earning an average income would not. In no country or region, for any level of LTC needs, would older men fall below the relative income poverty threshold and women not. The differences in income between older men and women observed in Figure 4.8 are a consequence of both lower starting incomes and financially insufficient public support. First, older women have, on average, lower incomes than older men, regardless of whether they have LTC needs or not. On average across the 25 countries included in this report, older women earn on average 88% less than older men. Thus, older women face greater financial risks associated with developing LTC needs. Yet, after accounting for public support and out-of-pocket costs of home care for moderate needs, the income of older women is on average 85% lower than the income of older men. The income gap between men and women is slightly wider after developing LTC needs, even after accounting for social protection. While public social protection for LTC is likely not

meant to address the gender income gap, it should address the gender gradient in financial risk associated with having LTC needs.

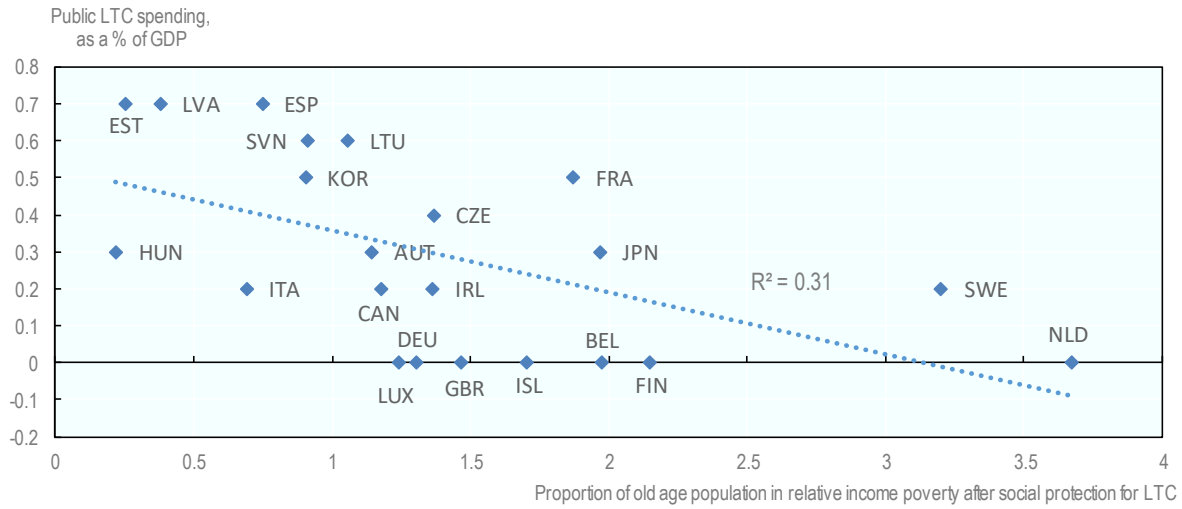
4.3. Efficiency of social protection for long-term care in old age

120. Public social protection is efficient when gains in wellbeing and reductions in poverty and economic vulnerability are achieved at minimum cost to the public purse. Efficiency is determined through comparing poverty reductions with the total costs of public social protection. Such a calculation is not possible for a large number of countries due to gaps in the availability of data on the costs of specific LTC programmes and schemes, the number of beneficiaries of those programmes and schemes, and the beneficiaries' income and net wealth. Another option is to compare estimates of poverty reductions from social protection for LTC with total public LTC spending, providing a proxy measure of efficiency. This comparison *should be interpreted with caution* as poverty reductions are estimates that do not take into account real-world access and utilisation, and total public LTC spending statistics include expenses that go beyond the components of LTC included in this report (e.g. ADLs, IADLs, and social activities). Furthermore, for some countries, subnational public support for LTC is compared to national-level LTC spending. Rather, such a comparison should be seen as a first rough attempt to estimate efficiency, illustrating how it could be determined as more data become available, as well as demonstrating clearly that there is a relationship between overall spending and poverty reductions.

121. Figure 4.9 illustrates how total public LTC spending compares to the estimated proportions of older people in relative income poverty after receiving public support and paying out-of-pocket contributions for *home care for moderate needs*. In countries where total public LTC spending is higher, older people tend to be at an estimated lower risk of poverty after developing LTC needs and receiving public support. The relationship is very similar for home care for low and severe needs (results not shown). While there is significant variation in total public spending as a share of GDP at the same level of poverty risk, caution should be taken in interpreting these differences due to the data limitations already mentioned. For example, not all LTC spending goes towards social protection and it is not possible to allocate spending to specific programmes, and poverty risk in this report does not take into account access and uptake.

Figure 4.9. Higher public spending on LTC is associated with lower proportion of old age population in relative income poverty using home care for moderate needs and with access to social protection

Assuming no net total wealth (the most favourable case in countries that apply assets-tests)

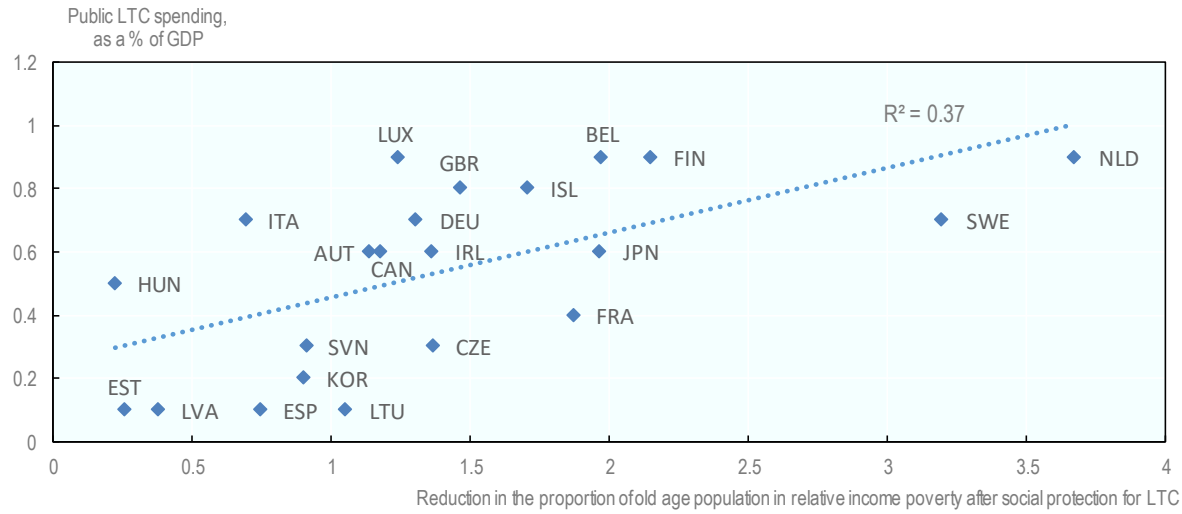


Note: Income deciles are derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database and OECD Health Statistics (2018).

122. Figure 4.10 shows how total public LTC spending compares to estimated reductions in the proportions of older people in relative income poverty after receiving public support and paying out-of-pocket contributions for *home care for moderate needs*. Reductions in the proportions of old age population in relative income poverty are defined as the difference between the proportion of old age population relative income poverty when using LTC without access to social protection, and the estimated proportion of old age population in relative income poverty when using LTC with access to social protection. The relationship is relatively clear: public social protection systems in countries that spend a higher share of their GDP on LTC tend to reduce the estimated risk of poverty associated with developing LTC needs more than public social protection systems in countries with lower public spending. As before, caution should be taken in interpreting differences in total public LTC spending as share of GDP at specific levels of poverty reduction due to the data limitations already mentioned.

Figure 4.10. Higher public spending on LTC is associated with higher reductions in share of old age population in relative income poverty using home care for moderate needs and after social protection

Assuming no net total wealth (the most favourable case in countries that apply assets-tests)



Note: The reduction in the proportion of old age population in relative income poverty is defined as the difference between the proportion of old age population relative income poverty when using LTC without access to social protection, and the proportion of old age population relative income poverty when using LTC with access to social protection. Income deciles are derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database and OECD Health Statistics (2018).

5 The distributive effects of potential policy options and scenarios

123. The modelling framework used in this report can be used to test the impact of different policies and scenarios, such as the introduction of a new LTC benefit or scheme, or a change of rules used by a specific LTC benefit or scheme, in one or more countries. Not only is it possible to estimate the impact of new policies on poverty risk associated with LTC but also, importantly, the distributional effects of such policies and reforms can be analysed, highlighting whether policy options are potentially progressive or regressive, as well as exposing winners and losers across the income and wealth distributions. In this chapter, proposed and hypothetical policy options and reforms are modelled and simulated, and their distributional effects analysed. The policy options include two hypothetical policies, included as theoretical exercises for illustrative purposes only (the introduction of a cash benefit in Ireland, and the introduction of a policy of free personal care in all of the 26 OECD and EU countries included in this paper). The effects of another two actual proposals for reform of the social care system in England (one from the Dilnot Commission and one adapted from a policy think tank) are also assessed. The analyses in this chapter are merely illustrative and *should not be considered policy recommendations*.

5.1. An international comparison of a hypothetical policy of free, universal personal and nursing care

124. There is growing interest in, and debate around, making personal (help with ADLs) and nursing care free to all in need (see Quilter-Pinner and Hochlaf (2019[25])), much like health care is free at the point of care in most OECD and EU countries. Free personal care for older people with specified long-term care needs is already available in Luxembourg, Ireland and Scotland. However, in these three countries, the costs of help with all or certain IADLs are not covered by the public social protection system and must thus be paid either partly or completely out-of-pocket by the care recipient. In Luxembourg, lunches provided by meals-on-wheels are not part of the LTC insurance package and thus must be paid for out-of-pocket, while in Scotland, the costs of help with housework, laundry, shopping, and supplying food or pre-prepared meals may be charged to care recipients. In Ireland, the costs of help with laundry and shopping are not covered by the public social protection system.

125. For modelling purposes, the policy would largely follow the Scottish model. In the Scottish LTC system, costs of help with ADL are paid in full by the public social protection system while the costs of help with IADLs and social activities are charged in full or in part to the care recipient. In principle, the Scottish system allows some public support for IADLs and social activities but in the absence of more detailed information, it is assumed that costs are paid fully out-of-pocket. Figure 5.1 illustrates the impact of a hypothetical free personal care policy on the proportion of the old age population that is in relative income poverty after receiving public support and paying for *home care for low, moderate and severe needs*, in all 26 countries and subnational areas modelled here, compared to the current systems of LTC benefits and schemes in use. It is assumed care recipients have *no net total wealth* (the most favourable case in countries and subnational areas that apply assets-tests). The estimates of the effects of a free personal care policy included here do not take into account the costs of implementing such a policy, which would

likely include significant investments in case-management and staff training to avoid supply-induced demand for LTC.

126. The effects of implementing a free personal care policy for *home care for low needs*, in place of the existing LTC benefits and schemes, differ across countries and subnational areas. Very generally, in places with an estimated lower risk of poverty under the current LTC system (e.g. France and Finland), a new policy of free personal care would actually increase the risk of poverty associated with needing and paying for home care for low needs. Conversely, in places with an estimated higher risk of poverty under the existing system of LTC benefits and schemes (e.g. Latvia and Lithuania), the hypothetical new policy would lead to lower risk of poverty. In the Czech Republic, the Slovak Republic, Vienna (Austria) and Illinois (US), the risk of poverty would remain unchanged.

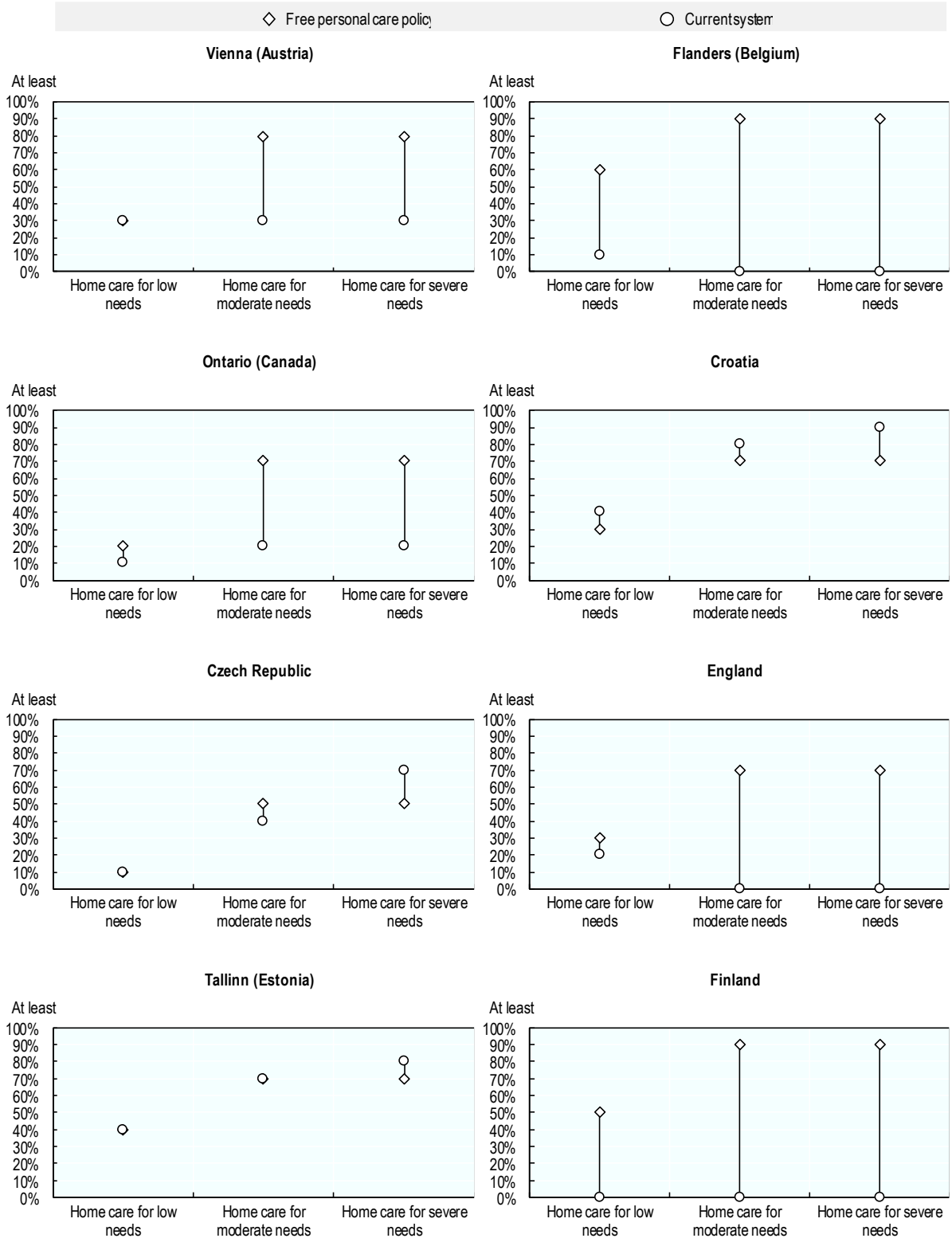
127. The same pattern is observed for moderate needs as for low needs. In places with an estimated lower risk of poverty under the current LTC system (e.g. Germany and the Netherlands), a new policy of free personal care would actually increase the risk of poverty associated with LTC. In places with an estimated higher risk of poverty under the existing system (e.g. Croatia and Spain), a free personal care policy would lead to lower risk of poverty, although with limited improvements in the risk of poverty. The large increases in risk of poverty from a free personal care policy for countries and subnational areas where public support for LTC is currently estimated to be most generous are due to reductions in public support for help with IADLs and social activities. This is more noticeable in home care for moderate needs compared to care for low needs, given the substantial increase in the hours allocated to supporting IADLs and social activities.

128. The same pattern observed for home care for low and moderate needs is clear in Figure 5.1 for severe needs, but more markedly. The effects are again very distinct depending on the country under analysis. In Finland and Flanders (Belgium), for example, the introduction of a free personal care policy without any public support for help with IADLs and social activities would significantly increase the risk of poverty associated with LTC, when compared to the existing system. Conversely, in Slovenia, the risk of poverty would drop very significantly if a free personal care policy were implemented in place of the current system.

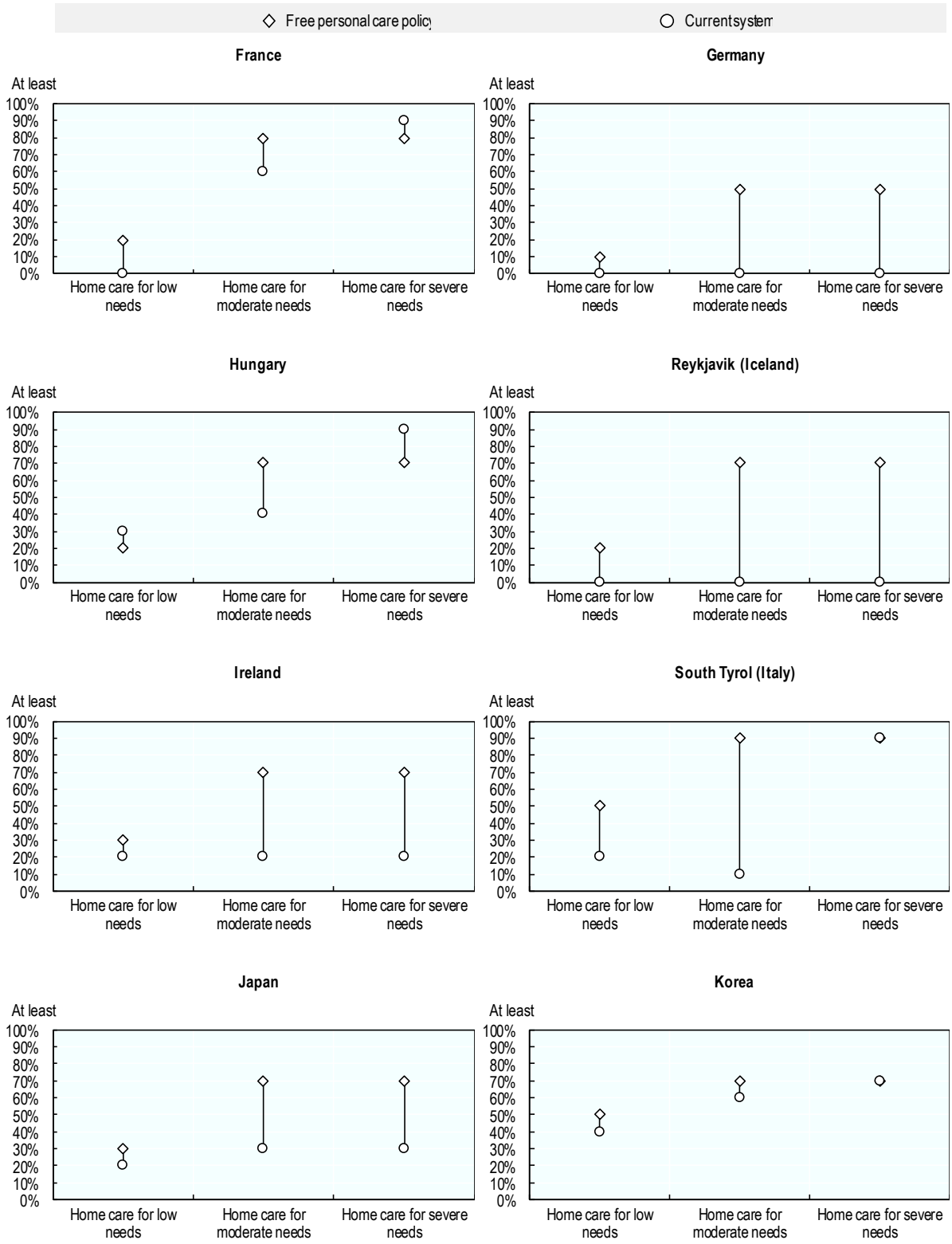
129. The analysis of the effects of a hypothetical free personal care policy in 26 countries and subnational areas leads to two conclusions. First, countries, regions and municipalities where the risk of poverty associated with LTC is estimated to be higher should consider providing greater support for personal care (help with ADLs), as this leads to clear reductions in the risk of poverty. Second, adequate social protection for LTC goes well beyond supporting help with ADLs, and should also include help with IADLs and social activities, the costs of which can push large shares of the old age population to relative income poverty. This is illustrated above by the fact that systems that provide comprehensive support for the costs of help with ADLs, IADLs and social activities would not see any benefits from introducing a free personal care policy that does not include public support for help with IADLs and social activities.

Figure 5.1. Share of old age population that would be in relative income poverty after paying for the out-of-pocket costs of home care, for different severities, before/after new free personal care policy

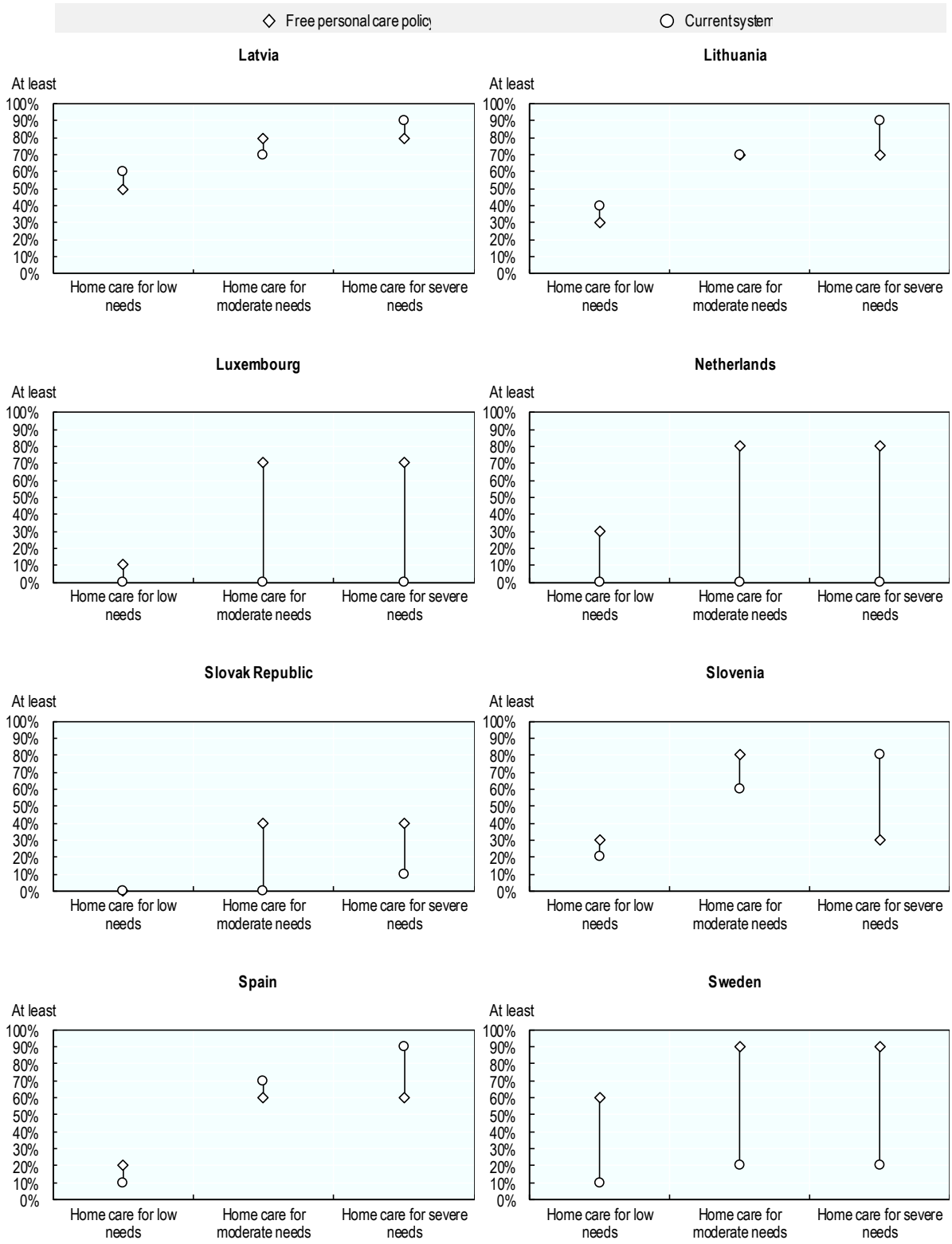
Care recipients have no net total wealth (most favourable case in assets-tested systems)



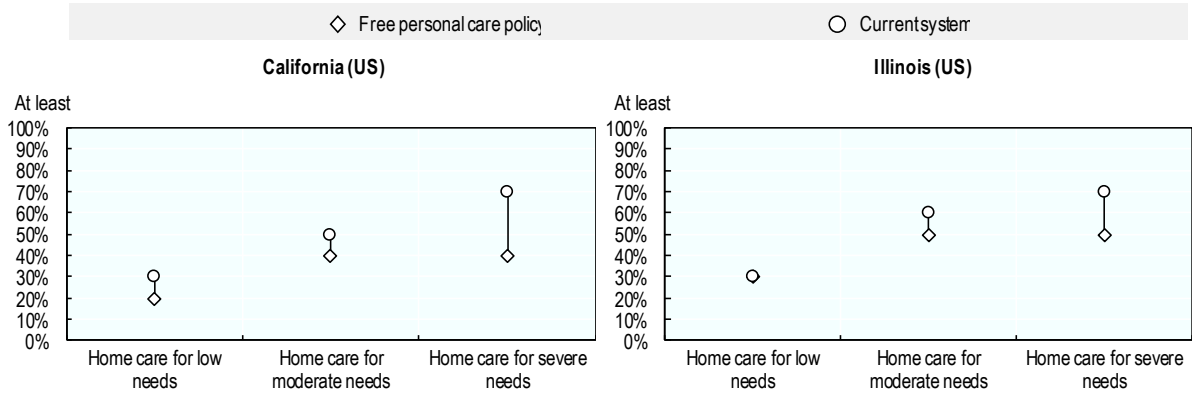
Care recipients have no net total wealth (most favourable case in assets-tested systems) – continued



Care recipients have no net total wealth (most favourable case in assets-tested systems) – continued



Care recipients have no net total wealth (most favourable case in assets-tested systems) – continued



Note: Jurisdictions are sorted alphabetically by name of the country. Income deciles are derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Care recipients have no net total wealth. Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

5.2. A hypothetical means-tested cash-for-care scheme in Ireland

130. As shown in previous chapters, in a number of countries, regions and municipalities, there are potential gaps in the public support of LTC. It is possible to design new hypothetical benefits that would fill those gaps and test their effects across whole distributions of income in the old age populations. In Ireland, for example, the Home Support Service (previously known as the Home Care Package Scheme) provides community care and home care support. Care provided through the Home Support Service is not means-tested and every person in need receives care without having to make any user contributions. However, the costs of laundry and shopping are not covered and care recipients must pay for these in full out-of-pocket. The current level of public support would not bring relative income poverty levels back to pre-LTC levels: while 20% of the entire old age population in Ireland are at risk of income poverty, should they need home care for moderate needs and have access to social protection, that share would go up to 40%. In other words, there is an estimated higher risk of poverty associated with needing LTC, even after receiving public support.

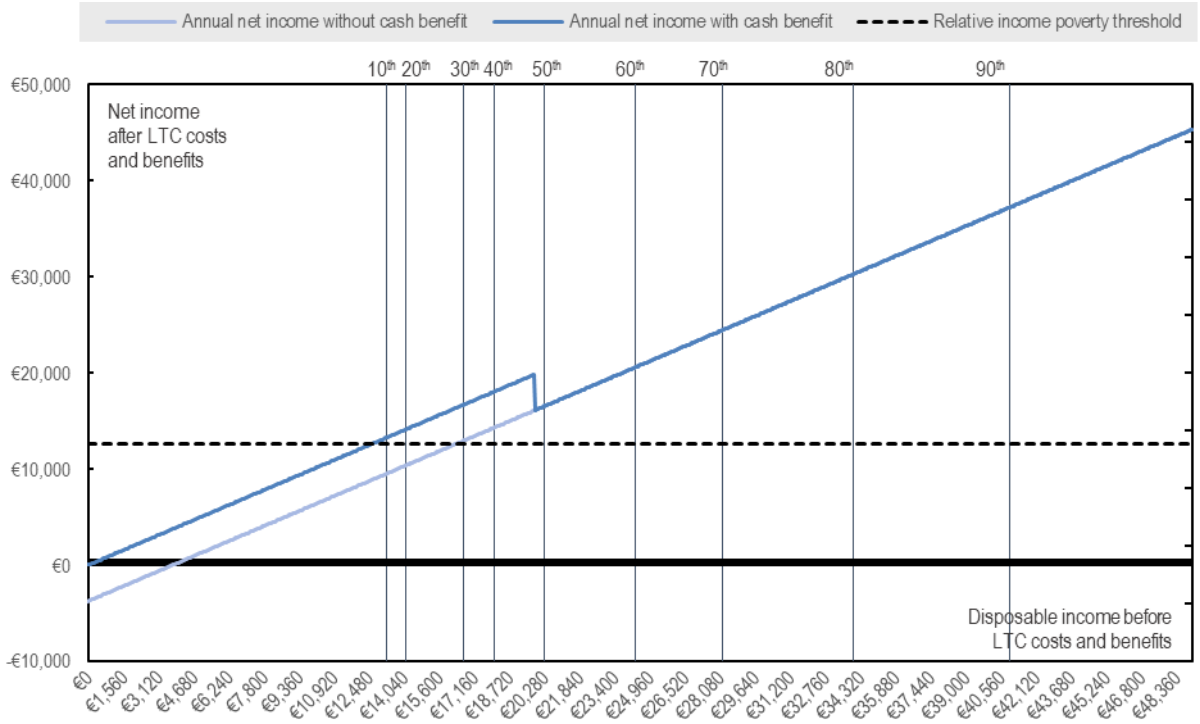
131. One way to fill this gap is to introduce an income-tested cash-for-care scheme for more economically vulnerable older people to pay for the costs of help with laundry and shopping. A similar benefit is available in Flanders (Belgium) in the form of service vouchers, although they are not income-tested. However, income-testing is desirable to make the extra public support from the new benefit more progressive, and guarantee that it is used by only those who cannot afford the costs of help with laundry and shopping. To ensure that the rules for the new benefit are easy to understand and administer, eligibility could be determined based on the Irish national minimum wage[20]. Anyone earning below the national minimum wage would be eligible for the new benefit, while older people with incomes above the national minimum wage would not be eligible. The value of the benefit could be set at the full cost of help with laundry and shopping (3 hours of help in the case of moderate needs).

[20] The Irish national minimum wage (at current prices) was EUR 19 864 in 2018 (source: OECD.Stat).

132. Figure 5.2 shows how such a hypothetical cash benefit would change care recipients' incomes after paying for the out-of-pocket costs of 12 months of home care for moderate needs. The relative income poverty threshold and deciles of disposable income are also shown to assist with interpretation. A hypothetical income-tested cash-for-care scheme, to specifically pay for the costs of help with laundry and shopping, targeted at older people with incomes below the national minimum wage, would reduce relative income poverty, providing greater support for older people on lower incomes[21]. Such a benefit would bring relative income poverty levels back to pre-LTC levels, guaranteeing that no older person would be at a higher risk of poverty because of needing LTC. This hypothetical benefit would also be progressive, supporting only those in the lower end of the income distribution, and might also stimulate a private market for provision of laundry and shopping services.

Figure 5.2. Care recipients' incomes after out-of-pocket costs of 12 months of home care for moderate needs, before and after the introduction of an income-tested cash-for-care scheme

Care recipients have mean net total wealth



Note: Care recipients have mean net total wealth. Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. A hypothetical income-tested cash-for-care scheme is considered alongside the existing means-tested social care benefit in Ireland. Income deciles are derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

133. This analysis is merely illustrative and *should not be seen as a policy recommendation*. In the absence of more detailed data on the number of older people eligible for such a benefit, it is not possible to determine how much such an income-tested cash-for-care scheme would cost the public social

[21] Care recipients in this hypothetical scenario are assumed to have no net total wealth, but the results are the same for any level of net wealth since the Irish home care system is not asset-tested.

protection system to implement. It shows how a new benefit with a clear objective and transparent rules could theoretically reduce the risk of poverty associated with developing LTC needs. However, it also shows how clear easy-to-understand rules can lead to a cliff effect: those earning just above the minimum wage would not be eligible for this new hypothetical cash-for-care scheme, and so their net income after out-of-pocket costs and public support would be significantly lower than the net income of older people earning just below the minimum wage. The income-testing rules could be changed but this might come at the expense of clarity and interpretability.

5.3. Proposed reforms of the social care system in England

134. Most support for people with LTC needs in England is provided through the social care system, administered by local authorities, who have some flexibility over eligibility and charging rules but must follow a national framework. Social care is a fully means-tested system, so that some people with high income and/or wealth receive no support at all. There are two asset thresholds. The lower threshold was set at GBP 14 250 in 2014, and anyone with assets below this level only has to contribute what they can afford from their income. In order to determine what someone can afford from their income, the system defines that amount that someone should be left with for non-LTC costs and requires them to contribute the rest. This "personal allowance" is defined differently for home care and residential care. For home care, it is equal to the pension credit minimum income guarantee (the minimum income that the pension system guarantees for pensioners), plus 25%. Since 2014, this has amounted to GBP 189 per week. Local authorities may also make a discretionary allowance for disability-related spending (policies on this vary, but this is not included in the analyses in this report). For institutional care, the personal allowance is GBP 24.90 per week.

135. Those with assets above the lower threshold, but below the upper threshold of GBP 23 250, are expected to make a defined contribution from their assets, in addition to the income contribution described above. This is equal to GBP 1 per week for every GBP 250 of assets that they have above the lower threshold (i.e. above GBP 14 250). Those with assets above the upper threshold of GBP 23 250 receive no support from the social care system. The assessment of a person's assets excludes their "primary residence" – which means a house that they own and are living in, or that their spouse is living in. In practice, this means that people are not expected to use their housing wealth to pay for home care (since they are usually living in their house) but if they move into residential care they might have to sell their house and use the proceeds to fund the cost of the institution.

136. The attendance allowance is a non-means-tested benefit available to older people who have LTC needs. A self-completed form and a medical assessment by a doctor determine eligibility. There are two levels of attendance allowance: people who need care both day and night receive the higher rate of GBP 82.30 per week, while those who need only day or night care receive the lower rate of GBP 55.10 per week. In general, eligibility for the lower rate of attendance allowance is more inclusive than eligibility for social care. Receipt of the attendance allowance is not dependent on income or assets, so everyone with care needs can claim this benefit. However, people in residential care cannot simultaneously claim the attendance allowance and social care.

5.3.1. Estimating the effects of proposals for reform of social care in England

137. The state of social care in England is a much-debated topic, involving a wide range of stakeholders, from government, to parliament, to civil society and the media. Since 1948, there have been several large public inquiries into the state of social care. The most recent one, the independent Commission on Funding of Care and Support – commonly referred to as the Dilnot Commission given it was led by the economist Andrew Dilnot – published its recommendations on 4 July 2011. It made several proposals for reform (see below). There have also been several calls from non-governmental institutions

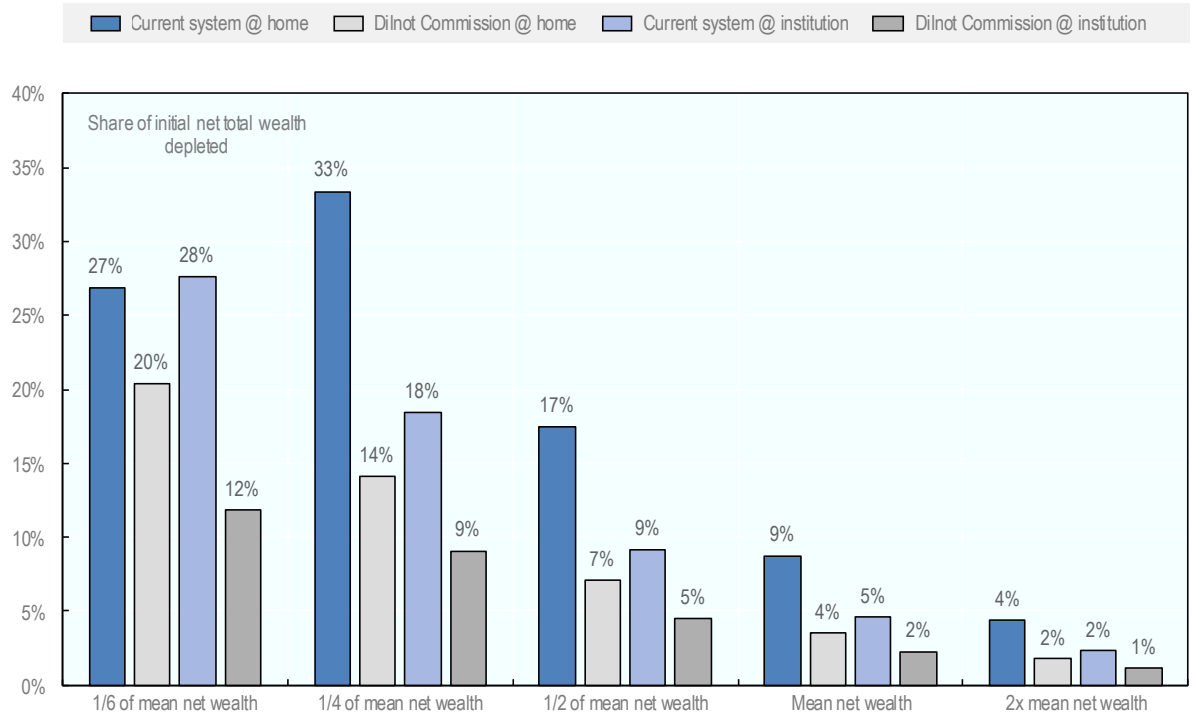
like charities and think tanks for reforms of the means-tested social care system. One proposal has been to cap user contributions at GBP 5 000 per year.

The Dilnot Commission proposals

138. Among other proposals, the Dilnot Commission suggested increasing the upper threshold of GBP 23 250 to GBP 100 000 in institutional care and creating a lifetime cap on user contributions set at GBP 35 000. The impact of these proposals on total net wealth depletion over a simulation period of nine years is illustrated in Figure 5.3, for different levels of starting total net wealth. The older person earns *a median income* that remains constant throughout the simulation. In those nine years, the care recipient spends six years in home care for low needs, one year in home care for moderate needs, and two years in either home care for severe needs or in institutional care (these durations are based on averages of actual observed durations for men and women in the United Kingdom derived from Kingston et al (2017[22])).

Figure 5.3. Share of net total wealth depleted at the end of nine years of LTC under current social care system and proposals from the Dilnot Commission, for different levels of total net wealth

Care recipient spends six years in home care for low needs, one year in home care for moderate needs, and two years in either home or institutional care for severe needs, and earns a median income throughout.



Note: Care recipients earn a median income (among people of retirement age or older) throughout the simulation. National-level mean net wealth is for over 65 year olds. Mean net wealth in the United Kingdom was GBP 630 850 in 2015. It is assumed 48% of mean net wealth is composed of financial wealth (based on average percentages across OECD countries for which data are available); in the absence of more detailed data, this asset composition is applied to all levels of total net wealth (although it is likely that older people with lower levels have higher shares of housing wealth). Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Annex A. Dilnot Commission proposals include an upper threshold of GBP 100 000 in institutional care and a lifetime cap on user contributions of GBP 35 000.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

139. The proposals of the Dilnot Commission would approximately halve the share of total net wealth depleted at the end of a nine-year period of worsening care LTC needs and use, across different levels of starting total net wealth. As previously discussed, spending the last two years of the simulation in institutional care would lead to lower asset depletion than spending those years receiving care at home. The biggest relative benefits from the Dilnot Commission proposals would be felt by older people with total net wealth well below the mean net wealth in the United Kingdom, especially those with net wealth closest to the upper thresholds of non-housing assets in home care and total assets in institutional care.

A cap on yearly out-of-pocket payments

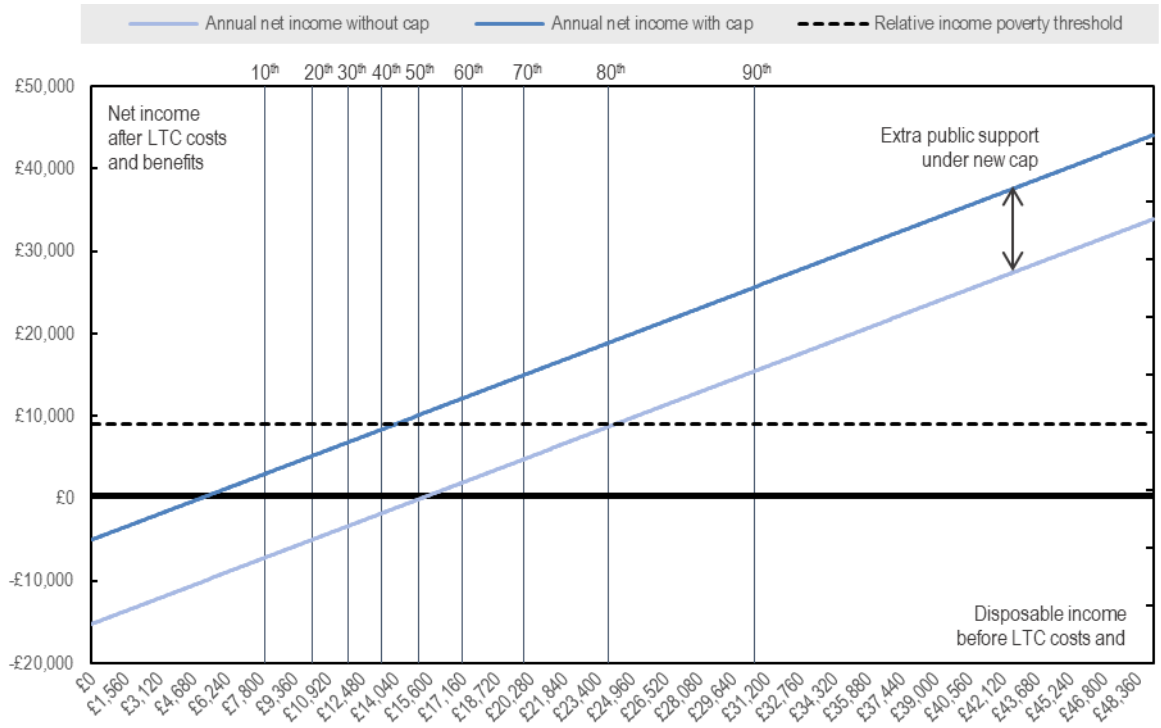
140. There have been many proposals from non-governmental organisations for reforming the social care benefit rules. One such proposal suggests ending the current asset-based means-testing in social care, and substituting this with an income-tested system with contributions capped at GBP 5 000 yearly, and with user contributions starting at one and half times the average annual pensioner income (Lightfoot, Heaven and Henson Grič, 2019[26]). As no details are given on the exact formula for the new income-testing, it is not possible to test the impact of such a policy. Alternatively, the distributional effects of a yearly GBP 5 000 cap on user contributions based on the existing asset-based means-testing can be analysed.

141. Figure 5.4 illustrates how such a cap would change care recipients' incomes after paying for the out-of-pocket costs of 12 months of home care for moderate needs. The relative income poverty threshold and deciles of disposable income are also shown to assist with interpretation. As the asset-based means-test for social care is still in place in this policy scenario, an older person with mean net wealth would not be eligible for social care. They would receive only the lower rate of the attendance allowance, regardless of their disposable income (the assumption being that the shortfall between the out-of-pocket costs of care and the older person's income could be covered from their net total wealth). This is why an older person with mean net total wealth earning between the 70th and 80th percentiles of disposable income in England would not be able to afford 12 months of home care for moderate needs (should they need it) from their incomes alone without being pushed into relative income poverty (see light blue line below).

142. Regardless of their disposable income, older people with mean net total wealth face annual out-of-pocket costs of approximately GBP 15 179. The introduction of a yearly cap of GBP 5 000 on user contributions corresponds to increasing public support by GBP 10 179 annually for this group of care recipients (i.e. older people with mean net total wealth). Such a cap would not be progressive, since someone earning below the 10th percentile of income would receive the same public support as someone earning above the 90th percentile, even though the latter can afford the costs of care from their income without depleting their net total wealth. Under such a cap, a greater share of the older population with mean net total wealth would be able to afford care from their incomes alone. Whereas before only those earning above the 80th percentile of disposable income could afford care without being in relative income poverty, under a new cap, those earning above the 50th percentile could also now afford care from their incomes alone.

Figure 5.4. Care recipients' incomes after out-of-pocket costs of 12 months of home care for moderate needs, before and after the introduction of a yearly cap on user contributions

Care recipients have mean net total wealth

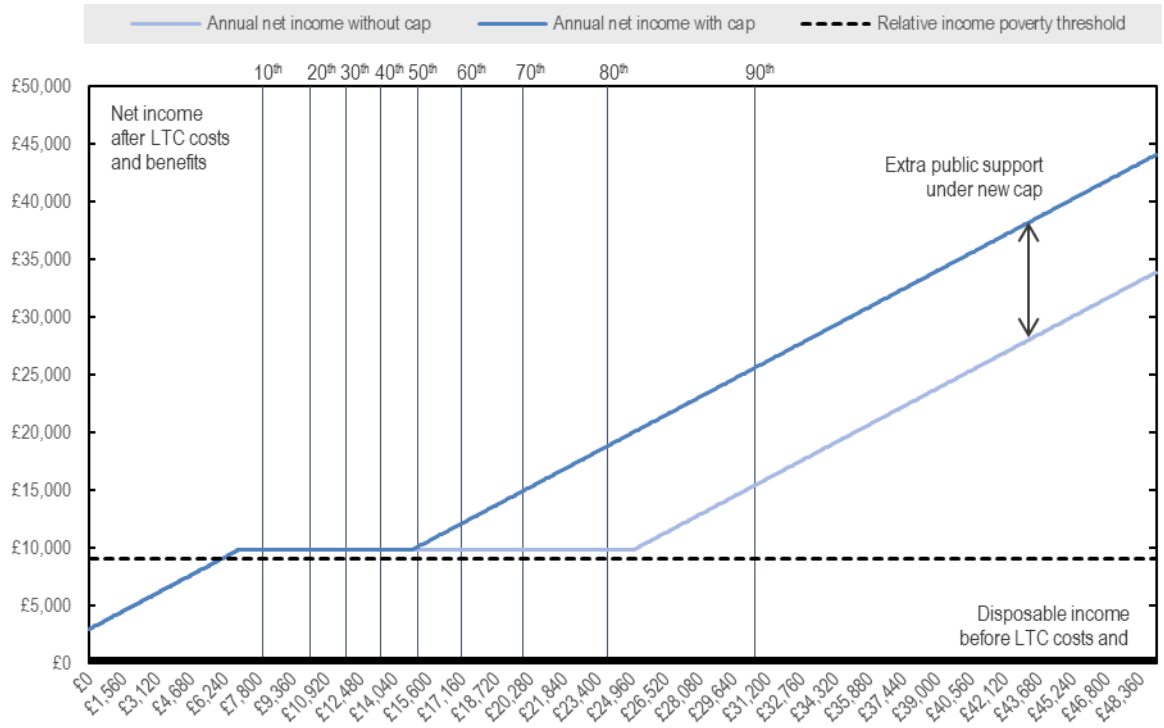


Note: Care recipients have mean net total wealth. National-level mean net total wealth is for over 65 year olds. It is assumed 48% of mean net total wealth is composed of financial wealth (based on average percentages across OECD countries for which data are available). Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. A yearly cap of GBP 5 000 is considered alongside the existing asset-based means-tested social care benefit in England. Income deciles are derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

143. It is also informative to explore the impact of such a cap on older people with limited or no net wealth, since care recipients with no net wealth are eligible for greater support in the current safety net system. Figure 5.5 shows how a yearly GBP 5 000 cap would change care recipients' incomes after paying for the out-of-pocket costs of 12 months of home care for moderate needs, if they had no net total wealth. In this case, care recipients would be eligible for social care, and would be able to keep a personal allowance of GBP 189 per week. For older people on the lower end of the income distribution, this effectively limits their out-of-pocket costs quite significantly. So much so that older people earning up to around GB 15 000 per year would not actually make enough user contributions to reach the GBP 5 000 annual cap. As such, the new cap would not actually result in higher public support for this group of older people. For older people with no net total wealth, the new cap would actually be regressive, providing increased public support only for care recipients earning above the median income.

Figure 5.5. Care recipients' incomes after out-of-pocket costs of 12 months of home care for moderate needs, before and after the introduction of a yearly cap on user contributions

Care recipients have no net total wealth



Note: Care recipients have no net total wealth. Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. A yearly cap of GBP 5 000 is considered alongside the existing asset-based means-tested social care benefit in England. Income deciles are derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

6 Conclusions

144. With populations across the OECD and the EU ageing rapidly, growing numbers of older people will struggle with everyday activities that were once second nature, such as getting dressed, shopping, or going out for a walk. While a comprehensive measure of the societal costs associated with old age dependency is difficult to estimate, even with information on total government spending on formal LTC services, it remains unclear how much of that spending is helping older people meet the out-of-pocket costs of LTC. This report addresses this gap by providing the first comprehensive international comparison of the effectiveness (adequacy, equity and efficiency) of public social protection systems for LTC in old age in OECD and EU countries. The analyses covered 25 of 41 OECD and EU countries, with an objective to make both methodological contributions (e.g. how to compare disparate public social protection for LTC in old age in different countries and subnational areas) and policy assessment contributions (e.g. is public social protection for LTC in old age reducing the risk of poverty associated with LTC needs?).

145. The costs of receiving LTC services can build over time and absorb a very significant share of an elderly person's income, if older people do not have access to social protection. Across the OECD and EU, the total costs of LTC represent one to six times the median disposable income for individuals of retirement age or older. Older people on lower incomes are unsurprisingly much more likely to not be able to afford the total costs of LTC (even as little as 6.5 hours per week for those with low needs considering home care can be too costly). High poverty rates among the elderly limit financial capacity to cover high out-of-pocket costs of LTC that, together with potential constraints on the availability of informal carers and limited private insurance options, highlight the importance of public financing and support for LTC. As countries, and even regions and municipalities, use different definitions of LTC needs and different assessments, comparisons of the generosity of LTC systems are very challenging. To tackle this, typical cases of LTC needs were used in this report.

146. Public support covers an important share of the costs in most countries and subnational areas modelled in this report, and tends to be more generous for older people with more severe LTC needs and lower incomes, and less generous for those with net wealth. Most public social protection systems provide lower levels of support to older people receiving informal care and, in twelve countries and subnational areas, an adult child providing 22.5 hours of care to an elderly parent would receive no direct or indirect public support despite the fact that the adult child would have to reduce working hours – or even stop working altogether – to provide care. Older people that receive a mix of formal and informal care are typically eligible for greater public support than those receiving informal care alone. Out-of-pocket costs (the share of the costs that are left after accounting for public support) of home care can be very high for older people with severe needs, while institutional care for the same individuals is often more affordable. This suggests that public support is not well-aligned with ageing-in-place policies. In some countries, regions and municipalities, older people on lower incomes may have to contribute over half of their already limited incomes to pay for the out-of-pocket costs of LTC. For those living at home, these contributions can put them at risk of poverty given they still need to pay for basic costs of living, like electricity and food.

147. Most countries, regions and municipalities combine cash and in-kind benefits, and the large majority have some form of cost-sharing, the most common being means-testing. Cost-sharing is particularly common, and steep, in institutional care with many countries and subnational areas asking users to contribute to the costs of board and lodging. The exact formulas and rules used to determine the

amounts of public support that older people are entitled to can be very intricate and highly non-linear, usually taking into account care recipients' incomes, net wealth, or both. Assets-testing is more common in institutional care. While many countries and subnational areas do have safety nets, the income thresholds for receiving additional public support are often set far below the OECD relative income poverty thresholds, and can leave economically vulnerable older people at a higher risk of poverty. Assets thresholds above which individuals may need to make higher out-of-pocket payments are also often low compared with mean net wealth levels, potentially affecting large numbers of older people, although in almost half of the countries with such tests, primary residence is excluded to protect individuals from having to sell their house. A few countries, regions and municipalities offer deferred payment options.

148. While public social protection systems do seem to reduce the risk of poverty associated with having LTC needs, in a majority of countries and subnational areas, the estimated risk of poverty is still higher for those with LTC needs than in the older population in general. Public support for institutional care completely reduces poverty risks associated with needing LTC in all but a small number of countries and subnational areas, while in more than 20 countries, regions and municipalities, public support for home care for moderate and severe needs does not bring relative income poverty levels back to pre-LTC levels. Again, these results suggest more could be done to align public support with ageing-in-place policies.

149. With respect to equity, most countries and subnational areas are also providing limited support to economically vulnerable older people who cannot afford to make any user contributions without falling further into poverty. To compensate for the gaps in social protection, older people may be forced to deplete their assets, pushing them into asset-based poverty and potentially forcing them to sell their house to afford the care they need. Older women also face greater financial risks associated with developing LTC needs, due to both a higher likelihood of developing LTC needs in the first place, and a lower likelihood of having the means to pay for care. Yet, on average across countries and subnational areas, the income gap between men and women is effectively wider after developing LTC needs, even after accounting for social protection. First rough estimates of the efficiency of public social protection systems suggest that in countries and subnational areas that spend a higher share of their GDP on LTC, public support tends to reduce the risk of poverty associated with developing LTC needs more than public social protection systems in countries with lower public spending.

150. Prospective assessments of the distributional effects of hypothetical and proposed policies and reforms shine a light on potential ways forward, as well as possible risks. Countries, regions and municipalities where, even with public social protection, the risk of poverty associated with LTC is estimated to be higher, should consider providing greater support for personal care (help with ADLs), as this leads to clear reductions in the risk of poverty. However, adequate social protection for LTC goes well beyond supporting help with ADLs, and should also include help with IADLs and social activities, the costs of which can push large shares of the old age population to relative income poverty. A free personal care policy that does not include public support for help with IADLs and social activities is unlikely to be adequate. Assessments of other hypothetical and proposed policies also suggest that well-intentioned policies (like a cap on out-of-pocket spending) can be regressive, and actually lead to higher public spending on those earning more than the median income, while leaving those earning lower incomes still facing high out-of-pocket costs.

151. As population ageing continues and even accelerates, countries will increasingly face difficult choices in trying to balance an adequate level of social protection for LTC with a sustainable level of total public spending. While diversifying revenue sources beyond payroll contributions will be increasingly important in the context of an ageing population, this report shows that well-designed cost-sharing mechanisms within social protection systems are crucial. Public support should be targeted at those groups of older people that are most likely to be at risk of poverty from developing LTC needs, and the level of protection should be proportional to that risk. This report provides a basis for further work seeking to measure, quantify and improve the effectiveness (i.e. access, adequacy, equity and efficiency) of public social protection for LTC in old age.

Annex A. Typical cases of long-term care needs

152. The typical cases of LTC needs used in this report were developed from a number of sources, including (Muir, 2017[6]): a set of LTC scenarios that were developed as part of a 2006 review of the United Kingdom's social care system; 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 might not be 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 yet 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. All eight cases are described below.

Typical case 1 | Home care for low needs

Description of low needs

Activities of daily living | Barthel Index score: 17/20	
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.
Instrumental activities of daily living | Lawton IADL score: 6/8	
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.
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 home care services for low needs

	Services provided by professional caregiver 6 hours and 30 minutes per week Except where support or supervise is specified, the caregiver must completely take over the activity
Activities of daily living | 2 hours and 30 minutes per week	
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
	Supervise hair care, combing
	Wash the lower part of the patient's body and back
	Cleaning of care area
Instrumental activities of daily living | 4 hours per week	
Shopping	1 hour of support, twice a week
Cleaning	1 hour, once a week
Laundry	1 hour, once a week
Social needs | None	
None	

Typical case 2 | Home care for moderate needs

Description of moderate needs

Activities of daily living	Barthel Index score: 11/20
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 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 was not considered in questionnaires of phase 1)
	Can leave the house without help 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.
Instrumental activities of daily living	Lawton IADL score: 6/8
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.
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. If relevant, assume that this person lives alone.	

Description of home care services for moderate needs

	Services provided by professional caregiver 22 hours and 30 minutes per week Except where support or supervise is specified, the caregiver must completely take over the activity
Activities of daily living | 6 hours per week	
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
	Supervise hair care, combing
	Wash the lower part of the patient's body and back
	Cleaning of care area
Incontinence management 15 minutes, twice a day	Application of new sanitary pads
	Removal and disposal of used ones
Instrumental activities of daily living | 14 hours and 30 minutes per week	
Shopping	1 hour of support, twice a week
Cleaning	1 hour, once a week
Prepare meals	1 hour and 30 minutes, per day, in total
Laundry	1 hour, once a week
Social needs | 2 hours per week	
For example, being taken out for a walk twice a week.	

Typical case 3 | Home care for severe needs

Description of severe needs

Activities of daily living	Barthel Index score: 4/20
Mobility	Cannot get up or go to bed independently. Needs to be lifted manually into/out of 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 before losing balance and falling.
	Can only make one or two steps before losing balance even when holding onto a person or object, so is put in a wheelchair for most 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 a car/taxi when accompanied by a caregiver.
	Cannot travel regularly to see the doctor, so requires home visits (the cost of these adaptations was not considered in questionnaires).
Hygiene	Cannot dress or 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 that 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 and 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 that need to be changed twice a day.
	Cannot cut food into pieces but can move food and drink (with straw) to own mouth under supervision.
Food intake	Can cut food into pieces and independently consume food and drinks.
Instrumental activities of daily living	Lawton IADL score: 0/8
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.
Social needs	
Unable to maintain any social activities without assistance.	
Other details	
Also requires significant health care, 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 home care services for severe needs

	Services provided by professional caregiver 41 hours and 15 minutes per week Except where support or supervise is specified, the caregiver must completely take over the activity
Activities of daily living | 24 hours and 45 per week	
Washing and dressing 30 minutes, six times a week	Transfer out of bed, lifting patient into wheelchair
	Support patient to undress and dress again
	Support patient in washing face
	Support patient in hair care, combing
	Washing the patient's upper body, back and lower body
	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
	Support patient in hair care, combing
	Washing the patient's upper body, back and lower body
	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
Instrumental activities of daily living | 14 hours and 30 minutes per week	
Shopping	1 hour of support, twice a week
Cleaning	1 hour, once a week
Prepare meals	1 hour and 30 minutes, per day, in total
Laundry	1 hour, once a week

Social needs | 2 hours per week
For example, being taken out for a walk twice a week.

Typical cases 4A – 4D | Informal care for moderate needs

Description of moderate needs

Activities of daily living | Barthel Index score: 11/20	
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 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 was not considered in questionnaires of phase 1)
	Can leave the house without help 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.
Instrumental activities of daily living | Lawton IADL score: 6/8	
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.
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. If relevant, assume that this person lives alone.	

Description of care provided by spouse | Typical case 4A

The informal carer is an 80-year old spouse, retired (no lost income as consequence of caring), residing with the care recipient, with fair health and no LTC needs, and with all relevant contributions to social insurance paid.

	Services provided by spouse 22 hours and 30 minutes per week Except where support or supervise is specified, the caregiver must completely take over the activity
Activities of daily living | 6 hours per week	
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
	Supervise hair care, combing
	Wash the lower part of the patient's body and back
	Cleaning of care area
Incontinence management 15 minutes, twice a day	Application of new sanitary pads
	Removal and disposal of used ones
Instrumental activities of daily living | 14 hours and 30 minutes per week	
Shopping	1 hour of support, twice a week
Cleaning	1 hour, once a week
Prepare meals	1 hour and 30 minutes, per day, in total
Laundry	1 hour, once a week
Social needs | 2 hours per week	
For example, being taken out for a walk twice a week.	

Description of care provided by spouse and professional caregiver | Typical case 4B

The informal carer is an 80-year old spouse, retired (no lost income as consequence of caring), residing with the care recipient, with fair health and no LTC needs, and with all relevant contributions to social insurance paid. The informal carer provides 12 hours and 30 minutes of the 22 hours and 30 minutes of care.

	Services provided by spouse and professional caregiver 22 hours and 30 minutes per week Except where support or supervise is specified, the caregiver must completely take over the activity
Activities of daily living | 6 hours per week provided by professional caregiver	
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
	Supervise hair care, combing
	Wash the lower part of the patient's body and back
	Cleaning of care area
Incontinence management 15 minutes, twice a day	Application of new sanitary pads
	Removal and disposal of used ones
Instrumental activities of daily living | 14 hours and 30 minutes per week	
Shopping	1 hour of support, twice a week provided by professional caregiver
Cleaning	1 hour, once a week provided by professional caregiver
Prepare meals	1 hour and 30 minutes, per day, in total provided by spouse
Laundry	1 hour, once a week provided by professional caregiver
Social needs | 2 hours per week provided by spouse	
For example, being taken out for a walk twice a week.	

Description of care provided by adult child | Typical case 4C

The carer is the care recipient's adult child, 55 years old, gave up or reduced work to provide care (losing what they would have earned in number of hours spent caring), residing within 5 km of the care recipient, with good health, and with all relevant contributions to social insurance paid.

	Services provided by adult child 22 hours and 30 minutes per week Except where support or supervise is specified, the caregiver must completely take over the activity
Activities of daily living | 6 hours per week	
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
	Supervise hair care, combing
	Wash the lower part of the patient's body and back
	Cleaning of care area
Incontinence management 15 minutes, twice a day	Application of new sanitary pads
	Removal and disposal of used ones
Instrumental activities of daily living | 14 hours and 30 minutes per week	
Shopping	1 hour of support, twice a week
Cleaning	1 hour, once a week
Prepare meals	1 hour and 30 minutes, per day, in total
Laundry	1 hour, once a week
Social needs | 2 hours per week	
For example, being taken out for a walk twice a week.	

Description of care provided by adult child and professional caregiver | Typical case 4D

The carer is the care recipient's adult child, 55 years old, gave up or reduced work to provide care (losing what they would have earned in number of hours spent caring), residing within 5 km of the care recipient, with good health, and with all relevant contributions to social insurance paid. The informal carer provides 12 hours and 30 minutes of the 22 hours and 30 minutes of care.

	Services provided by spouse and professional caregiver 22 hours and 30 minutes per week Except where support or supervise is specified, the caregiver must completely take over the activity
Activities of daily living | 6 hours per week provided by professional caregiver	
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
	Supervise hair care, combing
	Wash the lower part of the patient's body and back
	Cleaning of care area
Incontinence management 15 minutes, twice a day	Application of new sanitary pads
	Removal and disposal of used ones
Instrumental activities of daily living | 14 hours and 30 minutes per week	
Shopping	1 hour of support, twice a week provided by professional caregiver
Cleaning	1 hour, once a week provided by professional caregiver
Prepare meals	1 hour and 30 minutes, per day, in total provided by adult child
Laundry	1 hour, once a week provided by professional caregiver
Social needs | 2 hours per week provided by adult child	
For example, being taken out for a walk twice a week.	

Typical case 5 | Institutional care for severe needs

Description of severe needs

Activities of daily living | Barthel Index score: 4/20	
Mobility	Cannot get up or go to bed independently. Needs to be lifted manually into/out of 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 before losing balance and falling.
	Can only make one or two steps before losing balance even when holding onto a person or object, so is put in a wheelchair for most 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 a car/taxi when accompanied by a caregiver.
	Cannot travel regularly to see the doctor, so requires home visits (the cost of these adaptations was not considered in questionnaires).
Hygiene	Cannot dress or 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 that 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 and 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 that need to be changed twice a day.
	Cannot cut food into pieces but can move food and drink (with straw) to own mouth under supervision.
Food intake	Can cut food into pieces and independently consume food and drinks.
Instrumental activities of daily living | Lawton IADL score: 0/8	
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.
Social needs	
Unable to maintain any social activities without assistance.	
Other details	
Also requires significant health care, 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.	

Description of institutional care services for severe needs

	Services provided by professional caregiver 41 hours and 15 minutes per week Except where support or supervise is specified, the caregiver must completely take over the activity
Activities of daily living | 24 hours and 45 per week	
Washing and dressing 30 minutes, six times a week	Transfer out of bed, lifting patient into wheelchair
	Support patient to undress and dress again
	Support patient in washing face
	Support patient in hair care, combing
	Washing the patient's upper body, back and lower body
	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
	Support patient in hair care, combing
	Washing the patient's upper body, back and lower body
	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
Instrumental activities of daily living	
Whole institution	Laundry, cleaning, preparing and serving meals. Services are provided to all residents, so it is not possible to assign an amount of professional caregiver time for a single care recipient.
Individual level	Help with finances, 20 minutes, once a week
	Help taking medications, 15 minutes daily

Social needs
The institution organises regular social activities for all residents.

Annex B. Sensitivity and uncertainty analyses

153. Modelled and simulated estimates are naturally contingent on a number of assumptions. It is good practice to test the impact of these assumptions on the resulting estimates and associated policy implications. This annex provides two sensitivity and uncertainty analyses.

Poverty thresholds

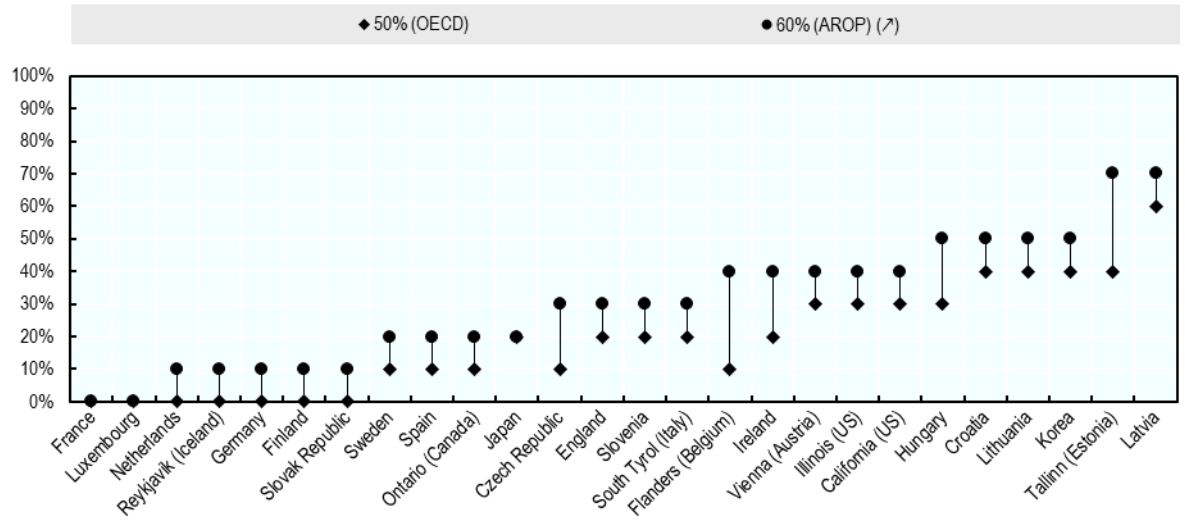
154. As mentioned, the relative income poverty threshold used by the OECD is 50% of median equivalised household disposable income (household income is equivalised using the square root scale). The EU uses a poverty threshold of 60% of the equivalised household median income (the so called at-risk-of-poverty or AROP threshold, with household income equivalised using the OECD-modified scale). This section presents a sensitivity analysis of how relative income poverty rates change depending on which relative income poverty threshold is used.

Impact of different thresholds on poverty rates after social protection

155. The figures below show the impact of different relative income poverty thresholds on the proportion of older people that would fall below the relative income poverty thresholds after paying the out-of-pocket costs of LTC. Figure B.1 shows the proportions of older people that would fall below the EU and OECD relative income poverty thresholds after paying the out-of-pocket costs of *home care for low needs*, assuming they have *no net total wealth* (the most generous case in countries that apply assets-tests). Unsurprisingly, the proportion of older people that fall under the relative income poverty threshold is generally higher when that threshold is set at 60% rather than 50% of the median income in the general population. In some countries and subnational areas, there is no difference, while in Belgium and Estonia the differences can be larger.

Figure B.1. Proportion of old age population that would fall below EU and OECD relative income poverty thresholds after paying for the out-of-pocket costs of home care for low needs

Care recipients have no net total wealth (the most favourable case in countries that apply assets-tests)

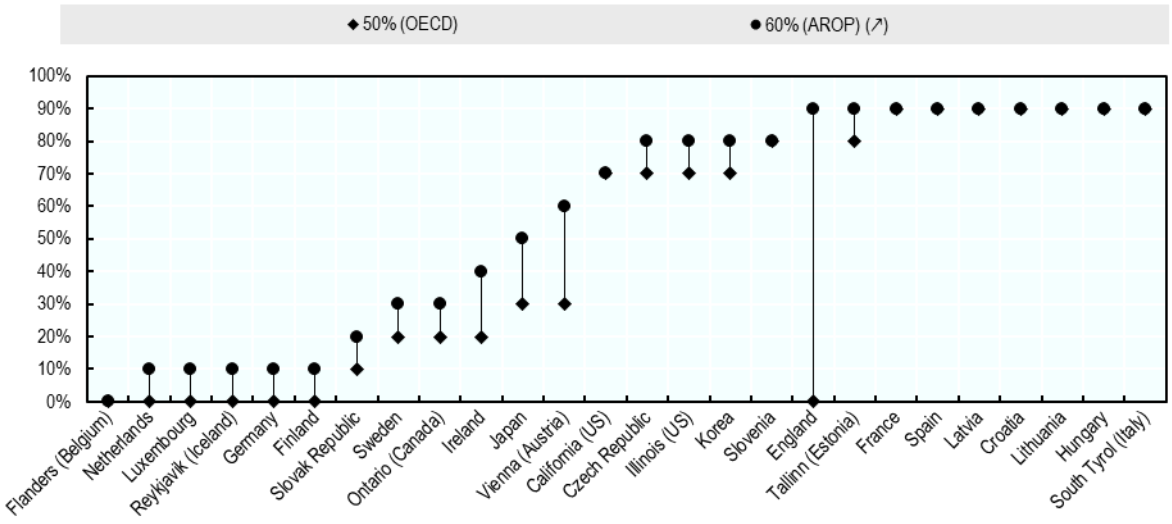


Note: Income distribution is derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Low needs correspond to 6.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being at risk of poverty if their equivalised disposable income is less than 60% of the median equivalised disposable income, and identified as being in relative income poverty if their equivalised disposable income is less than 50% of the median equivalised disposable income, in both cases after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

156. Figure B.2 shows the proportions of older people that would fall below the EU and OECD relative income poverty thresholds after paying the out-of-pocket costs of *home care for moderate needs*, assuming they have *no net total wealth* (the most generous case in countries that apply assets-tests). The standout country is England, where the choice of relative income poverty threshold has a very significant impact on the proportion of older people in relative income poverty after paying for home care for moderate needs. This is because England is a means-tested safety net system, in which benefits are targeted so that older people are left with just enough income (after paying the out-of-pocket costs of care) to stay above the relative income poverty threshold, and that threshold is lower than 60% of the median disposable income (the AROP threshold). The policy implication is that the English system is very effective at keeping older people with LTC needs above the relative income poverty threshold used by the OECD, but not effective at keeping the elderly with LTC needs above the AROP threshold.

Figure B.2. Proportion of old age population that would fall below EU and OECD relative income poverty thresholds after paying for the out-of-pocket costs of home care for moderate needs

Care recipients have no net total wealth (the most favourable case in countries that apply assets-tests)

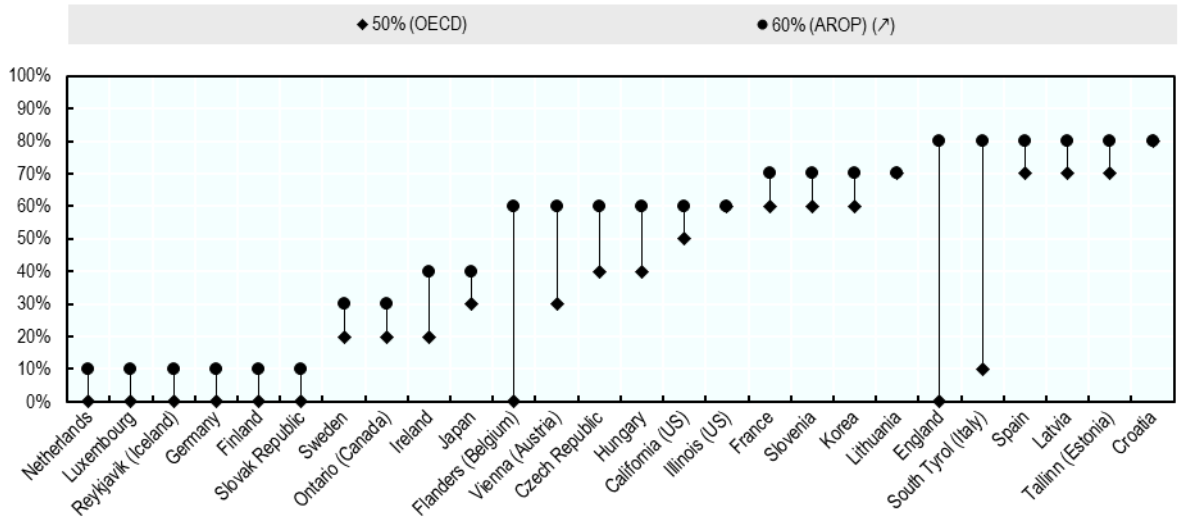


Note: Income distribution is derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being at risk of poverty if their equivalised disposable income is less than 60% of the median equivalised disposable income, and identified as being in relative income poverty if their equivalised disposable income is less than 50% of the median equivalised disposable income, in both cases after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

157. Figure B.3 shows the proportions of older people that would fall below the EU and OECD relative income poverty thresholds after paying the out-of-pocket costs of *home care for severe needs*, assuming they have *no net total wealth* (the most generous case in countries that apply assets-tests). In three countries and regions (Flanders in Belgium, England, and South Tyrol in Italy), the choice of relative income poverty threshold leads to significant changes in the resulting poverty rates and the impact of public social protection systems for LTC. As with home care for moderate needs in England, these differences are likely due to targeting of benefits to the poorest, using a definition of relative income poverty that is lower than the AROP threshold.

Figure B.3. Proportion of old age population that would fall below EU and OECD relative income poverty thresholds after paying for the out-of-pocket costs of home care for severe needs

Care recipients have no net total wealth (the most favourable case in countries that apply assets-tests)

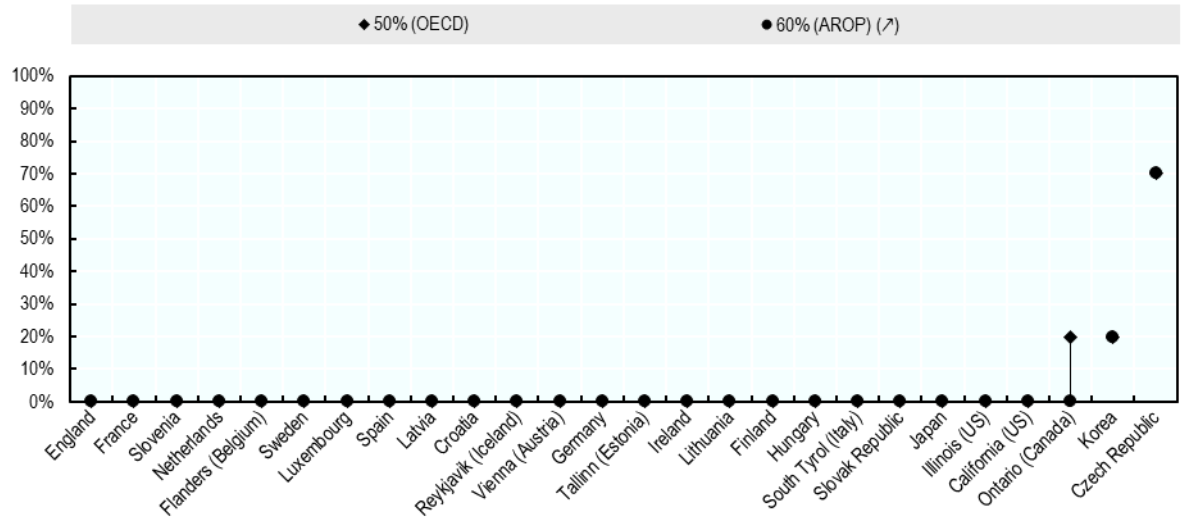


Note: Income distribution is derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Severe needs correspond to 41.25 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being at risk of poverty if their equivalised disposable income is less than 60% of the median equivalised disposable income, and identified as being in relative income poverty if their equivalised disposable income is less than 50% of the median equivalised disposable income, in both cases after social transfers have been taken into account. Countries, regions and municipalities are first sorted based on membership of the European Union.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

158. Finally, Figure B.4 shows the proportions of older people that would fall below the EU and OECD relative income poverty thresholds after paying the out-of-pocket costs of *institutional care for severe needs*, assuming they have *no net total wealth* (the most generous case in countries that apply assets-tests). In all but Ontario, in Canada, the choice of relative income poverty threshold makes no difference in the proportions of older people in relative income poverty after paying for institutional care. In Ontario, the choice of relative income poverty threshold is important.

Figure B.4. Proportion of old age population that would fall below EU and OECD relative income poverty thresholds after paying for the out-of-pocket costs of institutional care for severe needs

Care recipients have no net total wealth (the most favourable case in countries that apply assets-tests)



Note: Income distribution is derived from the incomes of all people of retirement age or older, whether or not they have LTC needs. Severe needs correspond to 41.25 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being at risk of poverty if their equivalised disposable income is less than 60% of the median equivalised disposable income, and identified as being in relative income poverty if their equivalised disposable income is less than 50% of the median equivalised disposable income, in both cases after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

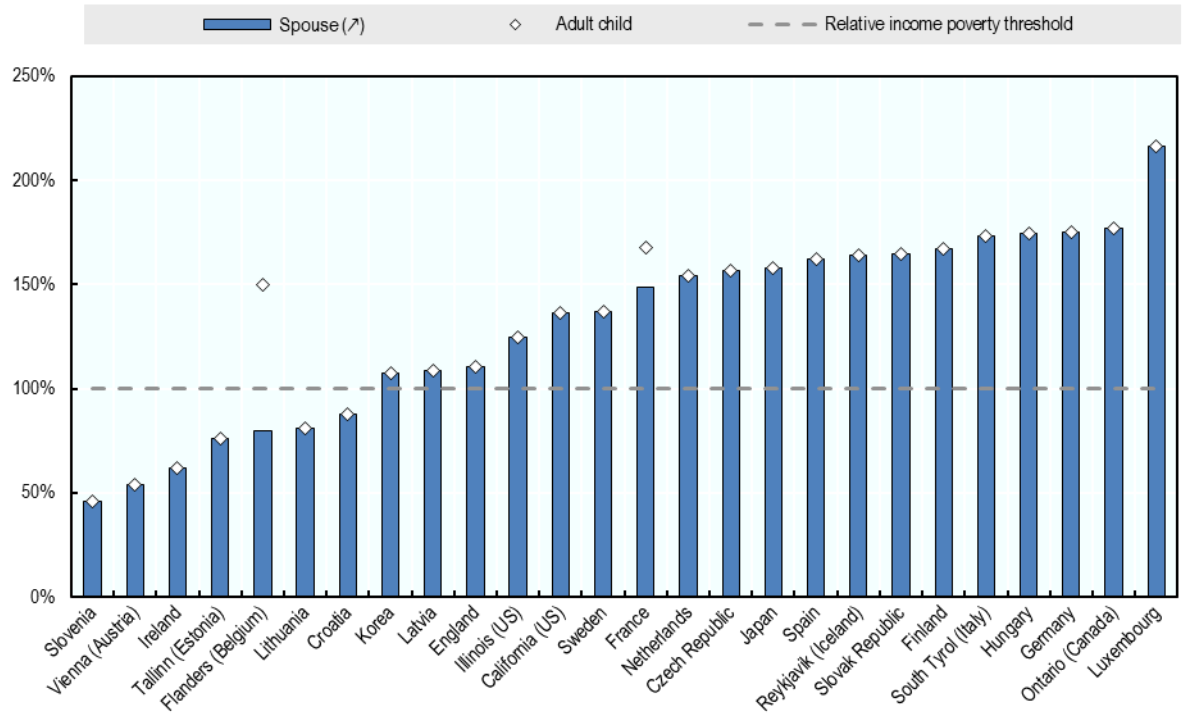
Combining formal care services with informal care

159. As noted in the introduction to this report, all findings and estimates are based on eight typical cases of LTC needs. Statements on the adequacy of LTC benefits and schemes apply to groups of older people that have those defined LTC needs. The national and subnational representativeness of the typical cases of LTC needs used in this report will vary from country to country, region to region, and municipality to municipality, based on how eligibility and levels of public support change as a function of LTC needs. The eight typical cases of LTC needs used in this report cover a wide range of LTC needs and situations.

160. One question that arises is whether older people that combine formal care services and informal care from a spouse or adult child would be able to afford the reduced formal care component (help with ADLs, shopping, laundry and cleaning). The informal care typical cases used in this report help answer this question. Figure B.5 shows the net incomes of older people after paying for *help with ADL for moderate needs*, for a care recipient *earning a median income among people of retirement age or older* and with *mean net total wealth*, as a share of relative income poverty thresholds. Values below the 100% threshold indicate care recipients' incomes – after public support and out-of-pocket costs – fall below the relative income poverty threshold. In seven countries and subnational areas, the out-of-pocket costs of help with ADLs, shopping, laundry and cleaning would be sufficient to push an older person with a median income below the relative income poverty threshold. This means that even when spouses and adult children provide help with meals and social activities, the out-of-pocket cost of the formal care components may be unaffordable from income alone.

Figure B.5. Net income of older people earning a median income with moderate needs after paying for help with ADLs at home, as a share of the relative income poverty thresholds

Care recipients earn a median income and have mean net total wealth

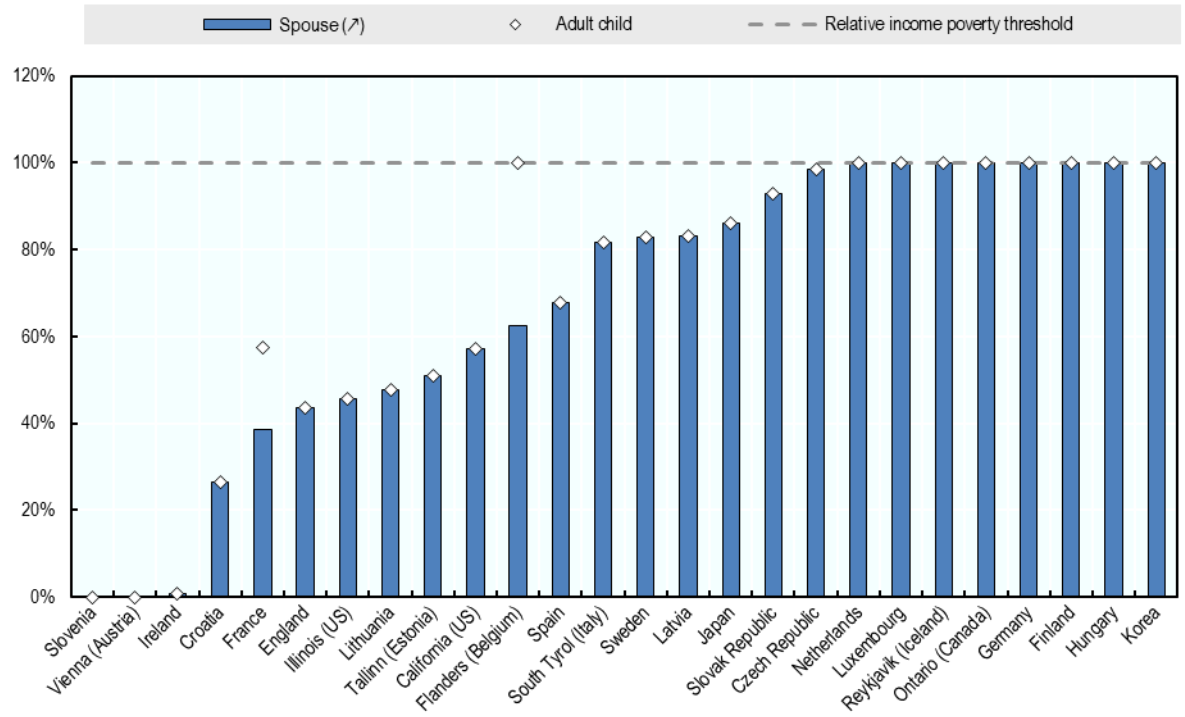


Note: Mean net wealth is for over 65 year olds. For countries with no net total wealth data (Czech Republic, Sweden, Iceland, Croatia, Lithuania) it is assumed mean net wealth is 17 times the median income (based on the average ratio between mean net wealth and median income across OECD countries for which both data are available). It is assumed 52% of mean net wealth is primary residence and 48% is other assets (based on average percentages across OECD countries for which data are available). Net income is equal to disposable income plus all benefits (including benefits for the informal caregiver) minus total costs of care. Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

161. Figure B.6 shows the net incomes of older people after paying for *help with ADL for moderate needs*, for a care recipient *at risk of poverty* (earning just above the relative income poverty threshold) and with *mean net total wealth*, as a share of relative income poverty thresholds. Values below the 100% threshold indicate care recipients' incomes – after public support and out-of-pocket costs – fall below the relative income poverty threshold. In the majority of countries and subnational areas, the out-of-pocket costs of help with ADLs, shopping, laundry and cleaning would be sufficient to push an older person at risk of poverty below the relative income poverty threshold. Again, this means that even when spouses and adult children provide help with meals and social activities, the out-of-pocket cost of the formal care components may be unaffordable from income alone.

Figure B.6. Net income of older people earning a relative poverty income with moderate needs after paying for help with ADLs at home, as a share of the relative income poverty thresholds

Care recipients earn just above the relative income poverty threshold have mean net total wealth



Note: Mean net wealth is for over 65 year olds. For countries with no net total wealth data (Czech Republic, Sweden, Iceland, Croatia, Lithuania) it is assumed mean net wealth is 17 times the median income (based on the average ratio between mean net wealth and median income across OECD countries for which both data are available). It is assumed 52% of mean net wealth is primary residence and 48% is other assets (based on average percentages across OECD countries for which data are available). Net income is equal to disposable income plus all benefits (including benefits for the informal caregiver) minus total costs of care. Moderate needs correspond to 22.5 hours of care per week. Detailed descriptions of care recipients' needs are available in Annex A. Individuals are identified as being in relative income poverty if their equivalised disposable income is less than 50% of the national median equivalised disposable income after social transfers have been taken into account.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, the OECD Income Distribution Database and the OECD Wealth Distribution Database.

Annex C. Modelling framework and process

Background

162. Phase 1 of this project, carried out in 2014 and 2015, and supported by the European Union, successfully developed a methodology for cross-country comparisons based on a set of "typical cases" of LTC need and produced a database of levels of public support in 14 OECD member countries and EU Member States (Muir, 2017[6]).

163. The database constructed in phase 1 consists of numerical estimates of the level of social protection that people with LTC needs receive, and includes results from 14 out of a group of 41 countries comprised of OECD and EU Member States. These estimates have been supplied by delegates and experts from these countries in response to a questionnaire sent out by the OECD in 2014. Each country has carried out its own hypothetical calculations and the database only includes estimates for the specific scenarios included in the questionnaire.

164. In phase 2, the OECD moved from the collection of numerical estimates to the construction of models of the social protection systems that exist in each country. These models codify the rules that determine eligibility for, and levels of, social protection for LTC in each country.

165. This approach has several benefits. First, by working with countries to understand the rules that govern access to, and the level of, LTC services, analyses can focus on the entire distributions of income and assets, as opposed to the few combinations used in phase 1. While estimates continue to be based on a finite number of typical cases of LTC need, social protection can now be assessed at any level of income and wealth. Second, it helps to ensure greater comparability of estimates. With all scenarios modelled in-house, it is easier to standardise any assumptions used. Finally – and perhaps most importantly – these models are able to explain the reasons for any observed differences or gaps in protection, allowing the OECD and EU to provide specific advice to countries on the policies that they could implement to improve social protection.

Annex D. Reference years used in report

Table D.1. Reference years for models of social protection for long-term care and input data

Country	Models	OECD IDD	OECD WDD
England	2016	2016	2015
France	2018	2015	2014
Slovenia	2017	2015	2014
Netherlands	2019	2016	2015
Belgium (Flanders)	2017	2015	2014
Czech Republic	2016	2015	-
Sweden	2016	2016	-
Luxembourg	2018	2015	2014
Spain	2016	2015	2012
Latvia	2018	2016	2014
Croatia	2016	2015	-
Iceland (Reykjavik)	2016	2014	-
Japan	2018	2012	2014
Canada (Ontario)	2018	2015	2016
Austria (Vienna)	2017	2015	2014
Germany	2016	2015	2014
Estonia (Tallinn)	2016	2015	2013
Ireland	2016	2015	2013
US (Illinois)	2018	2016	2016
US (California)	2018	2016	2016
Lithuania	2017	2015	-
Finland	2017	2016	2013
Hungary	2017	2014	2014
Italy (South Tyrol)	2018	2015	2014
Slovak Republic	2016	2015	2014
Korea	2017	2015	2015

Note: IDD – Income Distribution Database; WDD – Wealth Distribution Database; country in IDD and WDD used for England is United Kingdom; for regions and municipalities (e.g. Tallinn in Estonia), the national figures in IDD and WDD are used.

Annex E. Detailed descriptions of means-tests

In all countries and subnational areas, at least some care recipients will have to contribute to the costs of care (i.e. they will face out-of-pocket payments). How these contributions are calculated differs widely across countries and subnational areas, and often in such ways that care recipients might find it difficult to predict their out-of-pocket costs when planning care. lists the benefits and schemes available to older people with defined LTC needs in 25 countries (including two states in the United States) in the OECD and the EU, detailing whether they are provided in-kind or in cash, and if means-tests are applied. Most countries and subnational areas have multiple benefits and schemes (only the Czech Republic and Japan have one comprehensive scheme for all typical cases of LTC needs used here). The question of whether to provide social transfers in the form of cash payments or in-kind services is a recurring one in policy and academic debates. Most countries and subnational areas combine both in-kind and in cash transfers although some systems rely exclusively on cash benefits or purely on in-kind services.

Table E.1. Overview of formal LTC benefits and schemes in the OECD and the EU

Countries and subnational areas	Benefits and schemes	In cash or in-kind?	Income-tested?	Assets-tested?
Vienna (Austria)	Pflegegeld	In cash	No	No
	Fonds Soziales Wien	In-kind	Yes	No
Flanders (Belgium)	Federal Public Health Insurance (NIHDI)	In-kind	Yes	No
	Home care organisations	In-kind	Yes	No
	Service vouchers	In-kind	No	No
	Allowance for the assistance of the elderly	In cash	Yes	Yes
	Incontinence allowance	In cash	No	No
	Flemish care insurance	In cash	No	No
	Allowance for the chronically ill	In cash	Yes	Yes
Ontario (Canada)	Home and community care	In-kind	No	No
	Long-term care homes	In-kind	Yes[1]	No
Croatia	Subsidized home care for low income	In-kind	Yes	Yes
	Allowance for assistance and care	In cash	No	Yes
	Personal disability allowance	In cash	Yes	Yes
Czech Republic	Care allowance	In cash	No	No
England	Attendance allowance	In cash	No	No
	Social care	In-kind	Yes	Yes
Tallinn (Estonia)	Domestic care service	In-kind	Yes	No
	Institutional care	In-kind	Yes	Yes
Finland	Social care services	In-kind	Yes	No
	Care allowance	In cash	No	No
France	Allocation Personnalisée d'Autonomie	In cash	Yes	Yes
	Aide Ménagère	In cash	Yes	No
	Aide sociale à l'hébergement	In cash	Yes	Yes
	Targeted tax reductions	In cash	Yes[2]	No
Germany	Pflegegeld	In cash	No	No
	Pflegesachleistungen	In-kind	No	No
	Social assistance (Sozialhilfe)	In cash	Yes	Yes
Hungary	Assistance at home	Both	Yes	No
	Homes for the elderly	Both	Yes	Yes
Reykjavik (Iceland)	Social home service	In-kind	Yes	No

Countries and subnational areas	Benefits and schemes	In cash or in-kind?	Income-tested?	Assets-tested?
	Home nursing	In-kind	No	No
	Institutional care	In-kind	Yes	No
Ireland	Home support service	In-kind	No	No
	Nursing home support scheme	In-kind	Yes	Yes
South Tyrol (Italy)	Care allowance	Both	No	No
	Home care services	In-kind	Yes	Yes
	Residential services	In-kind	Yes	Yes
Japan	Long-term care insurance	In-kind	Yes	Yes
Korea	Comprehensive Elderly Care Service	In cash[5]	Yes	No
	Long-term Care Insurance for Older Persons	In-kind	Yes[3]	No
Latvia	Home care services	In-kind	Yes	No
	Care allowance	In cash	Yes	No
	Institutional care	In-kind	Yes	No
	State social maintenance benefit	In cash	No	No
Lithuania	Social care	Both	Yes	No
	Social assistance	Both	Yes	No
	Institutional care	In-kind	Yes	Yes
	Municipal support	In cash	No	No
Luxembourg	Long-term care insurance	Both	No	No
	Complément accueil gérontologique	In cash	Yes	No[4]
Netherlands	Wet langdurige zorg (Wlz)	Both	Yes	Yes
	Zorgverzekeringswet (Zvw)	Both	No	No
	Wet Maatschappelijke Ondersteuning (Wmo)	Both	Yes	Yes
Slovak Republic	Compensation allowances	In cash	Yes	No
	Institutional care	In-kind	Yes	No
Slovenia	Municipality-subsidized care	In-kind	Yes	Yes
	Attendance allowance	In cash	No	No
Spain	Ayuda al domicilio	In-kind	Yes	Yes
	Antención Residencial	In-kind	Yes	Yes
	Prestación económica vinculada al servicio	In cash	Yes	Yes
	Prestación económica de asistencia personal	Both	No	No
Sweden	Home care	Both	Yes	No
	Institutional care	In-kind	Yes	No
California (United States)	In home support services	In-kind	Yes	Yes
	Medi-Cal institutional care	In-kind	Yes	Yes
Illinois (United States)	Home and Community Based Services	In-kind	Yes	Yes
	Home and Community Based Services Waiver	In-kind	Yes	Yes
	Medicaid institutional care	In-kind	Yes	Yes

Note: [1]only costs of accommodation are income-tested; [2]tax reductions depend on income; [3]support for institutional care is not income-tested; [4]although the benefit is not asset-tested when it is given, all sums paid through this benefit can be recovered from the care recipient's estate upon death; [5]in Korean legislation, this benefit is considered an in-kind benefit, however since it is a conditional cash transfer, it is categorised here as in cash. Benefits and schemes that are not applicable to the typical cases of LTC needs used in this report are not included in this table. Benefits that are marked as income- or assets-tested if they are income- and/or assets-tested for at least one of the typical cases of LTC needs used in this report. Countries and subnational areas are sorted top to bottom alphabetically by the name of the country.
Source: OECD compilation based on the Long-Term Care Social Protection questionnaire.

166. Some home care benefits and schemes set minimum or maximum contributions based on the care recipients' incomes. In Vienna (Austria), the *Fonds Soziales Wien* defines maximum monthly user contributions ranging from zero for care recipients earning below EUR 624 to EUR 2 039 for care recipients earning EUR 3 308 or more. In Flanders (Belgium), annual user contributions for care provided by the NIHDI are capped at a certain amount, which can be lowered if the care recipient's annual income is less than EUR 17 303.80. Likewise in Japan, monthly user contributions are also capped (at JPY 44 000) but can be reduced (to JPY 15 000 or 24 000) if the care recipient is exempt from the local inhabitant tax.

167. In Flanders (Belgium), three LTC benefits and schemes apply means-tests, all three using different approaches (see below). As mentioned, annual user contributions for care provided by the NIHDI can be capped at a reduced value based on the care recipient's income, but also the hourly user contributions depend on care recipients' incomes. In this case, if the care recipient is entitled to increased reimbursement, then they pay a lower hourly fee (essentially, a binary function). Conversely, user contributions to the hourly costs of care provided by home care organisations increase linearly with income, from EUR 0.51 for care recipients on very low incomes up to EUR 14.14 for a care recipient earning EUR 2 772 or more per month (one hour of home care costs EUR 36.84). Finally, care recipients might be eligible for the allowance for the assistance of the elderly, an income- and assets-tested cash benefit. For the income-test, care recipients can deduct EUR 12 900.46 from their annual income plus 10% of whatever is left. Imputed rent (the income that the care recipient's home would produce if it were rented out in the real-estate market) must be included but only after a deduction of EUR 1 500.

168. In England, social care is both income- and assets-tested. Minimum allowances guarantee that a share of care recipients' incomes is protected and care recipients that have assets worth under GBP 14 250 are eligible for public support covering 100% of the costs of care. Conversely, older people with assets worth over GBP 23 250 receive no public support whatsoever and have to cover the full costs of care out-of-pocket (although they get to keep the minimum allowances from their income).

169. In France, Ireland and the Netherlands, income and assets are added and user contributions depend on the total monetary value of both, but there are a number of deductions. In France, if the care recipient's income plus any assets other than their primary residence add up to less than EUR 810.94 in a given month, then the care recipient is eligible to receive the maximum possible payment for their level of LTC needs (for the APA). The cash benefit is then reduced progressively down to 10% of the maximum possible payment for monthly resources above EUR 2 986.58. The rules are similar in institutional care although the values change (both the thresholds for monthly resources and the percentage of the maximum possible payment). In Slovenia, for institutional care, disposable income is used to determine contributions together with any assets in excess of EUR 2 500 with a deduction of 0.3 times the minimum income. If the resulting sum is insufficient, then municipalities pay the difference.

Box E.1. Determining public support and user contributions in Flanders (Belgium)

An intricate public social protection system with multiple LTC benefits and schemes

There are seven home care benefits and schemes available to older people with LTC needs in Flanders (Belgium). Navigating the rules and regulations for each benefit and scheme can be difficult, especially for older people who may be suffering from cognitive decline. To illustrate, take an older person with moderate needs seeking care at home.

Three needs assessment scales are used in Flanders to assess the older person's LTC needs. The Autonomy scale is used to determine eligibility for the allowance for the assistance of the elderly. The Katz scale is used to determine eligibility for the NIHDI and the incontinence allowance. The BEL scale is used, in Flanders only, to determine eligibility for the Flemish care insurance and care provided by home care organisations.

An older person with moderate needs scores 12 points on the Autonomy scale and so is eligible for the allowance for the assistance of the elderly. They are not eligible for the incontinence allowance. With a score of 25 points in the BEL scale, and category A on the Katz scale, the older person is eligible for both care from the NIHDI and home care organisations.

Hourly user contributions for help provided by home care organisations are income-tested, ranging from EUR 0.51 for older people on low incomes and EUR 14.14 for those earning above EUR 2 772. There is a surcharge of 30% for care provided on Saturdays and of 67% for care provided on Sundays.

This older person can purchase service vouchers at the cost of EUR 9 per hour. There is a tax rebate of EUR 2.70 for each voucher resulting in a net cost of EUR 6.30 (which is not income-tested). Even older persons with low incomes who do not pay income tax are entitled to the tax rebate.

An older person with moderate needs is eligible for Category 3 of the means-tested (both income- and assets-tested) allowance for the assistance of the elderly, a cash benefit. The maximum possible payment for this category is EUR 4 556.11 per year. The actual value of the cash benefit is determined using the following rule:

Annual income × 90% - EUR 12 900.46

+ Assets other than primary residence × 6%

+ (Imputed rent - EUR 1 500) × 100%

= Income and assets used to determine allowance

If the resulting sum of income and assets is greater than EUR 4 556.11, then the allowance for the assistance of the elderly is zero. For sums lower than EUR 4 556.11, the value of the allowance increases progressively, until it reaches the maximum value for persons with very low income and assets.

This older person may be entitled to increased reimbursement if their annual income is lower than EUR 17 303.80, and they are entitled to the allowance for the assistance of the elderly.

The user contributions for care provided by NIHDI depend on the Katz score and on whether the older person is entitled to increased reimbursement. The user contributions for an older person with moderate needs (Category A of the Katz scale) are EUR 4.31 per day for weekdays, and EUR 6.44 per day for Saturdays or Sundays. If the care recipient is eligible for increased reimbursement, then user contributions are EUR 0.25 for both weekdays and weekends. The NIHDI also has an annual ceiling on user contributions. If the care recipient is eligible for increased reimbursement, then the annual ceiling

is EUR 450. If the care recipient is not eligible for increased reimbursement, the annual ceiling is income-tested using a step function (see Table E.2).

Table E.2. Annual ceilings on user contributions to care provided by NIHDI

Annual income of care recipient	Annual ceiling on user contributions
Up to EUR 17 780.17	EUR 450
Between EUR 17 780.17 and EUR 27 333.69	EUR 650
Between EUR 27 333.69 and EUR 36 887.24	EUR 1 000
Between EUR 36 887.24 and EUR 46 024.70	EUR 1 400
Above EUR 46 024.70	EUR 1 800

Source: OECD Long-Term Care Social Protection questionnaire.

An older person with moderate needs may also be entitled to the allowance for the chronically ill depending on their annual contributions to care provided by the NIHDI. For annual contributions above EUR 450 (or EUR 350 if the care recipient is eligible for increased reimbursement), the care recipient receives an allowance of EUR 450.18.

Finally, the care recipient can combine these different benefits and schemes so that they cover different LTC needs. Home care organisations can provide help with ADLs and IADLs. Service vouchers can be used to pay for help with IADLs and social activities. The NIHDI can only be used for help with ADLs. Based on these constraints, there are four possible combinations of these different benefits and schemes, with different total costs, levels of public support and out-of-pocket costs to care recipients.

170. In the Netherlands, user contributions to home care provided by the Wmo, are both income- and assets-tested. In home care, the starting point is the care recipient's annual gross income. To this figure, 8% of all assets over EUR 21 330 are added. A deduction of EUR 16 887 is then made (since the care recipient is considered a pensioner). From the resulting sum, 15% is used to make user contributions (divided into 13 contributions, or periods, in one year). Each contribution cannot be lower than EUR 19.40.

171. In Ireland, the nursing home support scheme requires that 80% of the care recipient's income and 7.5% of their assets (for single households) be set aside to pay for the costs of care. However, a number of possible deductions, exclusions and minimum allowances can lead to lower user contributions. For instance, the care recipient can exclude EUR 36 000 worth of assets from the assets-test, and their primary residence is only included in the first three years of institutional care use.

172. In South Tyrol (Italy), user contributions for home care costs are based on the *indicatore della situazione economica equivalente* (ISEE), an indicator which takes into account household income, assets and basic living expenses The ISEE is equal to the sum of deducted income and assets, divided by basic living expenses (the base amount of EUR 408 is adjusted for household composition). For an ISEE of up to 1.1, there is a minimum user contribution of EUR 3.90 per hour of care (the actual cost is EUR 48 per hour). The user contribution then increases progressively, according to a function that depends on the care recipient's LTC needs. Up to EUR 20 000 in assets plus 80% of any remaining assets can also be excluded.

173. User contributions to the costs of home and institutional care in Spain are based on intricate formulas. These take into account the intensity of care (the number of hours provided), the care recipient's income and assets, and the *Indicador Público de Renta de Efectos Múltiple* (IPREM[22]). Individuals who

[22] The IPREM is a reference index used in the Spanish welfare system and amounted to EUR 537.83 per month in 2018.

earn less than the IPREM are exempt from user contributions while, for older people with moderate and severe needs[23], user contributions are calculated using a defined formula[24]. Regardless of the resulting sum, user contributions cannot be lower than EUR 20 per month nor higher than 90% of the total costs.

Table E.3. Means-tested and non-means-tested benefits and schemes for home care

Countries and subnational areas	Has home LTC benefits and schemes that are:			
	Both income- and asset-tested	Income-tested only	Assets-tested only	Non-means-tested
Vienna (Austria)	No	Yes	No	Yes
Flanders (Belgium)	Yes	Yes	No	Yes
Ontario (Canada)	No	No	No	Yes
Croatia	No	Yes	Yes	No
Czech Republic	No	No	No	Yes
England	Yes	No	No	Yes
Tallinn (Estonia)	No	Yes	No	No
Finland	No	Yes	No	Yes
France	Yes	Yes	No	No
Germany[1]	Yes	No	No	Yes
Hungary	No	Yes	No	No
Reykjavik (Iceland)	No	Yes	No	Yes
Ireland	No	No	No	Yes
South Tyrol (Italy)	Yes	No	No	Yes
Japan	No	Yes	No	No
Korea	No	Yes	No	No
Latvia	No	Yes	No	Yes
Lithuania	No	Yes	No	Yes
Luxembourg	No	No	No	Yes
Netherlands	Yes	No	No	Yes
Slovak Republic	No	No	No	Yes
Slovenia	Yes	No	No	Yes
Spain	Yes	No	No	Yes
Sweden	No	Yes	No	No
California (United States)	Yes	No	No	No
Illinois (United States)	Yes	No	No	No
Number of countries/regions	10/25	11/25	1/25	16/25

Note: [1]Germany includes social assistance (Sozialhilfe). Benefits and schemes are income- and assets-tested when the level public support changes with care recipients' incomes and assets. Benefits and schemes are income-tested only when public support changes with care recipients' incomes but not assets, and vice versa for assets-tested only benefits and schemes. Non-means-tested benefits and schemes provide the same level of public support to all care recipients, regardless of care recipients' income or assets. Countries and subnational areas are sorted top to bottom alphabetically by country name.
Source: OECD compilation based on the Long-Term Care Social Protection questionnaire.

[23] For low needs, the formula for user contributions uses 40% instead of 33%.

[24] ((33% × hourly costs × (income + 5% × assets other than care recipient's primary residence)) / IPREM) – 30% × hourly costs

Table E.4. Means-tested and non-means-tested benefits and schemes for institutional care

Countries and subnational areas	Has institutional LTC benefits and schemes that are:			
	Both income- and asset-tested	Income-tested only	Assets-tested only	Non-means-tested
Vienna (Austria)	No	Yes	No	Yes
Flanders (Belgium)	Yes	No	No	Yes
Ontario (Canada)	No	Yes	No	No
Croatia[1]	No	Yes	No	Yes
Czech Republic	No	No	No	Yes
England	Yes	No	No	Yes
Tallinn (Estonia)	Yes	No	No	No
Finland	No	Yes	No	Yes
France[1]	Yes	Yes	No	No
Germany[2]	No	Yes	No	Yes
Hungary	Yes	No	No	No
Reykjavik (Iceland)	No	Yes	No	No
Ireland	Yes	No	No	No
South Tyrol (Italy)	Yes	No	No	Yes
Japan	Yes	No	No	No
Korea	No	No	No	Yes
Latvia	No	Yes	No	Yes
Lithuania	Yes	No	No	Yes
Luxembourg[1]	No	Yes	No	Yes
Netherlands	Yes	No	No	No
Slovak Republic	No	No	No	Yes
Slovenia	Yes	No	No	Yes
Spain	Yes	No	No	No
Sweden	No	Yes	No	No
California (United States)	Yes	No	No	No
Illinois (United States)	Yes	No	No	No
Number of countries/regions	14/25	10/25	0/25	14/25

Note: [1]deferred payment from assets; [2]Germany includes social assistance (Sozialhilfe). Benefits and schemes are income- and assets-tested when the level public support changes with care recipients' incomes and assets. Benefits and schemes are income-tested only when public support changes with care recipients' incomes but not assets, and vice versa for assets-tested only benefits and schemes. Non-means-tested benefits and schemes provide the same level of support for all care recipients, regardless of how much income or assets care recipients have. Countries and subnational areas are sorted top to bottom alphabetically by the name of the country.
Source: OECD compilation based on the Long-Term Care Social Protection questionnaire.

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