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How Vulnerable are Care Systems to Future Changes in Demand and Supply?

Providing a Framework to Compare Austria, Spain, UK and Canada

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Abstract

This paper examines the evolving landscape of long-term care (LTC) provision in Austria, Spain, UK and Canada, four countries included in the collaborative research project WellCARE. Its aim is to provide a basis to understand the features and vulnerabilities of different care systems, highlighting the mechanisms affecting how and to what extent the demand for care is met today, and identifying the salient issues that will have to be addressed in the future. In the first part, we give an overview of different care regime classifications to provide the analytical framework for comparing and identifying the relevant traits of care systems as well as their trajectories over time. In the second part, we analyse the current care systems in the four countries in greater detail, using recent data covering a broad range of dimensions. Particular attention is paid to analysing how different factors influence the size and composition of the caregiving groups in society. Our analysis reveals the critical role of informal care in all countries, underscored by societal changes such as higher female labour force participation and declining fertility rates. While varying degrees of decommodification characterise LTC systems, all nations grapple with challenges of supply shortages and lengthy waiting lists, particularly in Canada and Spain. Microsimulation modelling is identified as a valuable tool for projecting future LTC demands and assessing policy interventions, accounting for demographic shifts, changing morbidity patterns, and social dynamics.

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1. Introduction[1])

This paper is part of the work on WellCARE, a collaborative research project funded as part of the JPI More Years Better Lives initiative. WellCARE investigates how the welfare state, the market, and the family interact to provide care along the lifecycle, and how economic and demographic changes will affect the demand and supply of care in a selection of highly industrialized, ageing countries (Austria, England, Spain, and Canada). The COVID-19 pandemic has made more evident how the market economy relies on non-market economic activities to provide welfare in general and especially care to dependent persons. At the same time, it has highlighted how the informal care economy is associated with gender gaps and how institutional settings shape the role and well-being of caregivers.

An important objective of the project is the development of the dynamic microsimulation model microWELT, to simulate and project into the future measures of care provided formally by the market or the government and informally by the family. The analyses carried out with this tool will help to identify challenges for care systems and form the basis for formulating policies to adapt the existing systems. The present study sets the stage for these projections by providing an analytical framework to understand the features and vulnerabilities of different care systems, highlighting the mechanisms affecting how and to what extent the demand for care is met today, and identifying the salient issues that will have to be addressed with the model-based projections. The focus of the analysis is on long-term care (LTC) of the population aged 65+. This choice should not detract from the relevance that LTC can have for younger population groups, nor from the importance of other care dimensions, most notably childcare, and the interdependencies that exist between these different care sub-systems. As noted by Gruber et al. (2023), in many countries a significant share of institutionalized LTC is devoted to those below age 65. The impact of ageing on affluent societies and their public budgets is however most clearly linked to the rising share of older persons and the strong increase in care needs for these persons. Focusing on LTC and on the older population also makes it easier to compare the systems of different countries, which remains a challenging task.

Demographic change will increasingly challenge public finances. Demographic forecasts show that the older population will increase substantially in all WellCARE countries. It is expected that a significant proportion of these people will require publicly supported care services. In the coming decades, the number of people in need of care will rise sharply (e.g., European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021). This finding is reflected in various analyses of the sustainability of public finances. The Ageing Report of the European Commission (2021) projects a significant increase in long-term care expenditure: from 1.8% of GDP in 2019 to 2.5% in 2040 and 3.2% in 2050. The issue of public spending on long-term care is therefore central to the future economic sustainability of the public sector.

[1]) We thank Philipp Warum for valuable research assistance on the Austrian SHARE data and Martin Spielauer for helpful comments.

In this study, as well in the WellCARE project in general, particular attention is paid to analysing how different care systems and policies influence the size and composition of the caregiving groups in society, combining formal and informal care, gender-mix of caregivers, the role of family vs the role of the state, and the relevance of migration as a component of care supply. An important issue concerns the (social) costs of informal care, which are often overlooked but should be part of any assessment of present care arrangements and future changes resulting from demographic and economic shifts. According to the calculations provided by Gruber et al. (2023) for a sample of ten developed economies, "informal care comprises at least one-third of all long-term care spending for all nations, with an average portion of nearly fifty percent" (Gruber et al., 2023, p. 6). Over-reliance on informal carers, particularly when these persons are not adequately supported, can drive their early exit or marginalization from the labour market, negatively affect the health and well-being of these persons and, given the fact that they are mostly women, exacerbate social inequalities based on gender (Pavolini, 2021).

Connected to institutional drivers of the mix between formal and informal care is also the split between natives and migrants as providers of care services. Numerous countries have met the shortage of care workers with large inflows of immigrant workers, the vast majority of them women (Da Roit & Weicht, 2013; Lightman, 2019; Simonazzi, 2009). These workers are employed in the formal as well the informal sector. Particularly in Southern European countries but also in Austria and Germany, many households have hired live-in caregivers from abroad to cover for familial care needs (Schmidt et al., 2016). The literature has mostly focused on the working conditions and experiences of migrant workers in formal and, especially, informal care arrangements. Less attention has been devoted to assess the implications that the reliance on migration to cover gaps in care supply might have for future developments and the associated vulnerabilities. This issue is salient also because demographic change will not only affect the demand-side but also the supply-side of LTC, leading to a lower number of persons who are available to provide informal care to family members.

This report is structured as follows: In the first part, we give an overview of different care regimes classifications to provide the analytical basis for comparing and identifying the relevant traits of care systems. In the second part, we analyse the current care regimes in the four WellCARE countries in greater detail. We describe the care systems against the background of the stated research objectives and illustrate these systems using a collection of aggregated data. The aim is to highlight similarities and differences between the countries, with special attention to the mechanisms and institutional interdependencies that determine the distribution of roles in the provision of care services. Based on these insights, in the final part of the paper the main vulnerabilities of care systems with respect to future developments of demand and supply are discussed.

2. The WellCARE countries and the literature on long-term care regimes

Starting in the 1990s, researchers have made numerous attempts to isolate the crucial features of systems to provide, organize and finance care in mature welfare states, with the objective to identify typologies and propose classifications as basis for systematic comparisons and policy recommendations. In view of the large number of existing typologies, the added value of a further classification in care systems would be low. Instead, in Section 2.1 we start by briefly overviewing the comparative literature and the position of the WellCARE countries within this research. Our aim is to show which core elements are crucial for understanding a national care system and identifying its vulnerabilities, resulting from shifts in demand but also from constraints concerning the supply of care services. The literature has devoted much attention to the division of responsibilities between the state, the market and families as well as to the mix between formal and informal care arrangements. These features are of great importance for the research questions that drive the WellCARE research endeavour. When building typologies and classifying care regimes, less attention has however been paid to the question of which specific groups of people provide care services under which conditions. Our focus in Section 2.2 is thus on the relevance of institutional settings and care regimes for the care-giving population, including the distribution between different types of formal and informal care arrangements.

2.1 Overview of the 'care regimes' literature

There is a wide body of literature devoted to analysing LTC institutions and policies in comparative perspective, with the goal to identify typologies or care regimes. Ariaans et al. (2021), Pavolini (2021) and especially Fischer et al. (2022) provide recent reviews and discussions of this literature, highlighting different research strands. Early studies, inspired by Esping-Andersen's seminal work on welfare state regimes, adopted a broad approach, covering both childcare and old-age care arrangements or even investigating social services in general (see e.g., Anttonen & Sipilä, 1996; Bettio & Plantenga, 2004; Kautto, 2002; Leitner, 2003). A second strand of the literature focuses specifically on LTC for older persons (Colombo, 2012; Damiani et al., 2011; Halásková et al., 2017; Kraus et al., 2010). These studies, including the most recent examples such as Ariaans et al. (2021) and Pavolini (2021), are of particular relevance to the comparative exercise at the centre of the present report. Relevant insights come however also from the third strand of the comparative LTC research, which is devoted to comparing specific features of LTC systems, such as the role of cash-for-care schemes (Ranci et al., 2019) or the link between care work and migration (van Hooren, 2012).

As highlighted by Fischer et al. (2022), typologies can help to order and reduce empirical complexity, to systematically assess diversity and to detect patterns, which in turn can facilitate the development of theories and policy recommendations. The choice of criteria and indicators to describe systems will however necessarily reflect a particular perspective and be more useful to shed light on some policy implications of care regimes than on others. For example, analysing long-term care systems jointly with the provision of other forms of care can be particularly conducive to highlight its implications for gender differences, while a greater emphasis on the modalities to finance care, can be better suited to assess the implications for public budgets.

According to Ariaans et al. (2021), LTC studies have analysed primarily four dimensions of care systems: Supply, with indicators for financial resources, staff and staffing levels, and bed density in institutional LTC, as well as type of provision (share of people in ambulatory or residential care); public-private mix, focusing on the role of the state and private actors; access regulations, because restrictions in LTC systems may pose barriers to access care (this dimension plays a prominent role in the definition of healthcare typologies, but it has proven more difficult to operationalize in LTC due to a lack of comparable institutional indicators); performance, which has however been included only in few typologies because indicators for measuring the quality of LTC service provision are scantly available. In their overview of the literature, Fischer et al. (2022) find that financing is the dominant criterion used to distinguish LTC systems (i.e., either different financing schemes, that is, taxes versus social insurance contributions or financing source, differentiating between private and public spending), followed by regulation (mainly looking at the extent of coverage and underlying entitlement criteria in the LTC system, but also at rules governing choice) and the provision of LTC – particularly the amount of (in)formal LTC services provided.

Given this range of dimensions and the large number of associated indicators, it is not surprising that no consensus on either the number and definitions of care regimes has emerged from the literature. Even if similar approaches were chosen, the classification of countries could vary depending on methodological issues or the period investigated. Most research follows either a qualitative approach to classifying LTC systems (using a few variables that are considered pivotal) or a quantitative approach (using a larger number of indicators and clustering analysis or other related methods) (Pavolini, 2021). Fischer et al. (2022), who limit their review of the literature to typologies for grouping countries according to their LTC arrangements specifically, be it for the elderly and/or other segments of the population, count no less than 17 typologies. Adding more recent studies not included in this review, such as Schulmann et al. (2019), Ariaans et al. (2021), Leichsenring (2020) and Pavolini (2021), we arrive at about 20 approaches to classifying care regimes. Northern European and particularly Scandinavian countries, which are characterized by universalistic traits, high levels of public expenditure and an emphasis on in-kind benefits, are most consistently grouped together in one cluster or care regime type (Ariaans et al., 2021). Countries with low expenditure levels and higher reliance on familial/informal care supply, particularly those in Eastern Europe, are also often grouped together. However, many of those countries are undergoing rapid institutional change, spurred by the acceleration of demographic ageing but also by catch-up dynamics in welfare state development. The position of a specific country in a comparative analysis depends however also on the level of detail with which the care regimes are defined and the resulting number of clusters or typologies. This depends in turn on the geographical areas and number of countries covered, which varies substantially between countries.

In a first step, we want to focus on the institutional characteristics determining the level and type of provision as well as the public-private mix. Most comparative research focuses on European countries, but only a part of these studies include all three European WellCARE countries. Table 1 provides an overview of the position that Austria, Spain and England (or the UK) take in care regime typologies that include all three countries. In those cases where only two countries were included in the study but where it was possible to assess the position of the

missing country, we expanded the classification to include all three European WellCARE countries. The selection includes studies with broad, qualitative approaches as well as with more sophisticated quantitative approaches from different time periods, with a focus on more recent studies. Canada is rarely included in care regime comparisons, we thus had to exclude Canada from the following compilation. The Canadian LTC system is characterised by a complex interplay of federal, provincial, and territorial responsibilities. Long-term care in Canada is primarily regulated and governed at the provincial and territorial levels, leading to a decentralized system with varying standards and practices across regions.

Table 1: **Care regime classification of Austria, England/UK and Spain, selection of studies**

Study	Austria	England/UK	Spain
Leitner (2003)	Explicit familialism		Implicit familialism
Damiani et al. (2011)	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)/I	LTC systems characterized by medium organizational depth and medium financial generosity (compared with cluster with Scandinavian and (some) Continental countries, characterized by profound organizational depth and high levels of financial generosity)		
Kraus et al. (2010)/II	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. (2021)	*Evolving private supply system*	Evolving private need-based system	Evolving private need-based system
Leichsenring (2020)	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

S: Authors' compilation. – Fields in italics have been added to include the missing country in the classification proposed by the study. – Kraus et al. (2010) follow two different approaches, resulting in two different typologies. In the first part of their paper (here I), they cluster countries by LTC system characteristics relying on qualitative information coded in an ordinal way. In the second part of their paper (here II), they cluster countries by use and financing of LTC, using quantitative factors, preferably of a continuous nature.

The synthetic overview given in Table 1 illustrates the variety of approaches applied to compare and classify LTC systems, which is also reflected in the different terminologies that are used. This diversity notwithstanding, in several instances the three European countries are associated with the same care regime. This is especially the case when the focus is on the care supply and the split between formal and informal care: Austria, Spain and also England (as well as the UK) all have rather low shares of formal care provision and a limited role for in-kind benefits, particularly when compared to the Scandinavian countries. There is also a tendency for more recent studies to group the three countries together, while older studies gave more emphasis to the differences. This corresponds to a broader trend observed in the evolution of LTC systems: In recent decades, numerous countries have evolved in a similar direction, reducing the systemic differences over time (Leichsenring, 2020). A study that investigated the LTC

trajectories between the early 1990s and the mid-2010s in a sample of European countries highlights that the two main trends in care policies concern a growing emphasis on supporting informal care (i.e., policies that give incentives and support to caregivers within the family) and on developing care markets (Le Bihan et al., 2019).

Differences between Austria, Spain and England (the UK) are more pronounced in those studies, which focus more closely on how care is provided outside of nursing homes, on the way in which institutions and policies support the respective roles of families and markets, and on the size and employment status of the (migrant) care worker community. In the next step, we thus discuss the comparative literature on LTC systems that has emphasized how differences between care regimes relate to the development of care markets and different types of care arrangements, and how they shape the situation of caregiving persons, particularly the split between formal employment, supported informal care arrangements and unsupported care arrangements.

2.2 Care regimes, care arrangements and the implications for caregivers

System characteristics such as financing and type of provision feature prominently in most comparative studies on LTC. Less attention has been paid to indicators describing the situation of caregivers and the implications that the mix between public and private supply on the one side and the mix between formal and informal care on the other side have on the employment perspectives of caregivers and on the labour market as whole. By and large, we can observe a convergence across countries towards the commodification of care, i.e., a shift of previously unpaid care activities toward professional services and facilities with related regulatory frameworks, costs and prices (Leichsenring, 2020). This shift is accompanied by policies to move LTC away from residential care towards home care and community care (Martinez-Lacoba et al., 2021). These broad, general trends do not change the fact, emphasized by Simonazzi (2009) that care regimes differ considerably in their ability to create a care market (which in turn can be dominated by public provision and governance or by private actors). This assessment is corroborated by recent data.

Employment in the care sector has been increasing across the board in industrialized countries with ageing populations. According to the OECD (2023a), between 2011 and 2021 on average in OECD countries the number of LTC workers has risen in line with the number of older people due to population ageing. This average development masks a large heterogeneity in formal care employment levels, ranging from over 100 LTC workers per 1,000 people aged 65+ in some, mostly Northern European countries (such as Norway and Sweden) to less than 10 in some Southern and Eastern European countries (Greece, Latvia, Lithuania, Poland and Portugal). The differences might be overstated because of measurement problems, as parts of the LTC sector may be classified as healthcare in some countries. Differences in institutions and policies, however, certainly go a long way to explain the heterogeneity in formal employment levels that we can observe. OECD projections forecast that the share of LTC workers in total employment will increase by 0.41 percentage points between 2023 and 2033 and 0.47 percentage points more in the following decade on average (OECD, 2023a). Clearly, demographic ageing and the resulting increase in demand will be the main driver behind this

development, and the projections show substantial uncertainty depending on the underlying assumptions about the extent to which ageing will be accompanied by an increase in healthy life years (or, vice versa, an expansion of morbidity). In all scenarios implemented in the OECD projections, however, differences across countries remain very pronounced, acknowledging the large role played by care regimes and the resulting path dependencies.

The rising demand for care, paired with commodification of care services, will thus push for a further expansion of LTC employment. The quantity but also the quality of jobs created in the care sector and, conversely, the size and supply conditions in the informal sector will continue to depend on the features of care systems and future reforms and policies. Policies affecting the supply of care have particularly strong implications for women, as women represent the bulk of LTC workers in all countries, with shares between 80% and over 90% (OECD, 2023a). Looking at the past, we see that countries that opted for a high public provision of care services, such as the Scandinavian ones, had a strong development in female participation rates, while countries with a more familialistic approach to care, such as the Mediterranean ones, stayed on a trajectory with low participation rates (Simonazzi, 2009). Important differences resulting from care regimes and the related employment models also concern the split between native and migrant workers in LTC. In general, welfare states in many ageing societies have developed an increasing dependence on migrant labour to meet care needs (Martinez-Lacoba et al., 2021; OECD, 2023a). In virtually all countries, the share of foreign-born workers is higher than in the rest of the economy. Both the level of foreign-born employment and the difference between the LTC sector and other sectors of the economy varies considerably (OECD, 2023a). Moreover, international variation in the role and distribution of migrant workers in LTC increases if we take into consideration also live-in LTC arrangements and self-employment in the LTC sector.

Several studies have highlighted the role of cash-for-care (CfC) schemes as determinants for the development of formal care markets and for the distribution of care supply between different types of arrangements. In contrast to Canada, most European countries have some form of long-term care benefit, usually in varying amounts depending on the severity of the need for care[2]).

The distinction between what is alternatively called a "conditional", "bound" or "tied" cash benefit, where beneficiaries must document how the money they have been received is spent, and a "unconditional" or "unbound" benefit, where beneficiaries can use the money according to their preferences without any form of accountability, is particularly important in this respect. Schemes based on conditional cash benefits tend to promote the creation of formal employment and the coordination and integration between the beneficiary and the long-term care public system (Martinez-Lacoba et al., 2021; Pavolini, 2021). In this respect, they push countries

[2]) In Canada, people in need for care can claim the disability tax credit under specific conditions. Caregivers can claim the Canada caregiver credit (CCC), which is a non-refundable tax credit. https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/lines-33099-33199-eligible-medical-expenses-you-claim-on-your-tax-return/attendant-care-care-a-facility.html and https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/canada-caregiver-amount.html (accessed 14. 5. 2024).

in the same direction as in-kind service provision, in what Simonazzi (2009) calls "the formal market grouping" of countries. Unconditional cash benefits, on the other hand, while allowing for more flexibility and freedom of choice, are less likely to support the coordination and integration of services bought privately with services provided by other actors in the LTC and the social and healthcare sectors more in general, and more likely to support the emergence of a grey care market with high participation of migrant labour (Martinez-Lacoba et al., 2021; Pavolini, 2021). Of the 19 European countries with CfC schemes surveyed in Pavolini (2021), twelve use an unconditional benefit (AT, BE, BG, CY, CZ, DE, FI, HR, IT, PL, PT, SI) and only seven use a conditional benefit (ES, FR, LT, LU, LV, NL, SK). Besides this distinction between conditional and unconditional benefits, however, there are other relevant features that characterize different CfC schemes, most importantly their generosity, eligibility criteria and the resulting level of coverage (Ranci et al., 2019).

Table 2 provides an overview of those studies from the comparative LTC literature that have a more specific focus on the employment implications of different care regimes and cover the WellCARE countries. When compared to Table 1, this area of the comparative literature shows more nuanced differences between Austria, Spain and England. England (and the UK) started earlier than the other countries to develop a market for care services with outsourcing of care supply to private actors. At the same time, starting in the 1970s England introduced provisions to support informal care, with an allowance for older people with care needs, conceived as a complement to informal caregiving, as well as with a (means-tested) allowance for caregivers providing care for a person receiving a disability benefit (Le Bihan et al., 2019). Austria and Spain come from a stronger familialistic tradition in the provision of care. Using 1990 as reference year, Le Behin et al. (2019). classify both countries in the same care regime, "unsupported familialism", characterized by low levels of service development and a lack of policies aimed at the informal care model. However, they also stress that the level of service provision was higher in Austria than it was in Spain. According to this study, which partly builds upon and modifies earlier familialism typologies such as the one proposed by Leitner (2003), over time both Austria and Spain have moved towards the model represented by England. In this care regime, which the authors define as "optional defamilialization through the market", families are encouraged to provide family care and are (directly or indirectly) given alternatives through the provision of market care.

This development can be interpreted as part of a broad trend across countries, underpinned by an expansion of CfC schemes, increasingly regulated care markets, standardization of professional figures in the LTC sector, and measures to support work and care (Bartha & Zentai, 2020). According to this interpretation of the evolution of care regimes, currently most countries have a hybrid care regime, with different combinations of similar elements. Other studies, however, stress more fundamental differences between countries, such as the fact that in Spain family members have stronger (legal) responsibilities to care for relatives (Spijker & Zueras, 2020), that England has a distinctive liberal model where the market takes centre stage, and that Austria represents a mixed model with high levels of public expenditure supporting formal as well as informal care (see e.g., Lightman, 2019, 2021).

Table 2: **Care regime classification of Austria, England/UK and Spain, focus on care arrangements and employment**

Study	Austria	England/UK	Spain
Simonazzi (2009)	Mixed formal and informal market, with mixed employment models (reliance on migration)	Formal labour market, with mixed employment models (reliance on migration)	Informal market with stronger reliance on migration
Le Bihan et al. (2019) in 1990	Unsupported familialism: No policies supporting informal care, weak/no service development	Optional familialism through market: Support for informal care, market service development	Unsupported familialism: No policies supporting informal care, weak/no service development
Le Bihan et al. (2019) since 1990	Austria and Spain have both moved in the direction of England, i.e., optional familialism through market: support for informal care, market service development		
Bartha & 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 (2019; 2021)	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

S: Authors' compilation.

To sum up, we can stress that all countries face similar, multidimensional challenges related to the provision of LTC against the backdrop of population ageing. Given the high debt levels and the resulting fiscal constraints, expanding the supply for care to meet increasing demand, while securing quality standards, is by itself a daunting task. This challenge is compounded by the fact that, if not properly designed, policies to expand the (formal and informal) supply of care will exacerbate existing inequalities, in terms of the share of the burden and the quality of working conditions for women and migrant workers. The comparative studies show that, even in a world in which there is a convergence towards hybrid care regimes and paradigmatic "worlds of welfare" distinctions have lost some of their explanatory power, differences between care regimes carry important implications for the labour market as well as for the employment options and working conditions of family members and other persons providing care in informal or quasi-informal settings. In the next chapter, we describe and contrast more in depth the four WellCARE countries, using a broad range of data and indicators to highlight the similarities and differences in the provision of care.

3. Comparing Austria, UK/England, Spain and Canada

The comparative care regime literature underscores how, while following similar trends, the individual care systems are still characterised by substantial differences and path-dependencies. The following overview compares the risks, the setup of the long-term care systems and the consequences of the different risks and setup. The Appendix gives an overview of the long-term care systems in Austria, Canada, Spain and the UK. The aim of this chapter is to provide an analytical framework to understand the features and vulnerabilities of the different care system. We examine the influencing factors of the current and future supply and demand for long-term care to inform the dynamic microsimulation model about the salient issues to be addressed with the model-based projections.

We carry out the analysis along the line of different indicators concerning framework conditions of the long-term care system, the regulation of the long-term care system, the benefits for long-term care and the situation of formal and informal caregivers (Table 3).

Table 3: **Indicators for the comparative analysis of the long-term care system in the WellCARE countries**

Indicator	Corresponding table/figure
Demographic challenges compared	Table 4
Health challenges compared	Table 5
Macroeconomic relevance of long-term care	Table 6
Cash-for-care systems compared	Figure 1, Figure 2
Basic regulation of long-term care and benefits	Table 7
Distribution of public long-term care services expenditure (age 65+)	Table 8
Commodification – Types of long-term care (65+)	Table 9
Gendered long-term care	Table 10
Unmet long-term care needs	Table 11
Support for informal caregivers	Table 12
The long-term care labour market	Table 13

S: Author's compilation.

Two key indicators show the extent of demographic change and its impact on care capacity (Table 4): The old-age dependency ratio is the ratio of the number of people aged 65+ to the number of people aged 20 to 64. In 2021, the dependency ratio in the WellCARE countries was quite similar: between 31 and 33 people aged 65+ for every 100 people aged 20 to 64. By 2050, the dependency ratio is expected to be substantially different: While in Spain there will be 59 people aged 65+ for every 100 people aged 20 to 64, this ratio is expected to be only 42 in Canada, Austria (52) and UK (46) ranging between the two extremes. The intergenerational support ratio, on the other hand, is the ratio of those aged 80 and over to those aged 50-64, or the ratio of those in need of care to those who generally provide informal care. This ratio clearly shows that the capacity for informal care will decline in all countries, but there are significant differences between countries, with Spain facing the greatest challenges. Whereas in 2021 there were 28 people aged 80+ for every 100 people aged 50 to 64 in Spain, by 2050 the intergenerational support ratio will rise to 64. This means that in 2050 there will be 64 people aged 80 and over for every 100 people aged 50 to 64 in Spain. The comparatively smallest challenge

is faced by Canada (49 in 2050), followed by the United Kingdom (51). Austria also faces considerable challenges, with an intergenerational dependency ratio of 60 in 2050.

Table 4: **Demographic challenges compared**

	Old-age dependency rate				Intergenerational support rate			
	Austria	UK	Spain	Canada	Austria	UK	Spain	Canada
2021	32	32	33	31	26	25	28	22
2050	52	46	59	42	60	51	64	49

S: OECD Database, Population Projections, Authors's calculations. – Old-age dependency rate: 65+ compared to 20-to 64-year-olds * 100. Intergenerational support rate: 80+ compared to 50- to 64-year-olds * 100.

Health indicators also reveal substantial differences between the WellCARE countries (Table 5). Due to a limitation of comparable data, not all health indicators can be shown for all four countries. Self-reported health statuses of old people vary between the three European WellCARE countries with England showing less health risks than Austria and especially Spain. While only 12% of the British aged 65+ report poor or very poor health, in Austria this figure is 17% and in Spain 19%. A self-reported data of people with some or severe limitations in daily activities provide a more nuanced picture. Taken together, nearly half of the adults aged 65+ in Austria, England and Spain report health limitations. While Banks et al. (2023) report that 21% of adults aged 65+ with severe limitations and 24% with some limitations for England (SHARE), Costa-Font et al. (2023) report only 12% with severe limitations, but 37% with some limitation for Spain (SHARE). The Austrian SHARE data show 18% with severe limitation and 31% with some limitations. Approximately 9% of adults aged 65+ have at least three ADL limitation in England, Spain and Canada, in Austria only 7%. Finally, there is an interesting difference in the prevalence of dementia, with the UK showing the lowest rate with 13 cases per 1,000 people and Spain the highest rate (17 cases per 1,000 people). Projections by the Institute for Health Metrics and Evaluation (IHME) for the Global Burden of Disease Study (OECD, 2023b) show an increase in dementia in all countries, but a relatively smaller increase in the UK.

Table 5: **Health challenges compared**

	Austria	England	Spain	Canada
Share of adults aged 65+ rating their own health as poor or very poor (2021, SHARE-Data)	17%	12% (2018)	19%	77% of people 65+: good health, 82%: satisfied with health (different dataset)
Share of adults aged 65+ with severe or some limitations in daily activities (2021, SHARE-Data)	Severe limitations:18% Some limitations: 31%	Severe limitations: 21% Some limitations: 24% (2018)	Severe limitations: 12% Some limitations: 37%	n.a.
Share of adults aged 65+ and with at least 3 ADLs[1])	7%	9.5%	9.5%	9.2%
Estimated prevalence of dementia		Per 1,000 population		
2021	16	13 (UK)	17	15
2040	22	16 (UK)	24	23

S: OECD (2023b, 2023c), Institute for Health Metrics and Evaluation cited in OECD (2023b), Milligan and Schirle (2023), Costa-Font et al. (2023), Banks et al. (2023), Author's calculations from SHARE Austria. – [1]) Proportion of people 65+ needing help with at least three activities (meals, errands, housework, finances, basic, personal care, moving).

According to OECD data, the UK and Canada spend a higher share of the GDP for long-term care (Table 6). However, Austria is underreporting its expenditure for social long-term care and Canada follows a different methodology (see OECD, 2020a, for details). All countries finance the public expenditures of long-term care by taxes (in contrast to social security contributions).

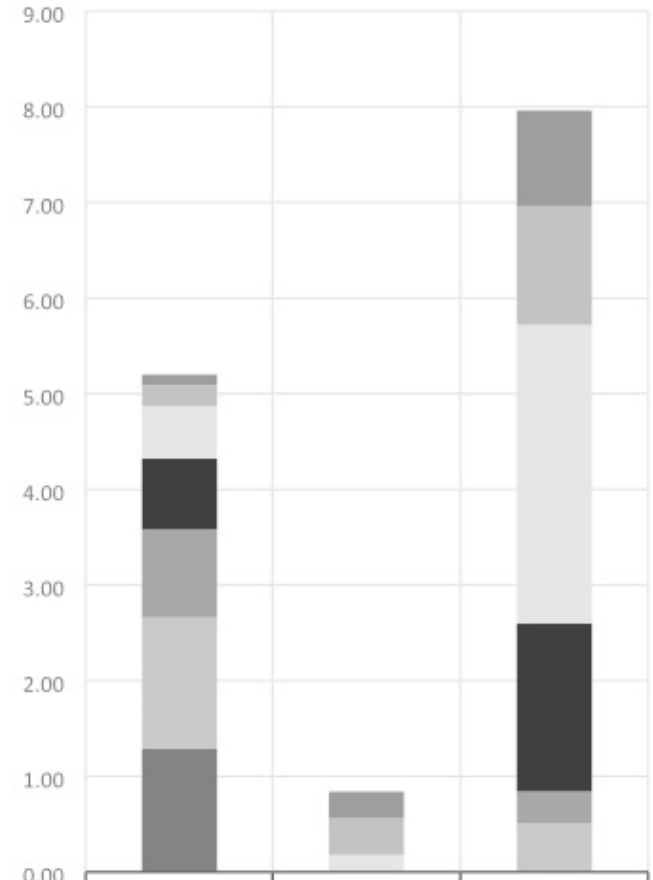
Table 6: **Macroeconomic relevance of long-term care**

	Austria	UK	Spain	Canada
Share of public LTC expenditure of GDP (2021)	1.6% (2021) (OECD)	2.6% (OECD)	1.0% (2021) (OECD)	2.3% (OECD 2023b; different methodology) [1])
Public financing of long-term care	Federal taxes	Federal and regional taxes	Federal and regional taxes	Federal and regional taxes

S: OECD (2023b, 2023c). – [1]) See https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Analysing different cash-for-care systems, Ranci et al. (2019) show that the Austrian system offers the highest level of support for people with strong health limitations but covers a smaller share of the population (5.2%) in contrast to the UK (8%). Spain, on the other hand, shows both, a lower level of financial support and a lower share of people covered (0.8%) (Figure 1 and Figure 2).

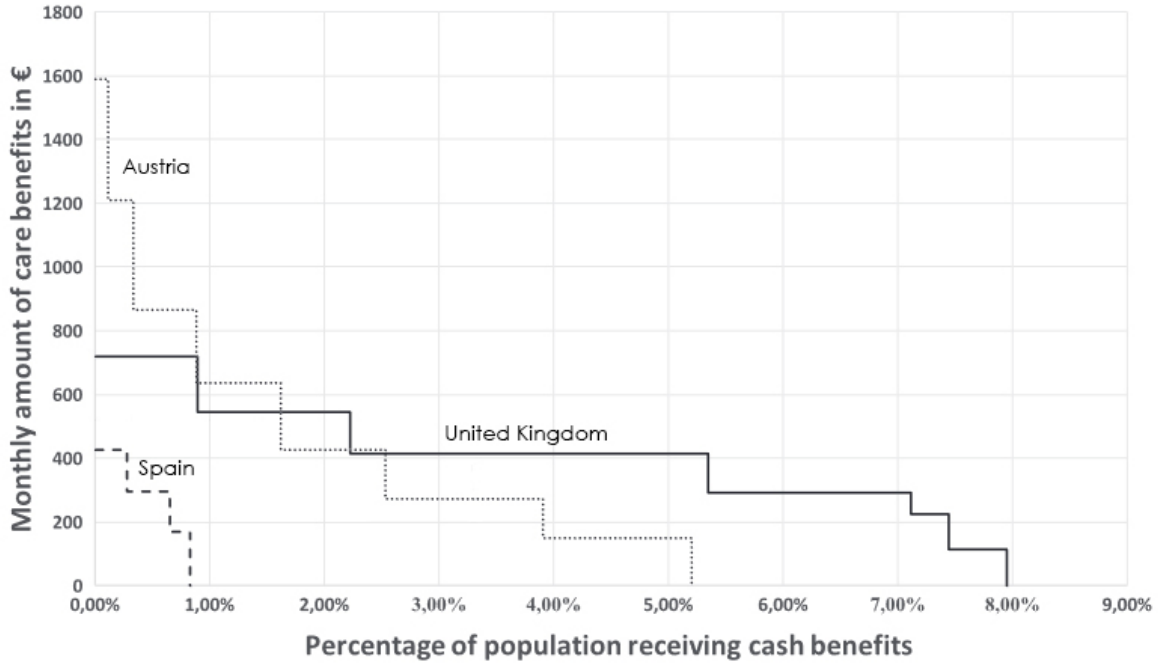
Figure 1: **Cash-for-care systems compared: Coverage rates (on the overall population) by levels of disability**



	Austria	Spain	Great Britain
7	0.11	0.28	1.00
6	0.22	0.38	1.24
5	0.55	0.18	3.12
4	0.74		1.76
3	0.92		0.33
2	1.37		0.51
1	1.29		

S: Adapted from Ranci et al. (2019). – Austria, United Kingdom: data from 2015, Spain: data from 2018. The vertical axis represents coverage rates (on the overall population) by levels of disability as stated in the national regulations. 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).

Figure 2: **Cash-for-care systems compared: Coverage rates and amount of benefits of cash-based programmes by disability classes**



S: Adapted from Ranci et al. (2019). – Austria, United Kingdom: data from 2015, Spain: data from 2018. Amount adjusted by Purchasing Power Standards (1 = EU28). Number of beneficiaries divided by total population.

In all WellCARE countries, most of the long-term care is provided by unpaid caregivers. Table 7 summarize the main forms of support in the WellCARE countries for people in need of long-term care and their caring relatives (see also the appendix for an overview of the different LTC systems in the WellCARE countries). There are various support measures for people in need of care – either through a LTC allowance or through the support for LTC services or both.

While the UK and Spain have seen budget cuts of LTC expenditures during a period of austerity policy in the 2010s, Austria has seen an expansion. Furthermore, Austria is the only WellCARE country where stays in nursing homes are heavily subsidized: Assets over and above regular income/pension and the LTC allowance are not considered when moving to a nursing home - any residual amount beyond the regular income/pension and LTC allowance is covered by social welfare funds (Famira-Mühlberger & Trukeschitz, 2023). In the UK, in contrast, support for LTC services is subject to a relatively low wealth threshold (see appendix for details). While privately owned and for-profit LTC facilities play a larger role in the UK, in Spain and in Canada, this is not the case in Austria where non-profit and public providers are predominant.

Table 7: **Basic regulation of long-term care and benefits**

	Austria	UK	Spain	Canada
Main forms of support	LTC allowance: 7 levels (needs-tested) (federal state) Support for LTC services (means- and needs-tested) (regions) Financial support for live-in carers (federal state) Carers allowance (needs tested)	NHS funds LTC for "complex health needs" (not social care) Attendance allowance or Personal Independence Payments (needs-tested) Carers allowance (needs tested) Support for LTC services by local authorities (means- and needs-tested)	Assessment: 3 levels, individual care plan If LTC services cannot be provided → cash benefits 40-50% receive cash benefit	Depending on the province; support may include financial assistance for home care and residential care
Formal 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	Public and private residential care, home care: public and private providers
Noteworthy	Wealth not included in means-test for institutional care (only income)	Support for LTC services subject to a very low wealth threshold (planned to be changed in 10/2025)	Budget cuts due to austerity policy led to a long waiting list for LTC services	Territorial differences in standards and support measures, concerns about low quality standards in public residential homes

S: Milligan and Schirle (2023), Costa-Font et al. (2023), Banks et al. (2023).

The public expenditure on long-term care is mainly directed towards institutional care, the most expensive form of long-term care. However, there is a substantial difference between the WellCARE countries. While England, Spain and Canada use roughly two thirds of the public expenditure on institutional care, Austria even uses 83%. Expenditure on home care and day centres is significantly lower (Table 8).

Table 8: **Distribution of public long-term care services expenditure (age 65+)**

	Austria	England	Spain	Canada
Share of public expenditure on institutional care	83%	66%	64%	67%
Share of public expenditure on home care and day centres	17%	34%	36%	33%

S: Milligan and Schirle (2023), Costa-Font et al. (2023), Banks et al. (2023), BMSGPK (2023), Pratscher (2023).

Although Austria uses a higher share of public long-term care expenditure on institutional care than the other WellCARE countries, there is only a small difference on the use of nursing homes (Table 9). In Austria und Canada, 17% of those in need for long-term care are cared for in nursing homes, while the respective figure for England and Spain in 14%. Informal care is the most important type of care in all WellCARE countries, although the data show significant

differences. Canada shows the lowest share of people receiving only informal care (35%). In Austria (Spain) 42% (49%) of those in need for care only receive informal care. In England, on the other hand, 70% are cared for exclusively informally. This difference between the countries also holds for the share of people that receive only formal care: While in England (Canada) only 5% (8%) state that they receive only formal care, this is 22% in Austria and 27% in Spain. A mixed use between formal and informal care is more prevalent in in Canada (40%) and less Austria (19%), England (11%) and Spain (10%). However, these data from the WellCARE countries come from different data sources which may explain the different numbers to some extent.

Table 9: **Commodification – Types of long-term care (65+)**

	Austria	England	Spain	Canada
Only formal care	22%	5%	27%	8%
Only informal care	42%	70%	49%	35%
Formal and informal care (mixed)	19%	11%	10%	40%
Care in nursing homes	17%	14%	14%	17%

S: Milligan and Schirle (2023), Costa-Font et al. (2023) (data based on SHARE, Wave 7), Banks et al. (2023) (data based on ELSA, Wave 9), Author's calculations from SHARE Austria.

Long-term care is highly gendered in all WellCARE countries (Table 10). However, in Austria, informal care is more gendered than in the other countries. Roughly three quarters of informal caregivers are women. In the other countries, this rate is substantially lower. Formal care is gendered to an even stronger extent: between 81% (Spain) and 89% (Canada) of the formal long-term care work force is female. The significant difference between Austria and the other countries could be explained by the different data source. However, Austria also has a much lower participation rate of older women (50.5% for women aged 55 to 64 in 2022 according to OECD data, compared to around 60% in the other countries). This difference may also partly explain the higher share of Austrian women among informal carers.

Table 10: **Gendered long-term care**

	Austria	UK/England	Spain	Canada
Informal caregivers: Share of women	73%	58%	58%	54%
Formal caregivers: Share of women (2021)	87%	83%	81%	89%

S: Milligan and Schirle (2023), Costa-Font et al. (2023), Banks et al. (2023), Nagl-Cupal et al. (2018), OECD (2023a).

Using data from SHARE for Austria and Spain, the OECD reports a relatively high unmet care needs among people aged 65+ that live at home and have at least three ADL or IADL limitations (Austria: 27%, Spain: 34%) (Table 11). Furthermore, there are roughly one fifth of the population aged 65+ that has at least three ADL or IADL limitations state that they receive no care at all (Austria: 18%, Spain: 22%). Thus, the reported unmet care needs are higher in Spain than in Austria. However, these data do not inform about the intensity of unmet care needs. Data from Canada and England also report a high level of unmet care needs, although from different data sources and definitions.

Table 11: **Unmet long-term care needs**

	Austria	England	Spain	Canada
Unmet long-term care needs among people aged 65+ living at home with at least 3 ADL/IADL limitations (2019/20)	27%		34%	
Share of the population 65+ with at least 3 ADL or IADL limitations, no care received	18%		22%	
Share of population with home care needs who reported some level of unmet needs (2015/2016)				35.4%
Share of population with unmet needs among those with qualifying social care needs (60+ with 1+ADL difficulty or 2+ IADL or mobility difficulties)		58%		

S: OECD (2023a, 2023b) based on SHARE, Gilmour (2018) based on the Canadian Community Health Survey, Dunatchik et al. (2019) based on ELSA.

There are various support measures for informal carers in the WellCARE countries, although we see substantial differences between the countries (Table 12). Except Canada, all countries offer a direct cash benefit to informal carers (subject to various conditions). Due to LTC benefits to the persons in need of care, most countries have a formal indirect cash benefit to carers which is usually income tested. Under certain conditions, most countries offer social security coverage for carers. Austria and Canada are the only countries with a paid care leave, Spain offers an unpaid care leave.

Table 12: **Support for informal carers**

	Austria	UK/England	Spain	Canada
Direct cash benefit to informal carer	Yes (from LTC level 4, net income 1,500 € max.)	Yes[1])	Yes, available with or without a contract to receive social security benefits[2])	No
Formal indirect cash benefit to carers	Yes (LTC allowance, support to hire a live-in carer)	Yes, on exceptional grounds	Yes	No, except in Newfoundland and Labrador
Income tested	Yes (LTC allowance: 2,5k; direct cash benefit: 1,5k)	Yes	Yes	
Social security coverage	Yes (from LTC level 3)	Yes, pension if receives the carer allowance	Yes, if has contract (pension, health, unemployment). Carers are exempted of social contributions since 2019	
Paid care leave	Yes	No	No[3])	Yes
Unpaid care leave	Yes	No[4])	Yes[5])	Yes[6])

S: Rocard and Llena-Nozal (2022). – [1]) Carer's Allowance provides a cash payment (60 £ per week) payable to adults who have low (less than 120 £ per week) earnings, are not in full-time education, and spends at least 35 hours a week caring for a person who receives disability benefits. [2]) The amount of the benefits depends on both the LTC needs of the care recipient and the means. The carer receives between 290 € and 388 € per month to take care of older people with the most severe LTC needs (grade 3), and 153 € if older people have low needs. The benefit lasts two years and it is renewable without limit. [3]) Care for a sick child or other serious family reason: Two days for the private sector (extended to three if involves traveling) and three for the central state public sector (five if traveling). [4]) Only "Emergency leave". The length of the leave should be "reasonable" – i.e., two days. [5]) Long-term leave for a dependent: Up to two years (extreme cases: three years). Pension credits granted by the state. [6]) Compassionate care leave up to 28 weeks within a 52-week period to look after a family member who has a serious medical condition with a significant risk of death. The leave can be shared between family members. Provinces and territories may also have provisions for unpaid caregiver leave (e.g., Ontario). A health care practitioner must sign a medical certificate. Unpaid leave is for employees working in federally regulated industries and workplaces. Restricted to family members.

The long-term care labour market differs between the WellCARE countries due to different labour market regulations and differences in organizing long-term care (Table 13). However, in all countries, there is an over proportional share of foreign-born workers in the long-term care sector. Although the share of long-term care workers in the labour market is small in all countries, the demographic development points to an increasing demand for long-term care services and, thus, to an increasing share of the long-term care sector. There are substantial differences in the number of LTC workers per 1,000 people aged 65+. In the UK, there are 56 LTC workers per 1,000 people aged 65+, while there are only 33 in Canada (Austria 41, Spain 49). These differences may also reflect different labour market conditions, e.g., the share of part-time employment. Finally, we see differences in the qualification mix of LTC workers: In Austria and Canada, there is stronger concentration of medium level education of LTC workers than in Spain and the UK. Austria shows the lowest share of highly educated LTC workers.

Table 13: **The long-term care labour market**

	Austria	UK	Spain	Canada
Share of foreign-born workers in LTC (share of foreign-born workers in the labour market)	33% (22%)	24% (18%)	27% (17%)	34% (26%)
Number of LTC workers as share of total employment (2021)	1.6%	2.2%	2.3%	1.2%
Projected share of LTC workers in total employment by 2033, baseline scenario	2.1%	2.8%	3.1%	1.7%
Number of LTC workers per 1,000 people aged 65+	41	56	49	33
Education level of LTC workers (low/medium/high, %)	13%/72%/16%	16%/54%/30%	35%/45%/21%	6%/75%/20%

S: OECD (2023a).

4. Conclusions

This analysis has shown that all WellCARE countries are characterised by the importance of informal care. However, informal care is coming under increasing pressure as younger female cohorts attain greater labour market integration. Lower fertility rates mean less potential informal care for daughters and sons. The postponement of births also increases the age gap between generations, meaning that the younger generation will increasingly be of working age when their parents need care. Finally, women are working longer because of higher education and (in some countries) pension reforms, further reducing the potential for informal care. Taken together, these developments are putting pressure on the future demand for formal long-term care in all WellCARE countries (and beyond).

This paper has highlighted significant differences between the WellCARE countries in terms of the governance of long-term care, which shapes the labour market in the long-term care sector. The different levels of LTC expenditure and the respective decommodification of LTC with a slightly stronger focus on institutionalisation in Canada and Austria, coupled with weaker (Spain) or stronger (UK, but especially Austria) cash-for-care benefits in the European WellCARE countries (and no nationwide cash-for-care benefits in Canada), result in family-based care systems supported by market options. However, recent labour market developments in long-term care in all WellCARE countries are increasingly reducing market options mainly because supply is not keeping up with increasing demand, with waiting lists for both mobile and institutional care. All WellCARE countries rely heavily on migration to sustain care provision, although we see differences in the composition of the LTC workforce by qualification.

Our results show that a microsimulation model that projects the demand for and supply of long-term care to eventually identify a possible gap in provision needs to address the following issues: Demographic change affects both the demand for and the supply of LTC. The evolution of the demand for LTC (based on the need for care) and hence of public and private costs is subject to a high degree of uncertainty. For example, increasing life expectancy, changes in morbidity and related health risks need to be considered and well specified in different national contexts. The development of long-term care provision for informal care depends strongly not only on demographic trends but also on country-specific social changes (e.g., educational

aspirations, family models). Furthermore, the governance of long-term care and long-term care policies influence the size and composition of care-giving groups (informal and formal).

The resulting trends in unmet care needs – the care gap – reveal the *vulnerability of specific groups in society*, with the aim of targeting long-term care policies at these groups. This report has highlighted the strongly gendered nature of informal care provision. This is more pronounced in Austria than in the other countries and is partly related to the low (female) labour force participation rate among people aged 55 and over. Demographic change, combined with increasing female labour force participation, will reduce the base for informal care provision and increase pressure on public systems. In addition, the comparative work in this report has shown the strong reliance on informal care in all WellCARE countries, but particularly in the UK. Microsimulation can help to identify/quantify the combined impact of demographic ageing and sharply rising labour force participation on informal care provision.

The comparatively high level of unmet care needs, particularly in Spain, and the increasingly long waiting lists for public long-term care provision in all the WellCARE countries, but particularly in Canada and Spain, reveal growing difficulties in accessing long-term care and highlight issues of equitable access to provision. Microsimulation can help to quantify vulnerabilities by projecting LTC needs and what-if scenarios to determine future trajectories of unmet care needs.

We have also highlighted the role of migration. There is a significant vulnerability of all countries to a reduction in the supply of care by migrant workers. What-if scenarios can be used to simulate how migrant LTC policies might (or might not) contribute to meeting increasing care needs.

Identifying future needs for institutional and home care can inform long-term care policy in order to better target future policy measures. Different scenarios for the development of long-term care demand and supply can be used to evaluate possible policy options. Finally, the distributional issues captured in the national transfer and time transfer accounts shed light on important questions of intergenerational equity regarding the future care needs of the baby boom generation.

Appendix

Long-term care in Spain

Regulation and governance of long-term care

The Spanish long-term care system's regulation and governance is regionally decentralised, with some coordination between the regions and the national government. It is based on the "Law on the Promotion of Personal Autonomy and Care for Dependent Persons" (LAPAD) from 2007, establishing the "System for Autonomy and Care for Dependency" (SAAD), which universalised access to long-term care services and supports (LTCSS) to all Spaniards. The national government oversees fundamental aspects of SAAD, encompassing service intensity, economic benefit terms and amounts, co-payment criteria, and dependency recognition scale. Operational system structure falls under the purview of regional authorities (Costa-Font et al., 2022; European Commission, 2022)

Financing long-term care

Long-term care (LTC) is predominantly funded through national and regional taxes and individual co-payments, considering assets and the nature of services availed. The distribution of public expenditure involves contributions from both the national government and regional authorities. In sum, the national government contributes 15%, autonomous communities/regions contribute 64%, and user contributions (co-payments) constitute 21%. There is no public long-term care insurance, and the prevalence of private long-term care insurance contracts is minimal (Costa-Font et al., 2022; European Commission, 2022)

Expenditure on long-term care

LTC spending as a percentage of GDP has risen from 0.5% in 2003 to 1% in 2021 (Costa-Font et al., 2022; OECD, 2023b). Costa-Font et al. (2023) estimate the overall costs of long-term care in Spain, encompassing informal care. Employing a conservative approach for calculating private costs of informal care results in approximately 36% public expenditure and 64% private expenditure. Using a less conservative method, the private share increases significantly to 73% (with 27% public expenditure). This amounts to 1.27% to 1.70% of GDP, contingent on the methodology employed.

Coverage and benefits

Following a needs assessment, individuals undergo categorization as "non-eligible," "moderate" (1), "severe" (2), or "major dependent" (3). Those identified as dependent receive an individual care plan, specifying optimal supports and care aligned with their overall care and social needs. The service catalogue encompasses preventative services, personal autonomy promotion, telecare, home care, day and night centre services, and nursing homes. In cases where competent administrations cannot provide these services, the dependent individual is entitled to economic benefits, except for telecare. Approximately 40% to 50% of SAAD LTC beneficiaries receive a cash subsidy. A consequence of the 2012 budget cuts (austerity measures post-recession) is the proliferation of SAAD waiting lists, measured as the disparity between entitled

individuals and those receiving benefits (as of April 2022: approximately 195,000) (Costa-Font et al., 2023).

Coverage and limitations of activities in daily living (ADL)

13.3% of individuals aged 65+ receive some form of care (22.2% for those aged 85+). The prevalence of individuals requiring care correlates with the number of ADL limitations. In the 65+ population, it varies from 28.4% for those with no ADLs and only one ADL to nearly 44% for those with at least three ADLs. Regarding the distribution of care types based on the number of ADLs, there is an increasing trend in the combined use of formal and informal care, as well as nursing home care, as the number of ADLs rises in the 65+ population.

Long-term care service provision

Residential care is predominantly provided by the for-profit private sector, with the public sector often contracting most beds. Public home care services are typically managed by municipalities. To qualify for both public and subsidized home care centres, individuals must require care, have a dependency level of 2 or 3, and their individual care plan must specifically indicate the need for access to a nursing home. Additionally, there are home and community-based services, overseen and funded by regional social service departments but delivered by either public or private centres. These services, which include prevention care, telecare, home help, and day and night care, are subsidized and appropriately accredited (European Commission, 2022).

Provision of residential care

Private for-profit providers dominate the residential care market with the highest bed share (59%), while public providers account for 26% of beds. The sector exhibits a trend toward consolidation, despite the presence of numerous small- and medium-sized companies struggling to align with LTC service demand standards. Insufficient availability of residential care spaces, coupled with Spain's aging population, has drawn interest from specialized multinational suppliers, particularly from France, into the residential care sector (European Commission, 2022).

Regional variation of long-term care support

The Spanish LTC market faces challenges in the inconsistent implementation and coverage of the system across various regions. This hampers the achievement of equality and effectiveness objectives. Additionally, shortcomings in institutional coordination between social and health services in the LTC domain are evident. Quality standards vary regionally, affecting personnel qualifications and minimum attention ratios, potentially fostering uneven market entry for private for-profit providers and exacerbating disparities in LTC service access.

Formal and informal care

In the 65+ population, 49% receive only informal care, 27% receive only formal care, 10% receive both types of care and 14% live in nursing homes (Costa-Font et al., 2022). Cash benefits are provided for informal care and personal assistance, as well as for purchasing services. Cash benefits associated with service procurement empower care recipients to engage private

licensed providers when the public sector cannot fulfil these services (European Commission, 2022).

Support for informal carers

Approximately 80% of individuals assisting those aged 65+ are informal caregivers. Informal caregivers are predominantly daughters (40%), spouses (30%), sons (19%), and other relatives (11%) (Costa-Font et al., 2023).

In Spain, cash benefit to carers are either paid directly to carers through a carer allowance or paid to those in need of care, part of which may be used to compensate formally carers (both means tested). Informal carer status can only be granted when the dependent person has a degree of dependency of at least two out of three on the national need assessment scale, except in rural areas. Informal carers have to be a co-resident and means-testing applies to both the carer and the care recipient. The amount of the benefits depends on both the LTC needs of the care recipient and the means. The carer receives between 290 € and 388 € per month to take care of older people with the most severe LTC needs (grade 3), and 153 € if older people have low needs (2021). The benefit lasts two years and it is renewable without limit.

Spain has developed a tax deduction for people combining paid employment and care responsibilities. There is a specific tax deduction for taxpayers who are employed or self-employed and who have made social security contributions. Furthermore, since April 2019, Spain has allowed carers to register to the social security with exemptions of contributions (pension, health and unemployment). These exemptions have boosted the registered number of carers, of which 89% are women.

There is the possibility of unpaid care leave of up to two years in Spain (if not refused by the employer on business grounds; in extreme cases, up to three years). The state grants pension credits for the time not working. Paid care leave, however, is very limited in Spain: Two days for the private sector (extended to three if involves traveling) and three for the central state public sector (five if traveling). There is no paid care leave for terminally ill relatives (paid by the employer) (Rocard & Llena-Nozal, 2022).

The OECD (2020b) argues that a lack of control of cash benefits to those in need of care has fuelled a grey market in Spain. Often, the care recipient's family uses the cash benefit to employ informally an undeclared worker, often migrant, to take care of older dependent people. This worker may live in the care recipient's household, but as they work informally, they receive virtually no social security protection.

Shortage of professional care workers

Spain faces a deficit of professional care workers, attributed to job insecurity, inadequate wages, and frequently suboptimal working conditions. This is exacerbated by the migration of workers to other European countries offering superior salaries and improved working conditions (European Commission, 2022; OECD, 2023a).

Long-term care in England/UK

Regulation, governance and financing

Long-term care in the United Kingdom encompasses a fusion of health and social care, delivered through residential settings and community-based care within individuals' homes. While the NHS finances long-term care for patients with "complex health needs," social care (non-medical services to assist individuals with LTC needs in their daily activities) is not covered by the NHS, but by the local authorities and is means-tested. Formal care services encompass home-based care, personal assistants, residential/institutional care, day care, and professional services like social work. Funding for means-tested social care involves a mix of public and private sources, subject to varying eligibility criteria across the UK.

The differentiation between non-health care and health care needs in long-term care relies on a multidisciplinary assessment, considering the intensity and complexity of required support across various care domains (Anderson et al., 2022). The differentiation between 'health' and 'care' results in inequality. Individuals identified with health needs might access social care through the NHS's continuing healthcare program, albeit with stringent eligibility criteria and prolonged waiting periods[3]). Conversely, someone with personal care needs, such as those stemming from dementia, and lacking medical requirements, is subject to means testing[4]). Recently, there are attempts for a better integration of health and care.

Public long-term care (LTC) services in England are administered by 152 local authorities, each employing unique funding formulas. These authorities predominantly finance public LTC, enjoying significant autonomy in organizing and delivering care. Eligibility for care depends on both a needs test and a means test. Individuals failing to qualify for support must resort to self-funded formal or informal care services, with ineligibility for local authority-funded care for those possessing (non-pension) wealth exceeding 23,250 £, and those with wealth ranging from 14,250 £ to 23,250 £ obligated to contribute to their care costs (these thresholds have been unchanged since 2010/11). Housing wealth is not considered in the means test for home-based care but is factored in for those in residential homes, such as nursing homes. Starting October 2025, barring any further delays, there will be a lifetime out-of-pocket spending cap set at 86,000 £. Additionally, the asset limit, determining eligibility for support, will rise from 23,250 £ to 100,000 £. Notably, "hotel costs" are excluded from the spending cap).

Private providers deliver most services, funded by the local authority, with recent reforms granting individuals increased control over budget allocation. Following a needs assessment, recipients are assigned a 'personal budget' specifying the local authority's financial contribution to their care. Recipients can choose to receive this budget directly as a 'direct payment', enabling them to decide how the allocated funds are spent, including the option to hire a care worker, often a family member, thereby introducing significant variability in care availability and quality across different local authorities.

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[3]) https://ltccovid.org/ltccovid-country-profile-england-uk/ (accessed 7. 1. 20224).

[4]) https://www.nuffieldtrust.org.uk/news-item/other-types-of-support-how-do-the-countries-compare (accessed 7. 1. 2024).

There is no public long-term care insurance, and the prevalence of private long-term care insurance contracts is minimal (Banks et al., 2023).

Expenditure on long-term care

From 2010 until the onset of the COVID-19 pandemic, a period marked by low economic growth and fiscal austerity, there were reductions in long-term care (LTC) spending, resulting in real spending in 2019 being lower than that in 2011. According to the UK Health Accounts 2018 (cited in Banks et al., 2023), in 2018, LTC spending constituted 1.8% of GDP, encompassing care for both younger disabled individuals and older people with disabilities and functional limitations. The majority (1.1% of GDP) was allocated to residential long-term care facilities (such as nursing and care homes), with 0.5% dedicated to home health services. If we broaden the LTC definition to include "social care" for Instrumental Activities of Daily Living (IADLs), such as assistance with cooking and cleaning, the total LTC expenditure reached 2.2% of GDP. Comparative OECD data indicates a 2.6% of GDP expenditure in 2021, inclusive of social care.

Coverage and benefits

Unpaid caregivers are pivotal in providing long-term care in the UK. In 2018, 12% of individuals above State Pension Age claimed Attendance Allowance (2023/2024: weekly £68.10 or £101.75, depending on the level of need – not means-tested), and an additional 8.4% received either Disability Living Allowance or Personal Independence Payments (2023/2024: weekly £68.10 or £101.75 for daily living part and £26.90 or £71, depending on the level of need – not means-tested)[5]).

Furthermore, the Carer's Allowance offers a monetary benefit to adults with low earnings (below £150 per week), not in full-time education, dedicating at least 35 hours a week to caring for a person receiving disability benefits (£77 a week in 2024). Those not eligible for local authority or NHS-funded long-term care (LTC) must either receive informal care or bear out-of-pocket expenses. Additionally, higher-income individuals receiving local authority-funded care often encounter co-payments. Due to LTC funding structures, individuals must deplete personal savings and assets before receiving substantial public assistance. While the affluent can afford private LTC, the considerable and uncertain costs associated with potential extended stays in nursing homes may make such care financially unattainable for those in the middle of the wealth distribution.

A Deferred Payment Agreement aids households in retaining their homes during their lifetime by allowing users of local authority co-funded care to defer payment for care costs until a later date, even until death, thereby avoiding the immediate sale of their home (relevant only to those receiving local authority-funded care). According to the Office for National Statistics, between 2022 and 2023, 37% of care home residents privately funded their own care[6]).

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[5]) One can either claim Attendance Allowance or Personal Independence Payments. Disability Living Allowance is gradually replaced by Personal Independence Payments.

[6]) https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/carehomesandestimatingtheselffundingpopulationengland/2022to2023 (accessed 29. 4. 2024).

Coverage and limitations of activities in daily living (ADL)

Banks et al. (2023) demonstrate that individuals who are older and in poorer health exhibit reduced financial resources across various dimensions. Consistent with ample evidence highlighting the socioeconomic gradient in health, the study reveals that individuals facing more limitations in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) typically have lower income and wealth. Additionally, all measures of subjective well-being show a negative correlation with the number of limitations.

Long-term care service provision

Locally organised, the formal care system, encompassing residential and formal home care, is supplied by private providers. Approximately two-thirds of its funding is public, while one-third is private.

Currently, 60% of recipients of public social care receive care in their homes. Around 78% of adult care services are privately owned and operated (Kearney & White, 2018). Despite the Care Act 2014's mandate for local authorities to ensure diversity and quality in the care provider market, financial challenges arise for many providers due to reduced fees stemming from cuts to local authority budgets. This funding gap often compels individuals self-funding their care to pay an average of 41% more than those funded by local authorities (CMA, 2017). Consequently, there is an emerging trend of care providers facing financial difficulties, going out of business, or returning contracts to local authorities[7]).

Regional variation of long-term care support

England's public long-term care (LTC) services exhibit considerable regional disparity, as 152 local authorities, each with unique funding formulas, oversee them, resulting in significant differences in organizing and delivering care. The National Audit Office reports a nearly 50% reduction in council funding over the past decade, prompting councils to limit care expenditure by lowering provider rates or supporting fewer individuals (NAO, 2018). This reduction exacerbates inequalities in care eligibility among localities, contrary to the standardized approach envisioned in the Care Act (2014), as wealthier areas can generate more funds through local revenue generation beyond national government grants.

Support for informal carers

Informal care is highly important in the UK. Spouses or children make up three-quarters of informal caregivers for older care recipients. Spouses constitute the most prevalent informal caregivers, comprising 35%, with daughters following at 25% (Banks et al., 2023). Estimates of the value of informal care (of older people and adults) range from 58.6 billion £ to nearly 100 billion £ per year (or 2.1% and 3.5% of GDP) (NAO, 2018).

Carers are entitled by law to a needs assessment and support, obliging local authorities or health and social care trusts to evaluate the support requirements of carers when evident.

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[7]) https://ltccovid.org/ltccovid-country-profile-england-uk/ (accessed 29. 4. 2024) and Glendinning (2021).

Informal carers are eligible for assessments, breaks from caregiving (such as day-care services and short-term institutional respite care), services for the care recipient to alleviate the caregiver's responsibilities, and Jobcentre support for skill enhancement if seeking employment while caregiving. Despite legislative provisions, the availability of respite support for unpaid carers in England has contracted, decreasing from around 57,000 recorded instances in 2015/2016 to 36,200 in 2022/2023[8]).

The UK provides direct cash benefit to carers and, on exceptional grounds, "formal" indirect cash benefits to carers (see above). The carer's allowance flat rate is 82 £ per week (April 2024). Furthermore, the UK provides paid care leave (income tested) and a short unpaid care leave (2 days). For paid care leaves, social security contributions are covered by the state, pension only if the person receives the carer's allowance (Rocard & Llena-Nozal, 2022).

Shortage of professional care workers

There are high vacancy rates in professional long-term care in the UK. For instance, Skills for Care, the workforce development and planning body for adult social care in England, estimates an average of 9.9% of roles in adult social care were vacant in 2022/23, equivalent to approximately 152,000 vacancies in England[9]).

Long-term care in Austria[10])

Regulation and governance of long-term care

In contrast to the healthcare system, which is financed by social insurance, long-term care (LTC) is financed by general taxation in Austria. The LTC system in Austria is characterised by a strong reliance on family and other informal care.

In Austria, the federal government (Ministry of Social Affairs) is responsible for the cash-for-care system (LTC allowance, benefits for informal carers, financial support for 24-hour care) and social insurance coverage for family caregivers (if eligible). The nine regional governments are responsible for the provision of LTC services (i.e., mobile care, nursing homes, day care, hospice and palliative care, daily assistance, meals on wheels, temporary care, alternative housing and case and care management). The regional governments regulate the conditions for the various LTC services and partly run nursing homes. Some regional governments delegate tasks to regional funds (social assistance associations) or municipalities. Most LTC services are provided by non-profit organisations and public providers. For-profit providers play a minor role.

In addition, there is financial support for those who employ 24-hour carers. The Ministry of Social Affairs regulates the legal framework for 24-hour care and provides most of the funding. In

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[8]) https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2022-23#(Table 48; accessed 29. 4. 2024) and https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/community-care-statistics-social-services-activity-england-2015-16 (Table LTS003a; accessed 29. 4. 2024).

[9]) https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx (accessed 29. 4. 2024).

[10]) This section is mainly based on Famira-Mühlberger and Österle (2024).

addition, the federal government regulates the professional regulations for qualified nursing staff, while the regional governments regulate those for auxiliary staff (nursing assistants or specialised nursing assistants, home helps, etc.).

The federal government and the nine regional governments coordinate the LTC system in a joint working group ("Arbeitskreis Pflegevorsorge"). While the most important cash benefits (e.g., LTC allowance, benefits for informal carers, financial support for 24-hour care) are organised and available in the same way throughout the country, the organisation, design and conditions of LTC services differ considerably in the nine Länder.

Financing long-term care, benefits, coverage and public expenditure on long-term care

In Austria, LTC is financed by federal taxes, while health care is financed by social insurance contributions. Part of the federal tax revenue is transferred to the provinces (Bundesländer) to enable them to fulfil their responsibilities, including the organisation of LTC services. According to OECD data, Austria spent 1.6 % of GDP on long-term care. However, these data exclude the social component of LTC spending (OECD, 2023b).

In 1993, Austria introduced a uniform, needs-based but not means-tested LTC allowance (Pflegegeld). There is a legal entitlement to this allowance - irrespective of income and assets and of the cause of the need for care. Depending on the intensity of care required, the LTC allowance is divided into seven levels, ranging from 192 € per month at LTC allowance level 1 to 2,062 € per month at level 7 (2024, yearly adjusted for inflation). Approximately 5.2% of the Austrian population receives LTC allowance. Financial support for the purchase of LTC services is mostly need- and means-tested, but conditions vary from province to province. Assets over and above regular income/pension and the LTC allowance are not touched when moving to a nursing home - any residual amount is covered by social welfare funds (Famira-Mühlberger & Trukeschitz, 2023).

The Austrian LTC system is characterised by a high importance of informal care (Nagl-Cupal et al., 2018). The share of LTC beds in institutions and hospitals per 1,000 population aged 65+ is slightly above the OECD34 average, but well below other Western European countries (e.g., the Netherlands, Germany) (OECD, 2023b). More than 40% of recipients of LTC allowance are exclusively cared for by relatives (Famira-Mühlberger, 2020). There are several benefits for informal carers, including paid caregiver leave and social insurance coverage. If recipients of LTC allowance receive LTC services (benefits in kind), the individual LTC allowance is usually used to finance these services or the necessary co-payments. Conditions and co-payments vary from province to province.

Private LTC insurance plays a minor role in Austria.

Long-term care service provision

Community-based care is organised and managed in very different ways in different provinces. Across the country, community-based care is dominated by a mix of home nursing and home help services. Other services often include meals on wheels, mobility and visiting services, or palliative care services. Public co-financing arrangements also vary between provinces, but usually take into account both the LTC allowance and the income of the user.

Following regional plans for the development of LTC infrastructure in the 1990s, which gave priority to community-based care arrangements, respective services were significantly expanded in the 1990s and the early 2000s. By the end of 2022, almost 100,000 people received mobile care services (with public co-financing), which corresponds to 20.9% of the recipients of the LTC allowance (Pratscher, 2023). The provision of community-based care is dominated by non-profit organizations. Both public and for-profit providers only account for smaller shares in community-based care. Apart from the range of publicly co-financed services, community-based care is based on informal care provision and, increasingly since the early 2000s, on live-in care arrangements.

Provision of residential care

The residential care sector is dominated by so-called *Alten- und Pflegeheime*, which provide a wide range of nursing, personal and social care. By the end of 2022, 67,576 residents (with public co-financing) – i.e., 14.4% of the recipients of the LTC allowance (470,647 recipients by the end of 2022) – were being cared for in residential care settings ((Pratscher, 2023). Following the LTC reform in the early 1990s (Österle, 2021), these settings started to emphasize the nursing home character and to focus more explicitly on the population with more extensive care needs. Later, access criteria were more explicitly tightened by requiring minimum levels of care needs (usually allowance level 4), but still taking into account broader social circumstances. The two main providers of residential care are the public sector and the non-profit sector. Homes in the for-profit sector have a much smaller (but growing) market share in Austria and their relative position also varies between the provinces. Except for one provider, multinational companies do not play a major role in this segment. Alternative residential care settings include assisted living arrangements, often in close cooperation with traditional nursing homes, flat-sharing communities, or day care centres.

Financially supported live-in care arrangements

Since the late 1990s, migrant live-in care – or 24-hour care, as it is widely known in Austria – has increasingly been used to fill gaps between the traditional arrangements of informal care giving, mobile care services, and residential care. Originally a grey economy of care, regulations in 2007 made self-employment the dominant live-in care arrangement, with migrant care workers rotating in two to more weekly shifts between their Central and Eastern European countries of origin and private households in Austria (Österle, 2018).

By the end of 2022, about 59,000 self-employed live-in care workers were registered, which means that care – according to the dominant arrangement of two care workers rotating in shifts – care is provided for about 29,000 care users, which corresponds to 6.2% of the recipients of the LTC allowance. Live-in care is financed from the users' private sourced (including the LTC allowance), an additional means-tested public benefit specifically addressing the use of live-in care (amounting to a maximum of 800 € per month) and additional financial support in some provinces.

Support for informal carers

The Austrian long-term care system relies heavily on informal care. Support for informal carers includes pension and health insurance coverage (the most important programme in financial terms), various leave options (family hospice leave, full- and part-time care leave options) and a care leave benefit linked to these options, respite care, and consideration of family care in inheritance law (Trukeschitz et al., 2022). In addition, in mid-2023, Austria introduced a direct cash transfer for informal carers (*Angehörigenbonus*), amounting to 125 € per month. However, eligibility rules limit these programmes to higher-intensity care. For example, the above-mentioned cash transfer for informal carers is only paid when caring for someone in long-term care allowance level 4. LTC leave (both full- and part-time) is available for a period of between 1 and 3 months when caring for someone in allowance level 3 and above (or from level 1, in the case of dementia care and when the person being cared for is a child). Family hospice leave (again with a full-time and a part-time option) is available for 3 months, with the possibility of extending to 6 months. Take-up of leave has increased but remains limited, while respite care is often limited by the limited availability of replacement services.

Shortage of professional care workers

The LTC workforce in Austria is highly gendered: 87% of formal carers are women (OECD, 2023a). According to a representative survey, 73% of informal carers are women (Nagl-Cupal et al., 2018). While the share of foreign-born workers in the labour market is 22%, it is 33% in the LTC sector – both indicators well above most OECD countries. Although projections show an increase (Famira-Mühlberger, 2023), the proportion of those working in the LTC sector is still low: 1.6% of those in employment work in the LTC sector (slightly below the OECD average). There are 41 formal LTC workers per 1,000 people aged 65+ in Austria, which is well below the OECD average. Most LTC workers have a medium level of education (72%), only 13% have a high level of education and 16% have a low level of education. Compared to the OECD, the proportion of LTC workers with a medium level of education is higher than the OECD average, and the proportions with high and low levels of education are lower than the OECD average. 67% of all formal LTC workers work in residential care (which is above the OECD average). Those working in residential care earn only 92% of the economy-wide average gross hourly wage, while those working in non-residential care earn 93% - well below those in education and health (OECD, 2023a).

In Austria, the LTC sector is experiencing significant labour shortages, leading to high workloads and job dissatisfaction. Recent reforms have included paid scholarships for nursing education, additional leave, and financial bonuses to make LTC jobs more attractive.

Performance of the LTC system in Austria

The Austrian LTC system is based on a comparatively broad coverage of the population with the LTC allowance as a cash benefit for those in need of LTC (Ranci et al., 2019). The coverage of residential care and community-based care services have been significantly diversified and extended over the last 30 years. However, these expansions have not met the growing need, a deficit that is exacerbated by staff shortages. In recent years, these shortages have meant

that some nursing homes have been unable to actually provide all the beds available. Tackling staff shortages has been at the heart of recent reform efforts in LTC. However, given projections of future care needs and the number of care workers retiring in the coming years and decades, significant shortages will persist unless further action is taken (Famira-Mühlberger, 2023; Juraszovich et al., 2023). Evidence on the extent to which LTC provision meets LTC needs is still limited for Austria. However, there is evidence of inequalities in the spatial distribution of LTC allowances that cannot be explained by the age and health of the population (Famira-Mühlberger et al., 2022; Pennerstorfer & Österle, 2023). Regarding services, regional differences in regulation and governance lead to different patterns of use. Finally, and as outlined above, central coordination, monitoring and quality assurance are limited in Austria mainly due to regional responsibilities for LTC and limited comparability of data on service provision.

Long-term care in Canada

Regulation and governance of long-term care

The regulation and governance of long-term care in Canada reflect a complex interplay of federal, provincial, and territorial responsibilities. Long-term care in Canada is primarily regulated and governed at the provincial and territorial levels, leading to a decentralized system with varying standards and practices across regions. Each province and territory is responsible for overseeing the delivery of long-term care services, setting regulations, and licensing care facilities within their jurisdiction. This decentralized approach allows for flexibility in tailoring care services to local needs and preferences but also presents challenges in ensuring consistent quality of care and access to services nationwide.

The regulatory framework for long-term care in Canada is guided by provincial legislation and regulations that outline the standards of care, staffing requirements, safety protocols, and quality assurance measures for care facilities.

In terms of governance, the ownership and management of long-term care facilities in Canada vary across provinces and territories. Some regions have predominantly public-owned facilities, while others have a mix of private for-profit and not-for-profit homes. The distribution of ownership can influence the quality of care, staffing levels, and accountability mechanisms within care facilities. For instance, Quebec has a unified public system that provides standardized care quality and oversight, while Ontario has a majority of private for-profit facilities (Milligan & Schirle, 2023).

Financing long-term care

Long-term care in Canada is financed through a combination of public and private sources, with each province and territory responsible for funding and administering long-term care services within their jurisdiction. Long-term care in Canada relies heavily on public funding, with government expenditure accounting for 78.4% of total spending. This significant reliance on public sources highlights the crucial role of government support in sustaining the long-term care system. In contrast, private long-term care insurance plays a minor role, contributing only 3.3% of total spending. Private, out-of-the pocket payments account for 18.3% of total spending (Milligan & Schirle, 2023).

Public expenditure on long-term care covers a range of expenses to ensure the provision of quality care services to individuals in need of ongoing support and assistance. Provinces and territories allocate public funds to support long-term care services, including staffing, facility maintenance, medical supplies, medications, and specialized equipment. Public expenditure supports various care settings, including nursing homes, assisted living facilities, home care services, and community-based programs. These services are designed to meet the diverse needs of individuals requiring long-term care. Investments in long-term care infrastructure, workforce development, and quality improvement initiatives are key components of public expenditure to enhance the accessibility and quality of care services.

As the impact of scarce resources for long-term care has been particularly evident in the COVID-19 crisis, the Canadian government has launched major investments in the long-term care system since the pandemic and adapted national LTC standards[11]). According to OECD data, Canada spent 2.3% of GDP on long-term care in 2021.

Coverage and benefits

78% of long-term care financing is covered by public means, 18% by private co-payments and only 3% by private insurance. Access to public long-term care facilities in Canada is typically based on eligibility criteria such as citizenship, residency, age, and health status. Public subsidies can often be used at private facilities. Need assessments evaluate an individual's functional abilities, health, and care requirements. Public subsidies are available for lower-income individuals to offset the costs of care. Needs assessments are conducted to determine the appropriate type of care for each individual, ensuring personalized and tailored services. However, disparities in coverage and benefits exist across provinces. Common benefits provided in long-term care settings include assistance with activities of daily living (such as bathing, dressing, and eating), medication management, nursing care, rehabilitation services, and social activities. Family members and caregivers of individuals in long-term care settings may also receive support services, education, and respite care to help them taking care of their relatives (Milligan & Schirle, 2023). Although there is no universal cash-for-care system in Canada, people who need care can claim a Disability Tax Credit and caregivers can claim the Canada Caregiver Credit, which is a non-refundable tax credit.

Regional disparities

Milligan and Schirle (2023) highlight that different provinces in Canada have varying systems for long-term care. For example, Quebec's system is largely in a unified public system, while New Brunswick's system is dominated by private not-for-profits, and Ontario has a majority of private for-profit facilities. These regional disparities in the public-private mix within Canada contribute to differences in funding mechanisms, service delivery models, and regulatory frameworks across provinces.

According to Milligan and Schirle (2023) the unique federal structure of long-term care in Canada presents challenges and opportunities. While the federal government has the capacity to

[11]) https://www.canada.ca/en/health-canada/programs/consultation-safe-long-term-care/document.html#a2

provide additional revenue for necessary investments, the decentralized nature of the system allows for experimentation and innovation at the provincial level.

Long-term care service provision

Despite increasing attention towards home and community-based care, the majority of public expenditures in Canada still go towards residential care in nursing homes. This emphasis on institutional care highlights the need for a shift towards more community-focused care models (e.g., home-based services, community care infrastructure) to better meet the evolving needs and preferences of an aging population.

Provision of residential care

The provision of residential care in Canada varies significantly across provinces, with different ownership structures and funding mechanisms influencing the quality and accessibility of care. While some provinces have predominantly public or not-for-profit facilities (e.g., Québec, Yukon, Northwestern Territories), others have a higher proportion of private for-profit homes (e.g., Ontario, British Columbia)[12]). In sum, 46% are publicly and 54% privately owned[13]). These facilities are funded and regulated by the government and provide care for elderly individuals who require 24-hour nursing and personal support.

Public subsidies are available to lower-income individuals to access long-term care services, including residential care. In many provinces, public subsidies can be used at private long-term care facilities. This allows individuals to choose from a range of care options, including both publicly owned and privately operated facilities, based on their preferences and needs. Residential care in Canada encompasses a variety of facility types, including nursing homes, seniors' residences, and combined nursing homes and seniors' residences. These facilities offer different levels of care and support to meet the diverse needs of elderly individuals requiring long-term care (Milligan & Schirle, 2023).

Support for informal carers

Informal caregivers play a vital role in supporting care recipients in both institutional and home-based settings. In Canada, one in four people aged 15 and older provided care to a family member or friend with a disability or issues related to aging in 2018 (Statistics Canada, 2020). There is a definition of a family caregiver or someone who is considered a family member for the purposes of government caregiver benefits (Government of Canada, 2023). Canada does not provide a cash benefit for informal caregivers; only the province Newfoundland and Labrador has a formal indirect cash benefit for caregivers (Government of Canada, 2023). However, all provinces provide some support for respite care, mostly in kind.

Canada offers paid and unpaid leave. Employment Insurance (EI) caregiver benefits provide financial assistance for up to 15 weeks to care for or support a seriously ill or injured person, or up to 26 weeks for someone who needs end-of-life care. A family member (or someone

12) https://www.canada.ca/en/health-canada/programs/consultation-safe-long-term-care/document.html#a2.

13) https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them.

considered by the caregiver to be a family member) can receive benefits for 52 weeks from the date the care recipient is certified by a doctor or nurse practitioner as being seriously ill or injured or in need of terminal care. The caregiver receives 55% of earnings up to a maximum of CAD 668 per week.

Unpaid leave is only available to those caring for a terminally ill relative. It can be taken for up to 28 weeks in a 52-week period to care for a family member who has a serious illness with a significant risk of death. Leave may be shared between family members. Provinces and territories may also have provisions for unpaid caregiver leave (e.g., Ontario). A doctor must sign a medical certificate. Unpaid leave applies to workers in federally regulated industries and workplaces and is limited to family members (Rocard & Llena-Nozal, 2022).

The labour market of long-term care workers

The demand for long-term care workers is expected to surge with the aging population, creating a need for a larger and more skilled workforce. Challenges in the long-term care labour market include low wages, high turnover rates, limited career advancement opportunities, and demanding work conditions. Addressing these challenges requires investment in workforce training, professional development, competitive compensation packages, and supportive work environments to attract and retain qualified caregivers (Milligan & Schirle, 2023).

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