# Care regimes and their relevance for projecting long-term care needs and impacts on caregivers

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# Objectives

- Setting the stage for dynamic microsimulation projections:
  - Providing analytical framework to understand features and vulnerabilities of different care systems
  - Examining factors influencing current care demand and its fulfillment and salient issues to be addressed with the model-based projections.

- Particular attention to how different care systems and policies influence size and composition of the caregiving groups in society:
  - Formal-informal care mix, gender differences and role of migration
  - Implications for employment and the LTC labour market

# The “Care Regimes” Literature

- Comparative LTC literature, different strands going back to 1990s:
  1. Early literature with broad approach, encompassing different forms of care/social services (Anttonen and Sipilä, 1996; Kautto, 2002; Leitner, 2003; Bettio and Plantenga, 2004).
  2. Studies with specific focus on LTC regimes (mainly for age groups 65+) (Kraus et al., 2010; Damiani et al., 2011; Halásková et al., 2017; Ariaans et al., 2021; Pavolini 2021)
  3. Comparative research on specific features of LTC systems, f.i. role of cash-for-care schemes or the link between care work and migration (van Hooren, 2012; Ranci et al., 2019)

- Large number of different approaches and diverse set of countries/time periods -> no simple, clear systematization possible

# The “Care Regimes” Literature

- Choice of criteria and indicators to describe systems necessarily reflects a particular perspective and line of research

- Main dimensions used in the literature:
  - Financing (taxes vs insurance, public vs private…)
  - Regulations (coverage and entitlement)
  - Supply of care (particularly formal/informal mix)

- Comparatively little attention on output indicators for situation of caregivers and systemic implications for their employment perspectives and LTC labour market

# The WELLCARE countries within the “Care Regimes” Literature / **Focus on institutional characteristics**

| Study | Austria | England/UK | Spain |
|---|---|---|---|
| **Leitner (2004)** | Explicit familialism | | Implicit familialism |
| **Damiani et al. (2010)** | High levels of both LTC and social benefits expenditures serving the elderly population, low level of formal care | | Lower LTC and social benefits expenditure, low level of formal care |
| **Kraus et al. (2010)** | LTC systems characterized by medium public spending, large role of informal care use, medium formal care use, high share of private expenditure, high reliance on cash transfers, high support for informal care (benefits for recipients, income support for caregivers…) | | |
| **Schulmann et al. (2019)** | Standard care-mix cluster: Medium/high demand for care, medium/low provision of informal care, medium provision of formal care | | Family based: High demand for care, high provision of informal care, low provision of formal care |
| **Expanded on Ariaans et al. (2019)** | Private supply system | Evolving private need-based system | Evolving private need-based system |
| **Leichsenring (2020)** | Austria in same cluster as England and Spain: Subsidiary LTC regime: Defined access, rationing of services, balancing residential and community care; strong reliance on cash benefits; market-oriented governance; users as customers with related rights | | |
| **Expanded on Pavolini (2021)** | Strong state intervention through cash benefits | Strong state intervention through cash benefits | Mild state intervention through cash benefits |

# The WELLCARE countries within the “Care Regimes” Literature / **Focus on caregivers and employment**

| Study | Austria | England/UK | Spain |
|---|---|---|---|
| **Simonazzi (2009)** | Creation of mixed formal and informal market, with mixed employment models (reliance on migration) | Creation of formal labour market, with mixed employment models (reliance on migration) | Creation of informal market with stronger reliance on migration |
| **Bartha and Zentai (2020)** | Close to double earner, supported carer ideal type | Loosely fitting the double earner, supported carer ideal type | Loosely fitting the double earner, unsupported carer ideal type |
| **Lightman (2018; 2020)** | Corporatist care regime: “mixed” model, traditional or modified male breadwinner model but with supportive policies | Liberal care regime: services primarily purchased on the market, no guarantee of universal access, outsourcing | Familialistic care regime: (legal) obligation to care for dependent family members and only means-/need-tested public care |
| **Le Bihan and Da Roit (2019) in 1990** | Unsupported familialism: No IC policies, weak/no service development | Optional familialism through market: support for IC, market service development | Unsupported familialism: No IC policies, weak/no service development |
| **Le Bihan and Da Roit (2019) since 1990** | Austria and Spain have both moved in the direction of England, i.e. optional familialism through market: support for IC, market service development | | |

# The WELLCARE countries within the “Care Regimes” Literature - Synthesis

- Countries often associated with same or similar care regime, because of:
  - Split between formal and informal care
  - Presence of cash-for-care benefits
- Tendency for convergence on familialistic model where home-care is fostered and supported, with choice given to families to purchase paid care
- Differences are however more pronounced (and persistent) when we look at:
  - Levels of expenditure/financial support (lower in ES than in AT and England/UK)
  - Role of market and employment models (see f.i. Simonazzi, 2009)

# The care systems in Austria, UK/England and Spain

- Demographic risks – Health risks
- Macroeconomic relevance and financing LTC
- Cash-for-care systems
- LTC basic regulation
- Distribution of public expenditure for LTC services
- Commodification – types of care
- Unmet care needs
- Gendered LTC
- Support for informal caregivers
- The LTC labour market

# Demographic risks in a nutshell

| | Austria | UK | Spain |
|---|---|---|---|
| **Dependency rate** (Persons 65+ compared to 20-64*100) | | | |
| 2021 | 32 | 32 | 33 |
| 2050 | 52 | 46 | 59 |
| **Intergenerational support rate** (Persons 80+ compared to 50-64*100) | | | |
| 2021 | 26 | 25 | 28 |
| 2050 | 60 | 51 | 64 |

Source: OECD Database, Population Projections

- Spain highest demographic risks, followed by Austria
- UK shows the lowest demographic risks

# Health risks

| | Austria | UK (2018) | Spain |
|---|---|---|---|
| **Share of adults aged 65+ rating their own health as poor or very poor (2021)** | 17% | 12% | 19% |
| **Share of adults aged 65+ with severe or some limitations in daily activities (2021)** | Severe limitations: 18%<br>Some limitations: 31% | Severe limitations: 21%<br>Some limitations: 24% | Severe limitations: 12%<br>Some limitations: 37% |
| **Share of adults aged 65+ with at least 3 ADL limitations** | 7% | 9.5% (England) | 9.5% |
| **Estimated prevalence of dementia (per 1,000 pop)** | | | |
| 2021 | 16 | 13 | 17 |
| 2040 | 22 | 16 | 24 |

Sources: Eurostat Database (EHIS), Banks et al. 2022, Costa-Font et al., 2022, SHARE, Institute for Health Metrics and Evaluation (IHME). Global Burden of Disease Study 2019.

- UK shows less health risks than Austria and Spain
- Differences in the actual and projected prevalence of dementia – with UK having lower risks

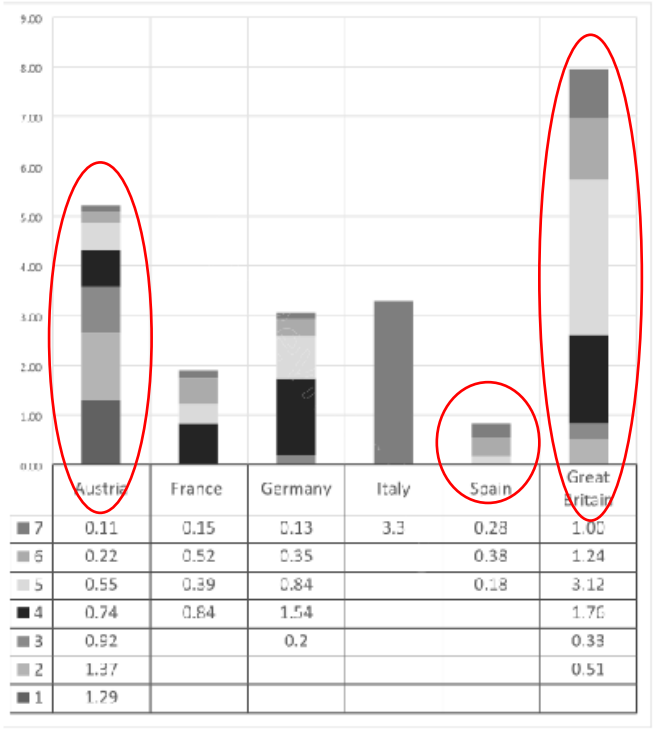
# Macroeconomic relevance and financing LTC

| | Austria | UK | Spain |
|---|---|---|---|
| **Share of public LTC expenditure of GDP (2021)** | 1.6% | 2.6% | 1.0% |
| **Public financing of LTC** | Federal taxes | Federal and regional taxes | Federal and regional taxes |

Source: OECD Health Statistics 2023 (Austria underreporting Social LTC)

- Higher public LTC spending in UK and Austria than in Spain
- All countries finance the public LTC spending through taxes (no public insurance system)

# Cash-for-care systems



| | Austria | France | Germany | Italy | Spain | Great Britain |
|---|---|---|---|---|---|---|
| 7 | 0.11 | 0.15 | 0.13 | 3.3 | 0.28 | 1.00 |
| 6 | 0.22 | 0.52 | 0.35 | | 0.38 | 1.24 |
| 5 | 0.55 | 0.39 | 0.84 | | 0.18 | 3.12 |
| 4 | 0.74 | 0.84 | 1.54 | | | 1.70 |
| 3 | 0.92 | | 0.2 | | | 0.33 |
| 2 | 1.37 | | | | | 0.51 |
| 1 | 1.29 | | | | | |

FIGURE 1 Coverage rates (on the overall population) by levels of disability as stated in the national regulations
*Source.* Own elaboration on national data.
*Note.* To allow for comparability, Level 7 includes beneficiaries in the highest disability level in all the countries (this does not necessarily correspond to the numbering of levels in the respective country). Data for Great Britain include AA, PIP (since 2013), and DLA (replaced by PIP in 2013 but still in force for children and those already in the programme). The number of levels were reduced to six combining together classes from different programmes with equal or similar amount of benefits. Year: Italy, Austria, and the Great Britain (2015); France and Germany (2016), Spain (2018) [Colour figure can be viewed at wileyonlinelibrary.com]

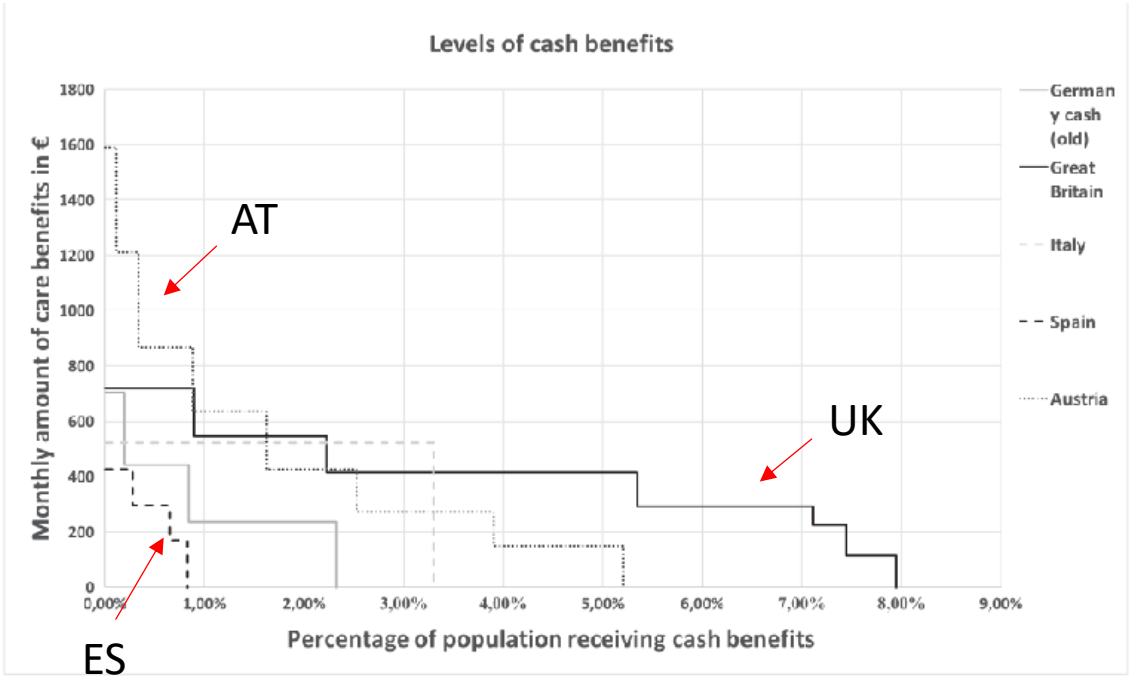



**FIGURE 3** Coverage rates and amount of benefits of cash-based programmes by disability classes
*Source.* Own elaboration on national data.
*Note.* Amounts adjusted by PPPs (1 = EU28), 2015 values except for Spain (2018). Year: 2015, except for France (2016) and Spain (2018). Number of beneficiaries divided by total population (also for France, where the APA is restricted to population aged 60 or more)

- AT: highest level of support for people with strong limitations
- UK: lower levels of support, but covering a higher share of the population
- ES: lower levels of support, only covering a low share of the population

Ranci et al. 2019

# LTC basic regulation and benefits

| | Austria | England | Spain |
|---|---|---|---|
| Main forms of support | • LTC allowance: 7 levels (needs-tested) (federal state)<br>• Support for LTC services (means- and needs-tested) (regions)<br>• Financial support for live-in carers (federal state) | • NHS funds LTC for „complex health needs“ (not social care)<br>• Attendance allowance or Personal Independence Payments (needs tested)<br>• Carers allowance (needs tested)<br>• Support for LTC services by local authorities (means- and needs-tested) | • Assessment: 3 levels, individual care plan<br>• If LTC services cannot be provided -> cash benefits<br>• 40-50% receive cash benefit |
| LTC providers | Not-for-profit, for-profit and public providers | Mostly privately owned providers | Residential care predominantly for-profit private providers, home care: public and private providers |
| Noteworthy | No wealth-test for institutional care (only income) | Support for LTC services subject to a very low wealth treshold (planned to be changed in 10/2025) | Budget cuts due to austerity policy led to a long waiting list for LTC services |

- The majority of LTC is provided by unpaid caregivers in all countries
- Health and LTC separate systems in all countries
- Budget cuts in UK and Spain due to austerity policy in the 2010s, expansion in Austria

# Distribution of public expenditure for LTC services

| | Austria | England | Spain |
|---|---|---|---|
| **Share of public expenditure on institutional care** | 83% | 66% | 64% |
| **Share of public expenditure on home care and day centers** | 17% | 34% | 36% |

Sources: Banks et al. 2022, Costa-Font et al. 2022, BMSGPK 2023

- More ressources on institutional care, especially in Austria

# Commodification - Types of care (65+)

| | Austria | (England) | (Spain) |
|---|---|---|---|
| **Only formal care** | 22% | 5% | 27% |
| **Only informal care** | 42% | 70% | 49% |
| **Formal and informal care (mixed)** | 19% | 11% | 10% |
| **Care in nursing homes** | 17% | 14% | 14% |

Sources: Banks et al. 2022, Costa-Font et al. 2022, SHARE

- Very low level of only formal care and high level of only informal care in the UK – substantially higher level of only formal care in Spain (Austria in between)
- Care in nursing homes – equal levels in all countries

# Unmet LTC needs

| | Austria | UK | Spain |
|---|---|---|---|
| **Unmet long-term care needs among people aged 65+ living at home with at least 3 ADL/IADL limitations, (2019/20)** | 27% | na | 34% |
| **Share of the population 65+ with at least three ADL or IADL limitations, no care received** | 18% | na | 22% |

Sources: OECD Health at a glance (2023), OECD Beyond Applause? (2023), based on SHARE

- Relatively high unmet care needs in Austria and Spain for people with limitations
- Higher unmet care needs in Spain than in Austria

# Gendered LTC

| | Austria | UK | Spain |
|---|---|---|---|
| **Informal caregivers: Share women** | (73%) | 58% | 58% |
| **Formal caregivers: Share women (2021)** | 87% | 83% | 81% |

Sources: Banks et al. 2022, Costa-Font et al. 2022, OECD Health Statistics, Nagl-Cupal et al. (2018)

- Formal care is highly gendered in all countries
- Informal care less gendered

# Support for informal caregivers

| | Austria | UK | Spain |
|---|---|---|---|
| **Direct cash benefit to informal carer** | Yes | Yes | Yes |
| **Formal indirect cash benefit to carers** | Yes | Yes, on exceptional grounds | Yes |
| **Income tested** | Yes | Yes | Yes |
| **Social security coverage** | Yes | Yes | Yes |
| **Paid care leave** | Yes | No | No |
| **Unpaid care leave** | Yes | No | Yes |

Sources: Rocard & Llena-Nozal (2022), OECD Health Working Papers, No. 140, OECD Publishing, Paris.

- Support for informal carers in all countries – under conditions
- Austria the only country with a paid care leave

# LTC Labour market

| | Austria | UK | Spain |
|---|---|---|---|
| **Share of foreign-born workers in LTC (share of foreign-born workers in the labour market)** | 33% (22%) | 24% (18%) | 27% (17%) |
| **Number of LTC workers as share of total employment (2021)** | 1.6% | 2.2% | 2.3% |
| **Projected share of LTC workers in total employment by 2033, baseline scenario** | 2.1% | 2.8% | 3.1% |
| **Education level of LTC workers (low/medium/high, %)** | 13/72/16 | 16/54/30 | 35/45/21 |
| **Number of LTC workers per 1,000 people aged 65+** | 41 | 56 | 49 |

Sources: OECD Beyond Applaus? (2023)

- Overproportional share of foreign-born workers in LTC in all countries
- Increasing share of LTC workers in all countries
- In Austria, concentration of medium level education of LTC workers
- Strong differences in the number of LTC workers in relation to old people, with UK most workers

# Conclusions /I

- How different systems and policies influence size and composition of caregiving groups
  - All three countries (still) characterized by large role for informal care -> informal care increasingly under pressure (better education of women -> stronger LM integration, lower fertility rates, pensions reforms with women working longer)
  - Substantial differences with respect to role of LTC for labour markets/formal employment, related to:
    - Levels of expenditure (-> driver of formal care sector)
    - Design of cash-for-care benefits
  - Common reliance on migration to sustain supply of care, but difference in:
    - Composition of LTC workforce by qualification
    - Different position of migrant workers

# Conclusions /II

- Issues to be addressed with the microsimulation model:
  - Implications of demographic change for demand and supply of care, especially:
    - Evolution of demand for care (based on care needs) and costs (high uncertainty -> longer lives, changes in morbidity)
    - Evolution of supply for informal care (effects of socio-demographic change)
    - Evolution of unmet care needs/care gap -> vulnerabilities; quantification of unmet needs; required nursery homes vs. home care; support for informal care
    - Evaluation of policy options using scenarios
    - Distributional issues, captured in NTA/NTTA accounting