



Ricardo Rodrigues / Manfred Huber / Giovanni Lamura

(Editors)

Facts and Figures on Healthy Ageing and Long-term Care

Europe and North America

EUROPEAN CENTRE FOR SOCIAL WELFARE POLICY AND RESEARCH
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List of figures and tables

INTRODUCTION AND KEY FINDINGS

Preface

Among the 20 countries with the highest life expectancy in the world, 17 belong to the Region of the United Nations Economic Commission for Europe (UNECE), which brings together 54 countries in and around Europe, as well as Canada and the USA.[1] But the population in Europe and (somewhat less so) in North America is not only the most long-living, but also the oldest worldwide in terms of the highest median age. However, this region is characterised by large and growing differences in terms of how people age, both between and within countries.

This calls for strong public health policies to make healthy ageing more equitable, which in turn requires a robust statistical evidence base to inform policy-making. In order to fill this gap, the European Centre for Social Welfare Policy and Research brought together a group of authors who have produced these "Facts and figures on healthy ageing and long-term care", which offers a broad statistical picture to inform the development of ageing policies in an international comparative perspective.

Ageing is high on policy agendas around the world. The European Commission has designated 2012 as the European Year for Active Ageing and Solidarity between Generations. In 2012, the world is celebrating the 10th anniversary of the Madrid International Plan of Action on Ageing with a Ministerial Conference in Vienna. Around April 7, 2012, World Health Day, activities and campaigns throughout the world have focused on ageing and health, raising awareness on what individuals and governments can do to promote active and healthy ageing.

This publication informs the joint vision shared in countries of Europe and North America of age-attuned and age-friendly societies, where older people can maintain maximum health and functional capacity and enjoy improved well-being and living in dignity, free of discrimination and with adequate financial means, and have access to high-quality health care and social support.

The European Centre for Social Welfare Policy and Research, affiliated to the United Nations in Vienna, wishes for this singular compendium of facts and figures to contribute to lively policy debates during 2012 and beyond.

Bernd Marin

Executive Director, European Centre

(1) Only states are counted here, not territories. The three other countries in this "top 20" are Japan, Australia and New Zealand.

Acknowledgments

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Introduction

Today, older people in many countries of Europe and North America have among the highest life expectancy in the world and in some countries enjoy access to elaborate long-term care services. Moreover, in many communities there are a growing number of voluntary actions supporting senior persons, many of which bridge across generations. At the same time, the commitment to informal care within the family, for partners and friends remains strong. Taken together, these trends represent important success stories of economic and social development in UNECE countries, as well as for health, social and long-term care policies. However, the acceleration of population ageing also raises concerns about the social and economic sustainability of current levels of care. The economic constraints and fiscal deficits experienced in many countries of the region since 2008 have not only increasingly put pressure on health and long-term care systems, but may also hinder future reforms – such as putting new long-term care benefits in place or increasing coverage for public support to informal care.

To age in good health, to maintain independence and autonomy in life choices as long as possible, and to continue residing and participating in the community, are not only important goals for individual persons. They also have political and economic consequences, e.g. by affecting the future sustainability of welfare states as well as of health and social care systems (WHO/Europe, 2012a: 46ff).

Many challenges remain to be tackled in this respect in Europe and North America. In too many cases, older persons with chronic health problems or who have started to need help on a continuous basis still have little resources they can rely on, other than their families and informal networks. This can put them in acute danger of social isolation, poverty and ultimately lead to hospitalization. In many cases little, if any, public support is available to support care in the family, and access to care in institutions may be limited, difficult or expensive. Moreover, problems of quality of health and social care still abound , as well as problems of coordination between health and social care systems.

Healthy ageing and long-term care

At first glance, 'healthy ageing' and 'long-term care' seem to refer to different challenges of successful ageing. 'Healthy ageing' is often referred to as prevention and monitoring of chronic diseases, often with a focus on the age group 50 years and above, what has been termed "early old age". On the other hand, "long-term care" deals mainly with the specific needs of people with functional limitations that are typical – although not exclusive – for people in their last years of life and related to the onset and aggravation of frailty. This can involve chronic disease, but usually includes other aspects of functional decline such as cognitive and mental limitations (WHO/Europe, 2012b). Furthermore, long-term care also entails a strong social component, because satisfying care needs also involves emotional support and maintaining social inclusion of both older people and of their – mainly informal – carers.

At the individual level, for many older people certain restrictions in their physical or mental condition might not necessarily be perceived as ill health or a threat to their independence, as long as sufficient alternative resources are available to compensate for deficits and still allow for – a redefined concept of – 'healthy ageing' in the future. For them, 'ageing well' also means that, despite the physical effects of ageing, they can continue to play an important role in their communities, labour markets and families, and take part in voluntary activities. Taking the perspective of older people sufficiently into account, and building upon the various resources of health, might therefore encourage a more realistic and sustainable concept of healthy ageing (WHO, 2002a).

Against this background, the authors of this publication have decided to link the comprehensive issue of 'healthy ageing' with the emerging concept of 'long-term care' for older people as well-defined social protection programmes. This publication builds on the findings of recent studies and research projects (such as INTERLINKS[1]), which clearly show that both quality and integration of care services for older people and their families are strongly related to quality of life and health in older age. Long-term care allows for bridging the gaps between health and social as well as formal and informal care, thus clearly representing a core resource for older people and their 'healthy ageing'.

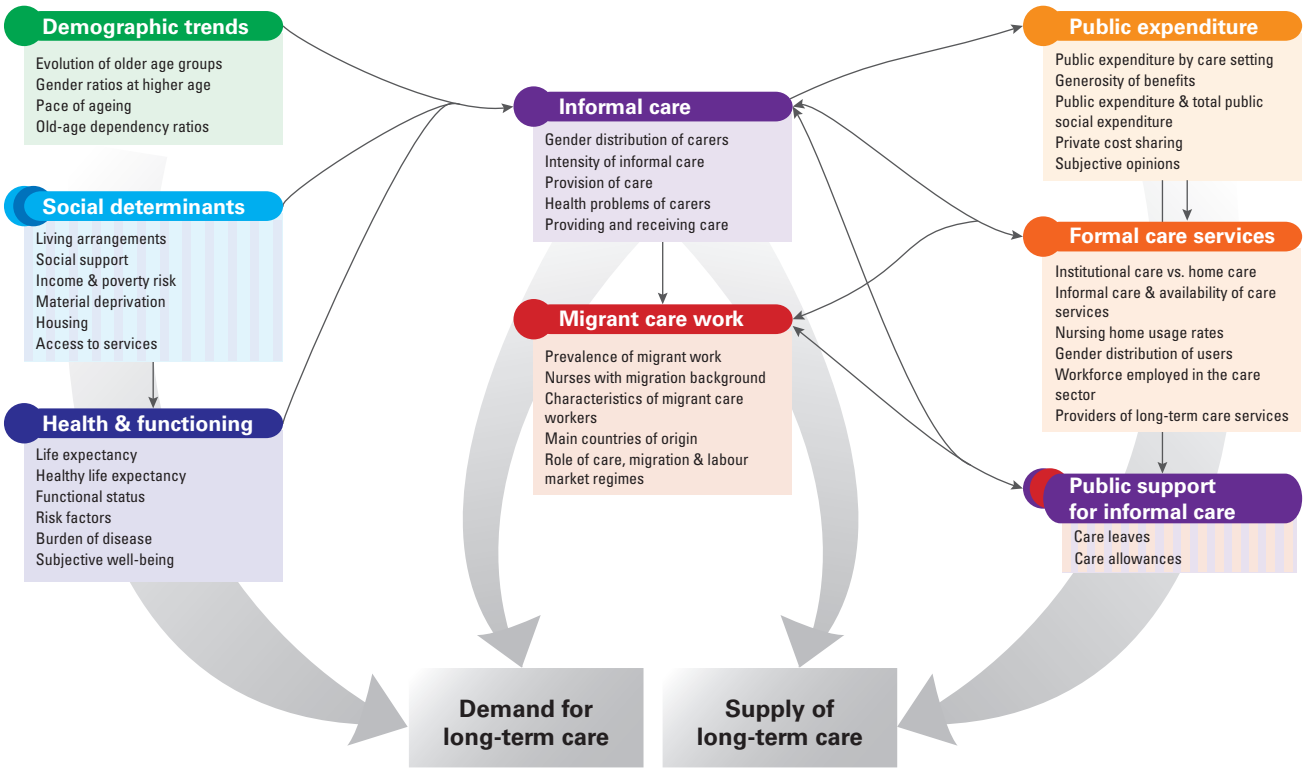
Aims and scope

This publication aims to provide governments, stakeholders and the broader public with a statistical portrait of cross-national trends and comparisons on population ageing in Europe and North-America, highlighting some of the main inter-connections mentioned above. It analyses how voluntary commitment as well as public and private provision of care can work together to help older people live independently as long as possible, and to support them when independent living becomes a challenge. It shows some of the solutions found by private households to solve care needs, such as hiring migrant care workers to deliver care. It also provides evidence for important social determinants of healthy ageing and independent living, such as housing and income situation, access to transportation and services, and staying socially connected.

This second edition of Facts and Figures has set out to grasp and do justice to this complexity and to the various dimensions of healthy ageing and long-term care as future-oriented concepts across eight chapters. As a data compendium, it highlights the achievements of longevity in Europe and North America, and provides a comprehensive picture of how governments have responded to the needs of older people for services at the boundaries between health and social care, and by focussing on the interplay between formal and informal care. The facts and figures presented here clearly show the great diversity characterizing countries in Europe and North America in this respect, as well as the remarkable challenges that lie ahead.

Perhaps most important, the statistical picture offered by this publication provides evidence on some of the main inter-linkages that affect and determine healthy ageing, and the demand and supply of long-term care (Figure a.1).

Figure a.1: Links affecting and determining healthy ageing and overview of the publication structure



First, there are common risk factors and social determinants that both affect healthy ageing during early old age as well as help prevent the onset or mitigate the course of frailty. Staying physically active is perhaps the most prominent example. Next, the demand for long-term care (be it formal services or informal support) is not only determined by demographic trends, health and functional status, but also strongly influenced by a number of social and economic determinants, such as living arrangements, social support or having a sufficient income.

Publicly funded support to long-term care and services, on the other hand, links to demand for long-term care in complex ways. It may take the form of direct or commissioned provision of care services (e.g. by private providers), or of cash benefits provided to either carers or those in need of care. Private cost-sharing and other financial (dis)incentives, such as means and asset tests or filial obligations, still play an important role in many countries. At the same time, there are multiple ways of ensuring public and private sector support to informal care at home by family or friends. This support is all the more important, as providing informal care can put the health of these carers at risk, many of whom are of "early old age" themselves.

Supply-side effects, such as institutional supply versus elaborated home care services, also play a role and these can interact with care provided by relatives in a number of complex ways (cf. Motel-Klingebiel et al., 2005, and Haberkern & Szydlick, 2010). The importance of migrants for providing both paid informal care in households and care in institutions has been growing fast in recent years in many countries. All this has implications in terms of the share of public resources devoted to long-term care and in terms of the public and private mix of funding.

All these aspects of healthy ageing and long-term care are covered in this publication, illustrating how the evidence base for healthy ageing and long-term care policy is progressing in an international comparative perspective.

As the new title suggests, this publication presents for the first time a number of novel topics and subject areas. In relation to the first edition (Huber et al., 2009), three additional chapters have been added to cover social and well-being of older people; their health status and selected risk factors, and important social determinants for successful ageing such as staying socially connected. In addition, there is a new chapter on migrant care workers.

Chapter 1 sets the scene, by analyzing the core demographic trends and population projections in Europe and North America. Although there are large differences between countries in their demographic structure, population ageing has been accelerating in many areas over the last decade. New measures and indicators provide innovative angles to look at demographic trends, such as identifying turning points of trends in the ageing process and non-standard measures of age-dependency ratios. Chapter 2 provides important additional information on living arrangements and on social determinants of health and well-being in older age groups, such as social participation and volunteering, which are key aspects of active[2] and healthy ageing. This is complemented in Chapter 3 by comprehensive information on the material well-being and living standards of older people. Information on the health status of older people across a number of domains, together with some of the main risk factors for chronic

conditions is presented in Chapter 4. This chapter also includes indicators on the subjective well-being of older people so as to present a broader picture of health in older age.

Chapter 5 confirms the huge commitment of families and the voluntary sector in supporting older persons with informal care. What is the scope of family care, how is it provided, and how does it impact on care-givers and their families? This chapter also provides insight into the complementarity of formal and informal care, and about outcomes, such as health threats for informal caregivers. Chapter 6 is a unique source of information on the growing importance of migrant care workers for long-term care, not only in private households, but also for care provided by formal providers. Chapter 7 illustrates the great diversity between countries in Europe and North America in the scope of publicly funded long-term care services at the boundary between health and social care. It also demonstrates large differences in the ways these services are provided. This variation and its impact on public expenditure is further analysed in Chapter 8, which focuses on public and private spending on long-term care.

This publication has been produced as a contribution to the MA:IMI project (Mainstreaming Ageing: Indicators to Monitor Implementation), undertaken by the European Centre for Social Welfare Policy and Research[3] and thanks to a specific financial contribution from the French Ministry of Social Affairs and Health.

Member Countries of the European Centre for Social Welfare Policy and Research have selected the development of a comparative set of indicators on long-term care as a thematic focus for the second phase of the MA:IMI project in the period 2008–2012.[4] The evidence base brought together in this publication is also an important contribution to inform the strategic work of other organisations, such as for the new framework for European Health Policy, Health 2020 of the WHO Regional Office for Europe, and its Strategy and action plan for healthy ageing in Europe, 2012-2020.

A note on methodology

The statistical picture provided in this publication brings together different kinds of data sets. First, it draws on available international data sets of cross-country comparisons. Moreover, it builds extensively on surveys, namely the European Union Statistics on Income and Living Conditions (EU-SILC) and the Survey of Health Ageing and Retirement in Europe (SHARE).[5] Although this means that for many items only a smaller number of countries could be compared, the use of survey data has allowed considerably broadening the picture on social determinants such as the interplay between formal and informal care.

As with the first edition, where possible, most UNECE countries are covered with some basic information, for example on demographic trends. For this edition, WHO datasets have been used for trends in health and disability among older persons. A number of topics have been researched by the European Centre based on detailed survey data, but with a more limited coverage, usually for the EU or a sub-sample thereof. For other topics, namely long-term care services and expenditure, data from the joint Eurostat/OECD/WHO data sets were expanded and complemented with original information from a number of additional country sources. The Statistical Annex reports a detailed review of the data sources used, comments on issues of data comparability and other aspects of data quality, as well as more background on the measurement of expenditure on long-term care in international comparisons.

(1) For more on INTERLINKS see http://interlinks.euro.centre.org/.

(2) As a concept that is related to healthy ageing, "active ageing" refers to "the process of optimizing opportunities for physical, social and mental wellbeing throughout the life course, in order to extend healthy life expectancy, productivity and quality of life in older age" (WHO, 2002a:12) and therefore places a stronger emphasis on the contribution of older people to society.

(3) The MA:IMI project has as its main goal to provide scientific and technical assistance to governments in the implementation and monitoring of their actions on ageing within the UNECE region (see Marin & Zaidi, 2007). This work is undertaken in the context of the Madrid International Plan of Action on Ageing together with its Regional Implementation Strategy (RIS).

(4) The UNECE currently has 56 Member States, including the Member Countries of the EU, CIS countries, countries of former Yugoslavia, Turkey, Israel, Canada and the United States.

(5) This paper uses data from SHARE wave 4 release 1, as of November 30th 2012 or SHARE wave 1 and 2 release 2.5.0, as of May 24th 2011 or SHARELIFE release 1, as of November 24th 2010. The SHARE data collection has been primarily funded by the European Commission through the 5th Framework Programme (project QLK6-CT-2001-00360 in the thematic programme Quality of Life), through the 6th Framework Programme (projects SHARE-I3, RII-CT-2006-062193, COMPARE, CIT5- CT-2005-028857, and SHARELIFE, CIT4-CT-2006-028812) and through the 7th Framework Programme (SHARE-PREP, N° 211909, SHARE-LEAP, N° 227822 and SHARE M4, N° 261982). Additional funding from the U.S. National Institute on Aging (U01 AG09740-13S2, P01 AG005842, P01 AG08291, P30 AG12815, R21 AG025169, Y1-AG-4553-01, IAG BSR06-11 and OGHA 04-064) and the German Ministry of Education and Research as well as from various national sources is gratefully acknowledged (see www.share-project.org for a full list of funding institutions).

Summary of key findings

The pattern and pace of population ageing across UNECE countries is not homogeneous. Countries with a relatively 'young' population today are expected to report a significant increase in their share of old-age population over a shorter period of time. At the same time, relatively 'older' countries will not necessarily witness a stabilization of their number of old-age people in the near future. Most countries will only reach the peak in terms of share of older people in the total population between 2055 and 2065, and many even later. There is one characteristic of the ageing process that sets apart countries in the UNECE region: Western European countries will witness a rapid 'ageing of the aged', as the share of those aged 80 and older among older people is growing fast.

Ageing is markedly different between men and women. The latter tend to live longer than the former, and although the over-representation of women among the 65 and older is projected to decrease in the future, women will still outnumber men in older age groups. While women live longer than their male counterparts, they tend to have poorer health in old-age, making them more prone to needing care. This is compounded by the fact that women are much more likely to live alone in older age than men.

Living arrangements, where single households become predominant, may also place older people at a higher risk of social isolation and exclusion. Again, there are marked cross-national differences. While across all countries studied many older people report to have much less chances to discuss personal matters (in comparison with the younger population), in many Central and Eastern European countries one out of four seniors meet friends or relatives less than once a month or never. Older people living alone, particularly women, are also much more likely to be at risk of poverty than other older people.

Country differences in poverty rates among those aged 65 and older mostly mimic the differences found between countries for the total population, while poverty among the oldest age group (80 and older) tends to be significantly higher. Marked differences between countries exist in terms of material deprivation (i.e. of access to basic goods): a much greater share of old-age people in Central and Eastern European countries lack access to basic goods than in other nations.

For the most part, older people have fairly adequate housing (i.e. not overcrowded or lacking adequate living conditions), in comparison with the total population. Furthermore, the costs of housing – which for the most part is related to seniors' own property – are not significantly different from those borne by the total population, unless they live in rental accommodation. However, old-age people in Central and Eastern Europe are much more likely to report poorer housing conditions than their Western European counterparts.

Demography, health and social conditions all play a role in shaping demand for care in older age. The probability of needing care is higher among the older age groups (aged 80 and older), which means that as their proportion among the total population increases, this is likely to translate into greater demand for care. Unlike any other stage of life, this is the age group in which living arrangements exhibit a prominence of single households, which could imply less access to informal care. While the prevalence of many conditions is not significantly different among older age groups, prevalence of dementia increases significantly in the fastest growing group of those aged 80 years and over.

Informal care continues to be the main form of care provided to dependent older people in Europe and North America, and recent policy options (e.g. cash benefits) mean that this picture is likely to hold in the future. While most carers are of working age and women, a significant number of older people, and among these increasingly older men, provide care to relatives or friends. Many of these older carers have health problems of their own. To address issues of reconciliation of work and caring activities, a number of countries have set up care leave programmes of various lengths and generosity levels.

Patterns of co-residency in old-age, but also policy options, account for some of the patterns of informal care in Europe. For example, among older age groups the share of men providing informal care is higher than that of women – a difference that disappears once the effect of living in a couple is accounted for among older men. Prevalence of informal care (both provided and received) is higher in countries with developed care services, while in those countries where services are not available, or that rely on cash benefits, the intensity of informal care resembles that of a full-time occupation.

Migrant care workers (most of whom are women) play an increasingly important role in care provision in many UNECE countries, particularly in home care. In Mediterranean countries they are mostly employed by private households in the grey labour market. This effectively means an outsourcing of care duties from the family to migrant carers. In countries such as the United Kingdom, Austria, Germany and Switzerland, migrant carers are also often employed in the formal care sector. Patterns of migration follow geographic or historical ties (e.g. carers from Latin America coming to Spain).

In most UNECE countries, dependent older people are cared for in their own homes. Despite population ageing, coverage of home care benefits (services or cash) has increased in the past decade for most countries, while the importance of institutional care has decreased in relative terms. In a testimony of the development of home care, people aged 80 and older are more likely to receive care at home than in institutions. Users of long-term care are on average 80 years or older, particularly in institutional

care, and overwhelmingly women. Only a very small minority of those aged 65-79 receive these care benefits for countries where data are available.

Public resources devoted to long-term care are still, for most countries, relatively small as a percentage of the Gross Domestic Product (GDP) or as part of total public social expenditure. Differences between countries go well beyond simply mirroring differences in demographic ageing. They also reflect differences in the mix of public-private provision and funding of care. Whilst most users of care benefits still reside in their homes, a significant share of public expenditure is devoted to institutional care. Users and their families remain heavy contributors to the funding of institutional care, with a number of countries requiring the contribution of children or convertible assets of older people to contribute to the payment of care.

LIST OF ACRONYMS

ADL	Activities of Daily Living
BMI	Body Mass Index
CAD	Canadian Dollar
CIS	Commonwealth of Independent States
DRESS	Direction de la Recherche des Etudes de l'Evaluation et des Statistiques (*France*)
ECFIN	European Commission, Directorate General for Economic and Financial Affairs
ECV	European Centre for Social Welfare Policy and Research (Vienna)
EFTA	European Free Trade Association
ESS	European Social Survey (European Commission)
EU	European Union
EU27	Group of 27 EU Member Countries (by end of 2012)
EU12	Group of 12 new EU Member Countries after May 2004
EuroCoDe	European Collaboration on Dementia
EUROFAMCARE	Services for Supporting Family Carers of Elderly People in Europe: Characteristics, Coverage and Usage (FP5 Project)
EUROFOUND	European Foundation for the Improvement of Living and Working Conditions
Eurostat	Statistical Office of the European Commission
EU-SILC	EU Statistics on Income and Living Conditions (Eurostat)
GDP	Gross Domestic Product
GGS	Generations and Gender Survey (UNECE)
ICT	Information and Communication Technology
IADL	Instrumental Activities of Daily Living
ILO	International Labour Organisation
INTERLINKS	FP7 project "Health systems and long-term care for older people in Europe. Modelling the interfaces and links between prevention, rehabilitation, quality of services and informal care" (2009-2012)
MA:IMI	Mainstreaming Ageing: Indicators for Monitoring Implementation
MIPAA RIS	Madrid International Plan of Action on Ageing, Regional Implementation Strategy
NA	Not Applicable
OECD	Organisation for Economic Co-operation and Development
OADR	Old age dependency ratio
OLS	Ordinary least squares
POADR	Prospective old age dependency ratio
SHARE	Survey of Health, Ageing and Retirement in Europe
SPRU	Social Policy Research Unit – University of York
UNDESA	United Nations Department of Economic and Social Affairs
UNECE	United Nations Economic Commission for Europe
UNPP	United Nations Population Programme
WHO	World Health Organisation
WHO/Europe	World Health Organization Regional Office for Europe
WHO FCTC	WHO Framework Convention on Tobacco Control
YLD	Years of life lived with disability
YLL	Years of life lost

Chapter I:

DEMOGRAPHY

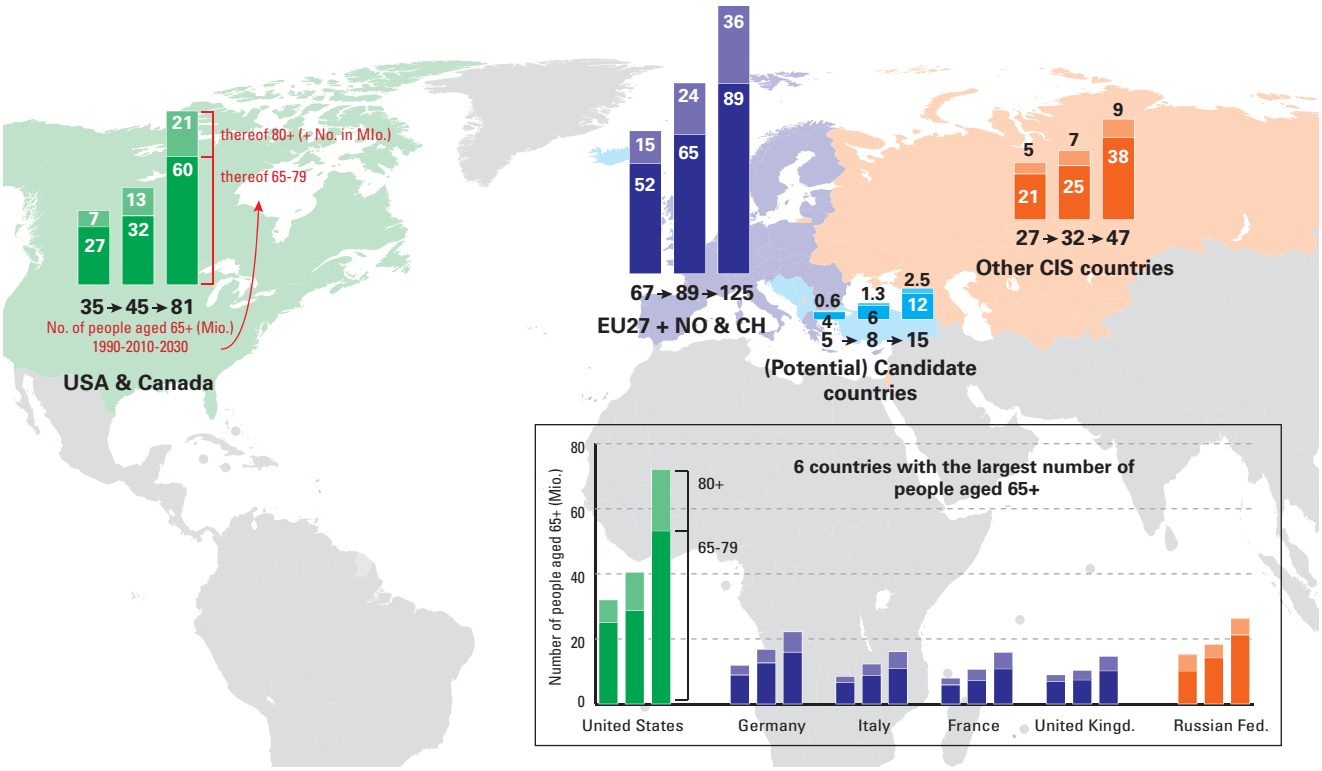
174 MILLION PEOPLE AGED 65 OR OLDER IN FOCUS

.... 40 million people more than 20 years ago

Evolution of the absolute number of people in older age-groups (65-79 and 80 and older) in UNECE regions

The cut-off point at the age of 65 is commonly used to define older age-groups, after which age a majority of the population has retired from paid work. But a large share of those aged 65 or older still enjoy good health. The share of people with functional limitations grows fast after the age of 80 and this is currently the fastest growing age group. The 65-79 age group also has implications for healthy ageing and long-term care policies, not least because many spend some of these years as informal carers of others.

Figure 1.1: Evolution of the population in the older age groups (65 and older, 65-79, 80 and older), 1990, 2010 and 2030



Source: own calculations based on UNPP (2011): World Population Prospects – The 2010 Revision.

- 174 million people in Europe and North America are aged 65 years or older. This is about 40 million people more than 20 years ago and a further increase of about 93 million people is expected within the next 20 years, which clearly illustrates that population ageing is accelerating.
- The EU together with Switzerland and Norway accommodates more than half of all older persons across the UNECE region. Although being relatively small in terms of surface area, more than 89 million people aged 65 and older live in this region and almost one third of them are at least 80 years old. Among the top six countries with the largest number of older people in the UNECE region, four countries belong to the EU.
- The share of those aged 80 and older within the total population is rising across countries of the UNECE region. However, among the country groups shown in Figure 1.1, the EU (plus Norway and Switzerland) is the only group of countries that is expected to face an even higher share of 80 and older among those aged 65 and older in 2030 than today.
- The most significant demographic changes are expected within the EU candidate and potential candidate countries. Although this group of countries will still be among those with the lowest share of people aged 80 and older in the total population, the number of people aged 80 and older will almost double within the next 20 years.

Limitations of population projections

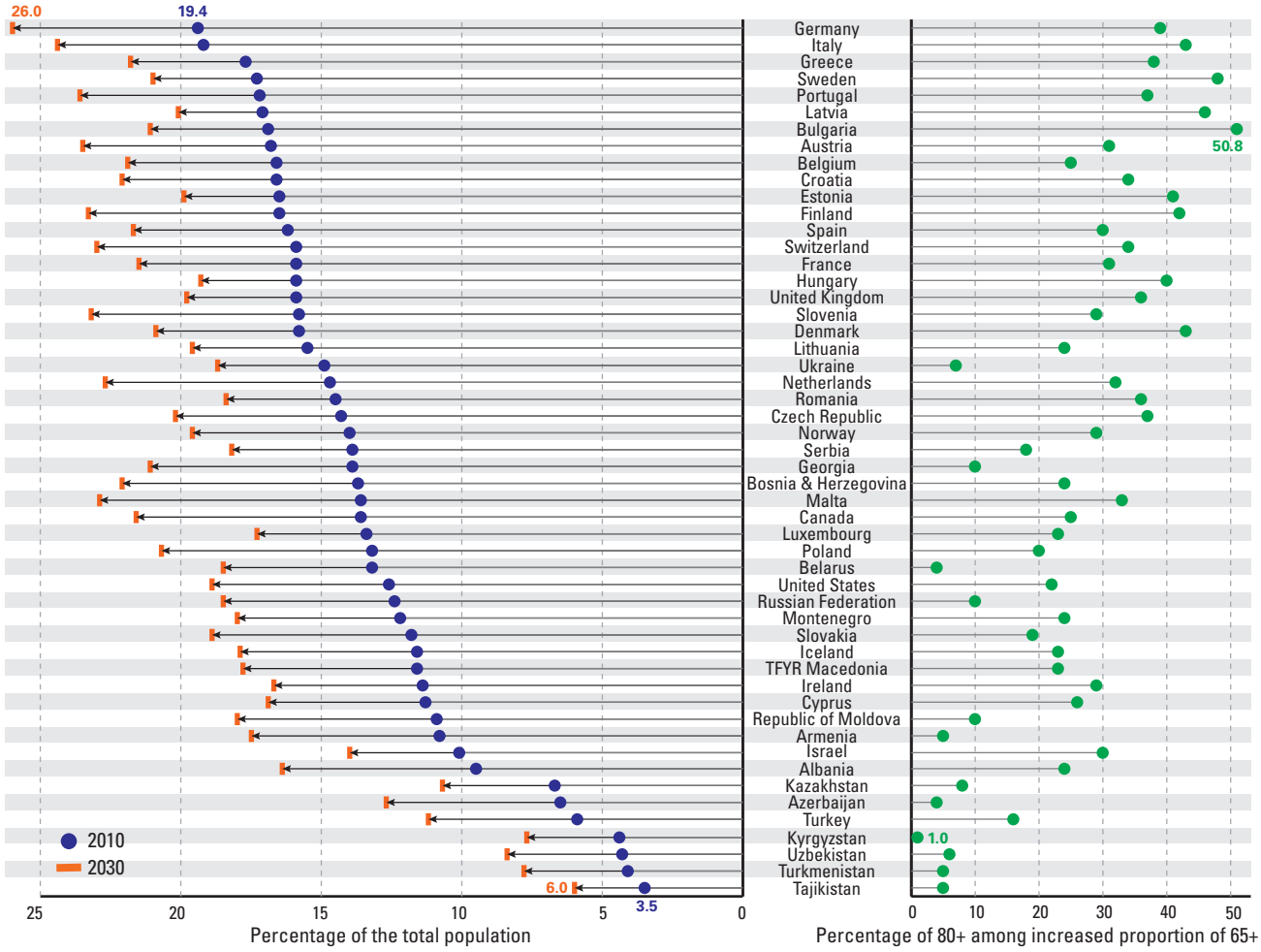
Projections are estimations based on assumptions about future fertility, gains in life expectancy and migration, which are all subject to revisions when new data become available. Projected gains in life expectancy for example, have been consistently underestimated in the past (OECD, 2005). There is also much uncertainty about the role migration will play in the coming decades.

EUROPE AND NORTH AMERICA: DIFFERENT SPEEDS OF AGEING

Evolution of the share of population aged 65 and older and the role of the 80 and older age group for population ageing

The share of those 65 and older in the total population shows the relative size of an older age group compared to the younger population. The chart on the right hand-side provides information on how much the increase in the number of older people from 2010 to 2030 is actually due to an increase in the 80 and older age group.

Figure 1.2: Evolution of the share of population aged 65 and older and of the share of those aged 80 and older among the increased proportion of 65 and older, 2010 and 2030



Source: own calculations based on UNPP (2011): World Population Prospects – The 2010 Revision

- The ageing of populations is unequal across the European and North American regions.
- The speed of change until 2030 is not necessarily connected to the share of 65 and older in 2010. Some countries with lower shares in 2010 will catch up with countries with higher shares (see for example Malta), while countries with already high shares among older age groups today continue to grow even older. But as a general rule the speed of change is highest in countries with the lowest share of those aged 65 and older in 2010.
- In most EU Member States, those aged 80 and older play a major role in the increase of older people until 2030.
- While in 2010 almost 20% of the population in Germany were aged 65 or older, less than 4% have already reached this age in Tajikistan. Although the share of people aged 65 and older is still increasing, the speed of change is much higher in Tajikistan with an increase of more than 70% compared with, for example, Germany with an increase of 34%.
- People aged 80 or older account for at least one third of the increase till 2030, especially in countries with the highest share in 2010. In fact, at least in these countries, the most important trend will be a change among the age group 65 and older towards an ever-larger share of those that are 80 or older – the ageing of the aged – which is expected to have a significant impact on health and long-term care needs.
- On the contrary, the share of those aged 80 and older plays a rather minor role in most Commonwealth of Independent States (CIS) countries like Armenia, Belarus, Kyrgyzstan and others. This is partly due to the "mortality crisis" of prime-aged men (DaVanzo & Grammich, 2001) which becomes apparent in Figure 1.3 where the over-representation of women in old age is discussed.

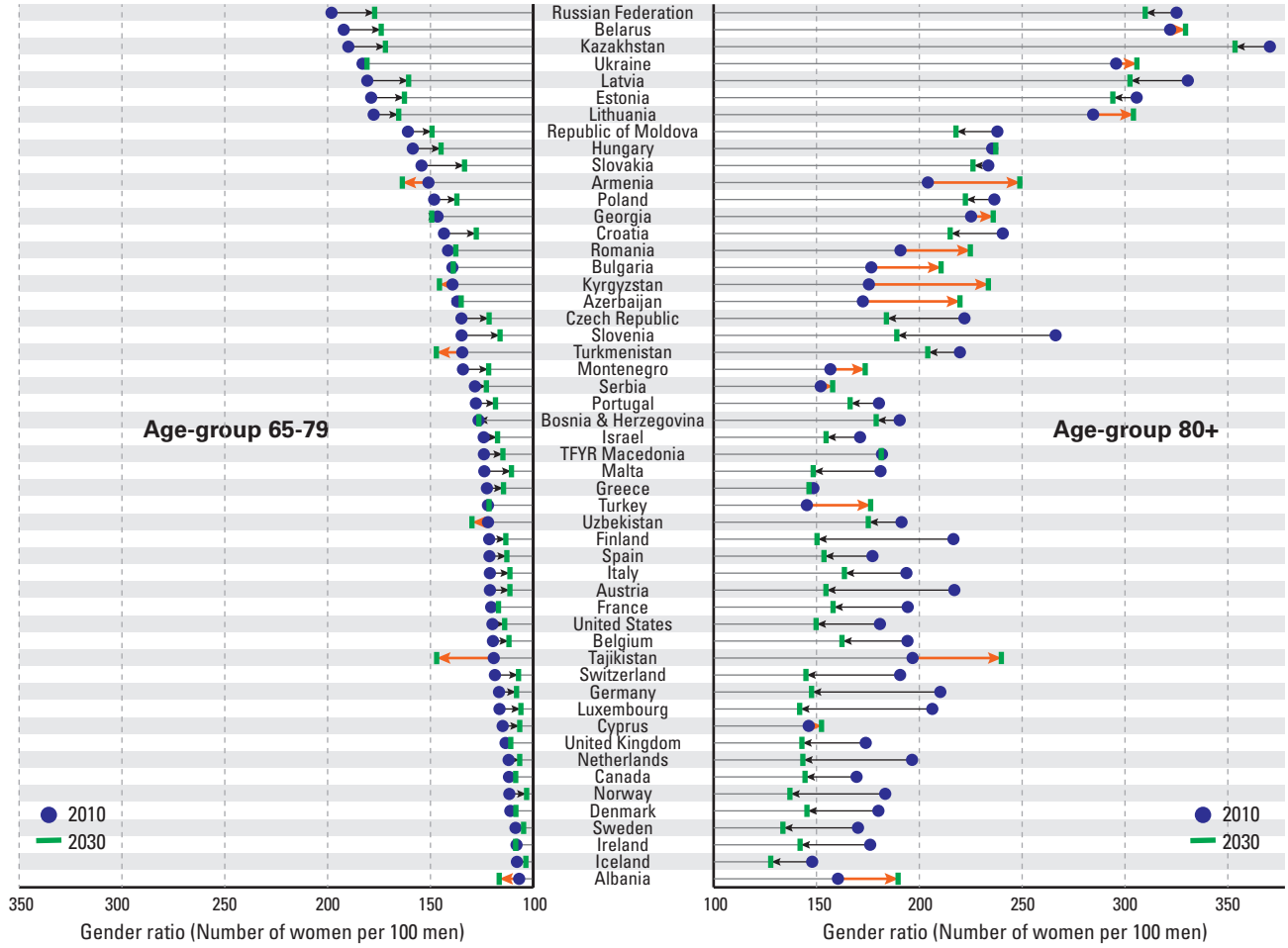
MORE OR LESS OF A WOMEN'S WORLD IN THIRD AGE

… but differences are expected to decrease over time

Evolution of the gender ratio of the age groups 65-79 and 80 and older

The gender ratio gives an indication of the female over-representation in older age, which has an impact on health and long-term care provisions.

Figure 1.3: Evolution of the gender ratio in the 65-79 and 80 and older age groups, 2010 and 2030



Source: own calculations based on UNPP (2011): World Population Prospects – The 2010 Revision.

- Women make up for the majority of older people and this is even more the case for the population aged 80 and older. As a general rule the older the age group, the higher the female share of the population which is also reflected by the higher life expectancy of women both at age 65 and 80 (see Chapter 4).
- Among all countries, the Russian Federation has the highest over-representation of women in the age group 65 to 79 (almost 100%). Among those 80 and older, the overrepresentation is highest in Kazakhstan (with more than 250%). Differences in life expectancy, as well as gender differences in disability levels, are important factors to explain why most beneficiaries in long-term care are women (see Chapter 7).
- For the future, almost all countries will experience a decrease in the over-representation of women in the age group 65 to 79, with the exception of Armenia, Georgia, Kyrgyzstan, Turkmenistan, Uzbekistan, Tajikistan and Albania. In 21 out of 52 countries the over-representation is estimated to be less than 15% in 2030.
- The development among the older age group (80 and older) is less homogenous. Almost one third (16 countries) will have a higher over-representation of women in 2030 than in 2010. Among these countries are mostly those of the Commonwealth of Independent States (CIS) but also EU Member States such as Cyprus, Bulgaria, Romania and Lithuania.
- The number of men and women in older age will be more balanced in the future. This offers the opportunity to live together longer in higher age groups (see Chapter 3) and thus may have implications for care giving.

Definitions

The gender ratio measures the gender parity by dividing the number of women of a given age group by the number of men of the same age group. 100 means that the number of women is equal to the number of men while values above 100 signal that women are over-represented in the given age group.

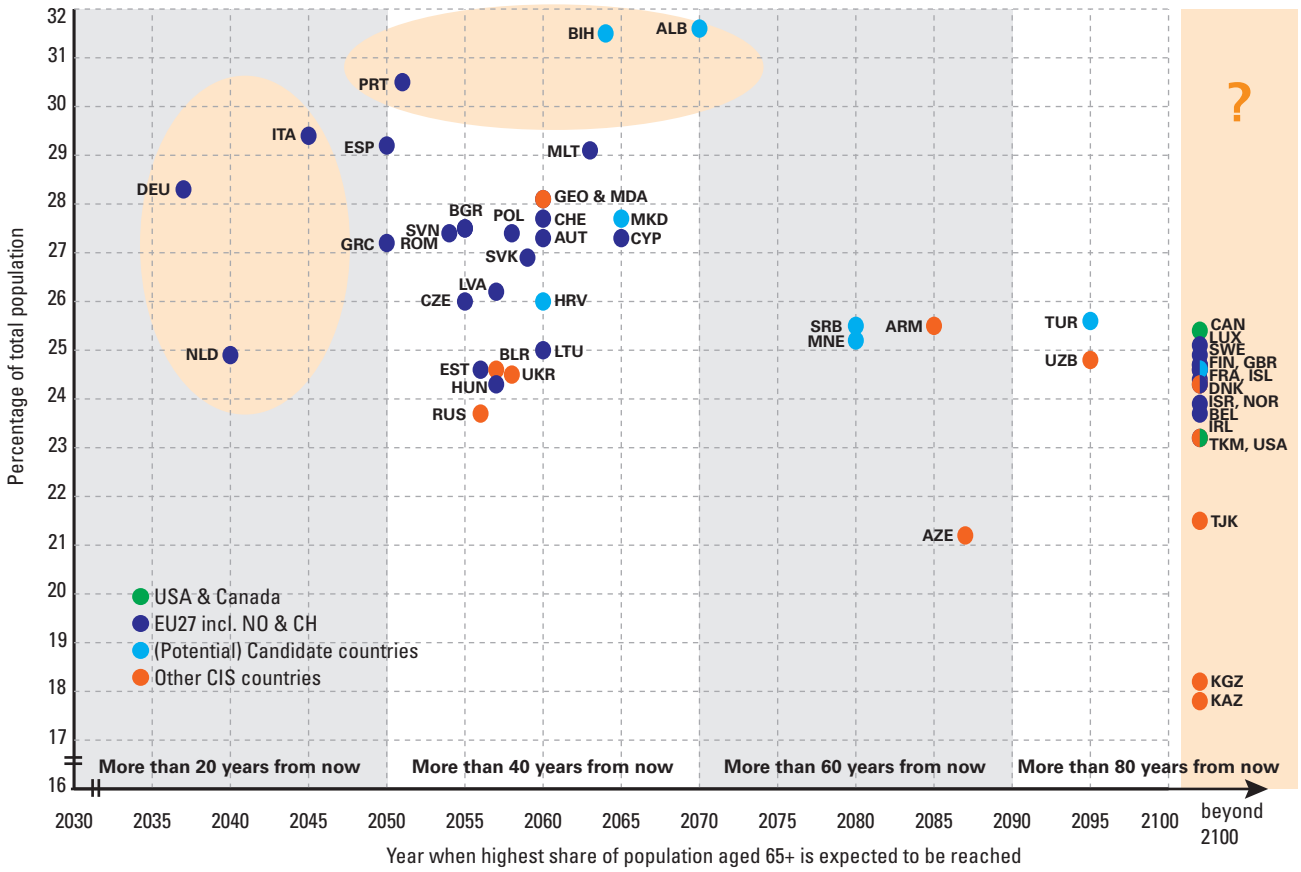
WHEN WILL COUNTRIES REACH A PEAK?

In terms of increasing numbers of older people

Year when the share of the population aged 65 and older is expected to reach a peak and share of people aged 65 and older in the peak year

Projections of the share of those 65 and older beyond 2030 give an indication of the time span populations will continue to age in terms of increasing numbers of older people. Due to several factors, such as the different timing of baby boomer generations or different levels of life expectancy as well as different levels of population change, population ageing occurs at different levels and pace.

Figure 1.4: Year when the share of the population aged 65 and older is expected to reach a peak and share of people aged 65 and older in the peak year



Source: own calculations based on UNPP (2011): World Population Prospects – The 2010 Revision.

- Most countries will only reach the peak year – with the highest share of the population aged 65 and older – in over 40 years. Countries with already high shares of the population aged 65 and older in 2010 tend to reach the peak year earlier than countries with comparably low shares.
- Despite the fact that countries are expected to reach the peak year in different decades, countries will also have to face different levels in the share of those aged 65 and older.
- Germany and Italy, the two countries with a share higher than 19% in 2010, together with the Netherlands are expected to reach the peak year at least five years earlier than other countries.
- A further exception is a very heterogeneous group of 17 countries that nevertheless share at least one characteristic, i.e. to have not reached an estimated peak year by 2100. This group consists of CIS countries (e.g. Kazakhstan), as well as EU 27 Member States (e.g. the United Kingdom) and the United States and Canada. The underlying data source does not provide figures beyond 2100, thus further developments cannot be depicted in the graph. In any case, projections that far into the future have to be interpreted with caution.
- The three countries with the highest projected shares in the peak year are Albania (31.6%), Bosnia and Herzegovina (31.5%) as well as Portugal (30.5%). Albania is also the country with the highest estimated increase from 2010 until the peak year in 2070, which amounts to 22%.

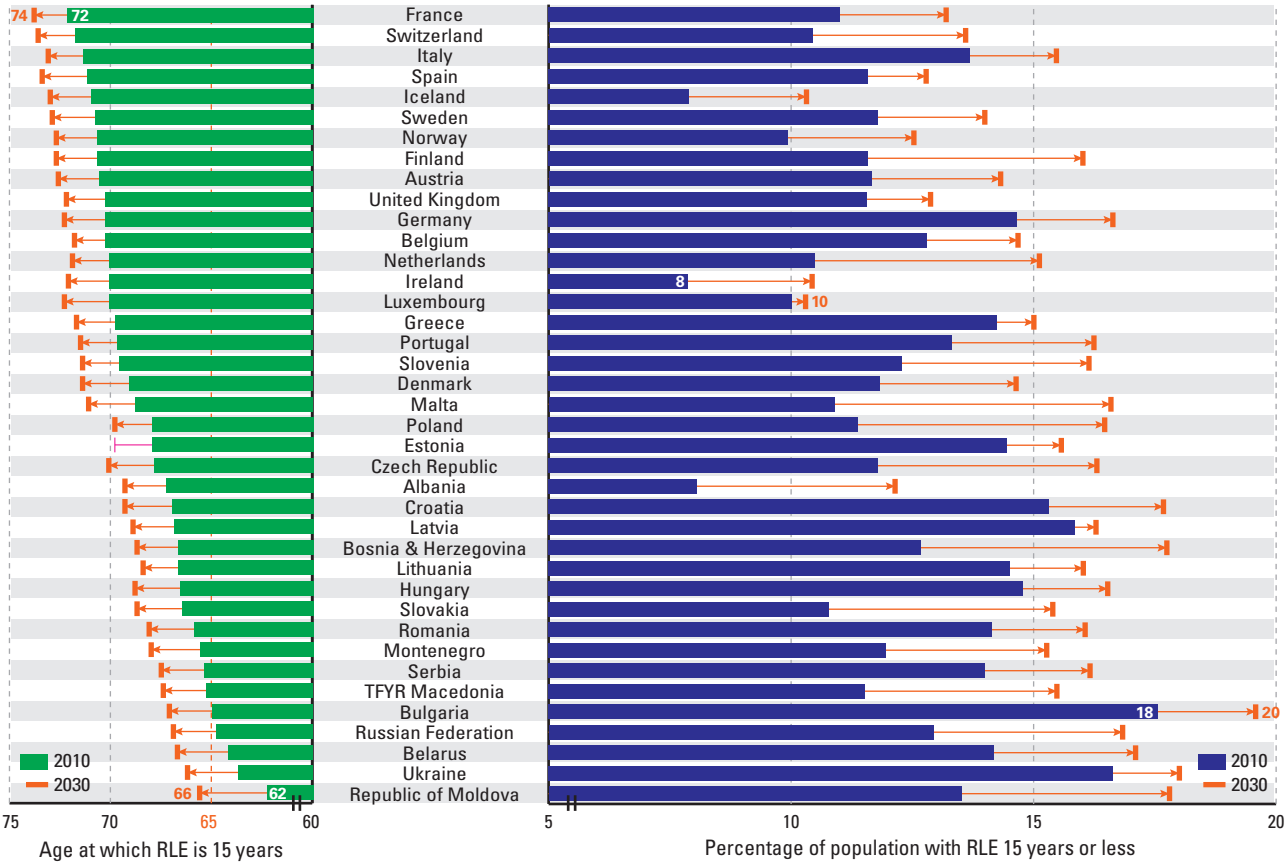
RE-DEFINING AGEING

From a chronological to a dynamic definition of population ageing

Age at which remaining life expectancy is 15 years on average and share of people with a remaining life expectancy of 15 years or less

This alternative indicator uses a dynamic age breakdown that takes rising life expectancy into account. Sanderson & Scherbov (2008) suggest using a prospective age definition instead of chronological age to take into account the fact that the meaning of years lived changes over time.

Figure 1.5: Age at which remaining life expectancy is 15 years on average and share of people with a remaining life expectancy of 15 years or less, 2010 and 2030



Source: Data kindly provided by W. C. Sanderson and S. Scherbov (calculations are based on UNPP (2011): World Population Prospects – The 2010 Revision).

- By using a dynamic age breakdown, the definition of people at older ages is different from country to country, depending on the life expectancy of the country and changes over time.
- Across countries, life expectancy in older age (see Chapter 4) is going to rise and with it the age 'free of severe disease and functional limitations' is expected to increase as well.
- In 2010, the age range starts at 62 years in the Republic of Moldova and goes up to 72 years in France. Four countries are below the usually used age breakdown of 65 years, including the Republic of Moldova.
- In 2030, France will still be the country with the highest age when 15 years of remaining lifetime are considered. Nevertheless, other countries are estimated to catch up. For example, the difference in years between the Republic of Moldova and France will change from 10 to 8 years.
- Applying this definition shows that in 2010, Bulgaria was the country with the highest share of older people (17.6%) and Ireland the one with the smallest share (7.9%). Projections until 2030 show that Bulgaria will continue to be the 'oldest' country according to this dynamic age cut-off, while Ireland is going to be replaced by Luxembourg.
- As mentioned before, with growing longevity, more and more people aged 65 and older live active lives in various roles for their friends, families and communities. The dynamic definition of ageing is therefore an important complement to standard age-dependency ratios (see Figure 1.6).

Definitions

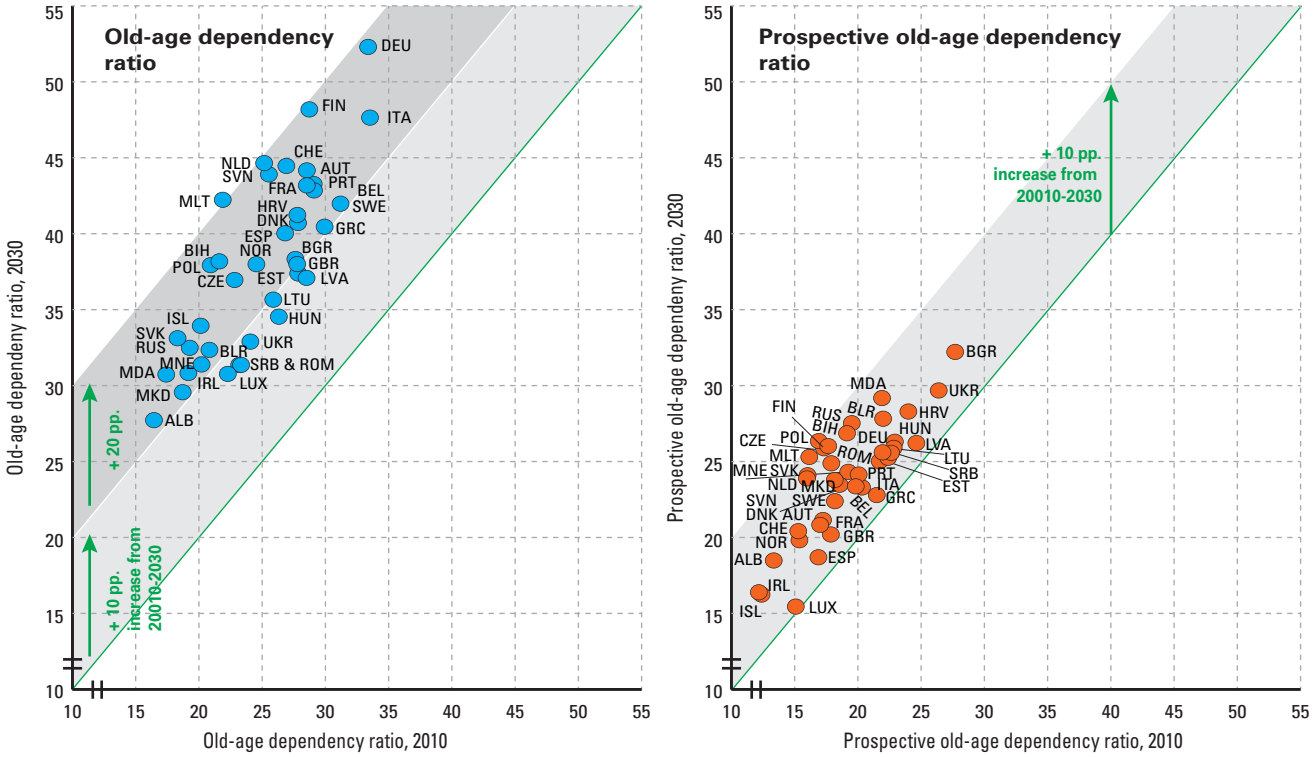
A dynamic age cut-off is defined as age where the remaining life expectancy is 15 years. This changes over time and differs between countries.

RE-DEFINING THE OLD-AGE DEPENDENCY RATIO

Evolution of the old-age dependency ratio and prospective old-age dependency ratio

Even though the growth of the population in the oldest age groups is only one factor impacting on public long-term care systems, it nevertheless plays an important role in their sustainability. Therefore, an old-age dependency ratio is often used as a key indicator in assessing the sustainability of health and long-term care policies. As an alternative indicator, Sanderson & Scherbov (2008) suggest using a dependency ratio that takes changes in life expectancy into account and uses a dynamic age breakdown, the so-called prospective old-age dependency ratio (see previous item).

Figure 1.6: Evolution of the old-age dependency ratio and prospective old-age dependency ratio, 2010 and 2030



Source: Data kindly provided by W. C. Sanderson and S. Scherbov (calculations are based on UNPP (2011): World Population Prospects – The 2010 Revision).

- As the left hand side of the graph shows, all countries will have to cope with an increasing old-age dependency ratio in the coming decades.
- Future scenarios of the prospective old-age dependency ratio provide a more optimistic picture than the classic old-age dependency ratio.
- Across countries, there will be up to 20 more persons aged 65 and older for 100 individuals of working age in 2030 than today. In Germany, the country with the highest share of older population today and in 2030, the ratio of people aged 65 and older to the working age population will change from 34 per 100 to 52 to 100.
- The right-hand side of the graph shows that both the starting point of the prospective old-age dependency ratio in 2010 as well as expected developments are less dramatic, ranging from 5 to 10 percentage points.
- Trends in old-age dependency ratios not only have implications for the sustainability of long-term care policies but even more for the pressure on pension and health care systems.
- As many people aged 65 and older provide informal care to their older relatives, in particular where welfare states fail to provide necessary long-term care services, the prospective old-age dependency ratio also has the potential to better highlight the future relationship between care recipients and potential numbers of caregivers.

Definitions

Old-age dependency ratio (OADR): ratio of the number of people 65 years and older to the number of people aged 20 through 64.

Prospective old-age dependency ratio (POADR): ratio of the number of people above the old-age threshold to the number of people from age 20 to the old-age threshold.

Chapter 2:

SOCIAL CONNECTEDNESS

HOME ALONE?
Living arrangements over the life-cycle

Living arrangements of two older age groups (65-79 and 80 and older) compared to the total population

Living arrangements give an indication of the potential support available within households and the effort older people need to make to stay in personal contact with others. Living arrangements may also have implications for informal care provision and care demand, as well as poverty.

Figure 2.1: Living arrangements of older people aged 65-79 and 80 and older compared to the total population, 2010

Source: Own calculations based on EU-SILC 2010 (release date March 2012). Note: Data for Cyprus and Ireland refer to EU-SILC 2009 (release date August 2011).

- Older people aged 65 to 79 tend to live as a couple, in contrast to the general population, where households with more people, with children or other constellations are the dominant living arrangement. Nevertheless, a third of those aged 65 to 79 in Bulgaria and Spain still live in larger households with more than 2 persons and/or children. On the contrary, this household type is almost non- existent within the 65 to 79 age group in Northern European countries such as Finland, the Netherlands, Norway and Sweden.

- Living arrangements of the oldest old (i.e. 80 and older) also show a clear South-North divide. While most people in this age group live on their own in the Nordic countries (between 57 to 67%), this is less common in Southern European countries such as Cyprus, Greece, Portugal and Spain. As data only cover older people living in private households and not in institutions, the figures might be influenced by the availability of care services at home. In countries where home care services are scarce, older people in need of care may find themselves in institutional care. Thus, the share of older people living alone may also display differences between 'care regimes' (see Chapter 7).

- One part of the explanation why single households increase with age is the higher share of older women within the 80+ age group. While men tend to live more often in households with more people, women often live alone which is often the result of a higher female life expectancy.

Definitions

The following household types are distinguished:

- Single: people living alone in the household.
- Living as a couple: Two adults living together in one household. This household type does not take the relationship between the two adults into account but only uses the age to identify the two-adult household.
- Other households: This category comprises all other households (e.g. single-parent households, households with children, other households with more than two people)

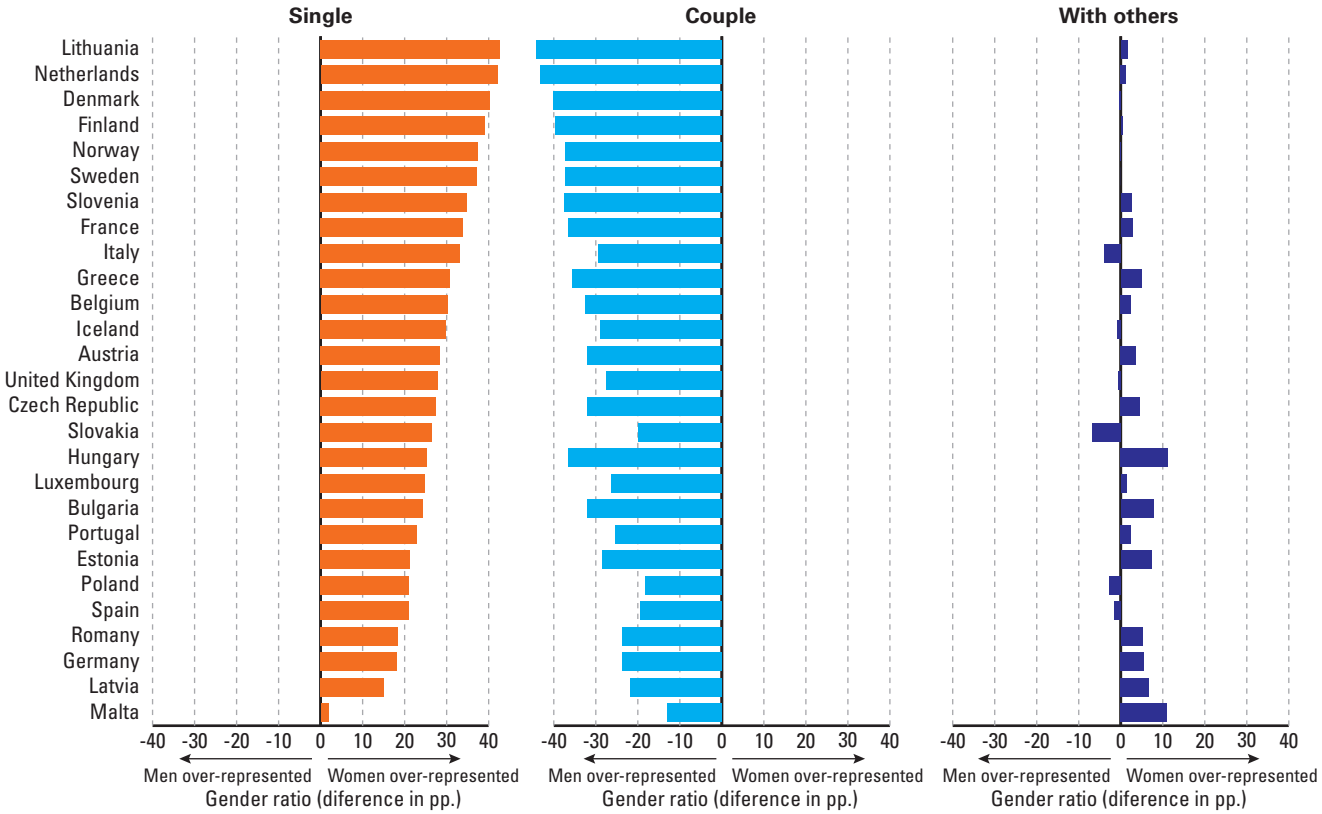
Household types do not include those residing in institutions.

IN VERY OLD AGE WOMEN LIVE ALONE MUCH MORE FREQUENTLY THAN MEN

Living arrangements of those aged 80 and older, by gender

This indicator presents differences in living arrangements of the oldest age group by gender. Living arrangements play an important role in social connectivity (e.g. allowing people to keep in touch with others), care demand (via provision of informal care by spouses) and protection from poverty.

Figure 2.2: Differences in living arrangements between men and women aged 80 and older, 2010



Source: Own calculations based on EU-SILC 2010, version of March 2012

- There is a striking difference in the living arrangements of men and women aged 80 and older. Across Europe women are much more likely to live alone, while men are more likely to live in 'couple' households.
- Gender differences are largest in Lithuania, the Netherlands and in the Nordic countries and less pronounced in most Eastern European countries.
- Malta has the smallest gender difference both with respect to single and to adult households, and it is also the only country where more women aged 80 and older live in 'other' or 'couple' households than alone.
- In all countries but five (Slovakia, Poland, Romania, Slovenia and Malta) more than 50% of men in this age group live with their spouses. In all countries but ten (e.g. Latvia, Germany, Romania, Greece, Slovakia, Hungary, Portugal, Bulgaria, Spain and Malta), the majority of women aged 80 and older live alone.
- Gender differences in 'other' living arrangements are in comparison rather small.
- Differences in life expectancy and marital status (e.g. men are more likely to remarry at older stages of life) explain much of these gender differences.
- The gendered differences in living arrangements may have implications in terms of the provision of informal care and demand for care services. Those living alone are less likely to receive or provide informal care and thus more prone to be in need of care services.

Definitions

Gender differences in a given living arrangement refer to the difference (in percentage points) between the percentage of women and that of men in a given living arrangement.

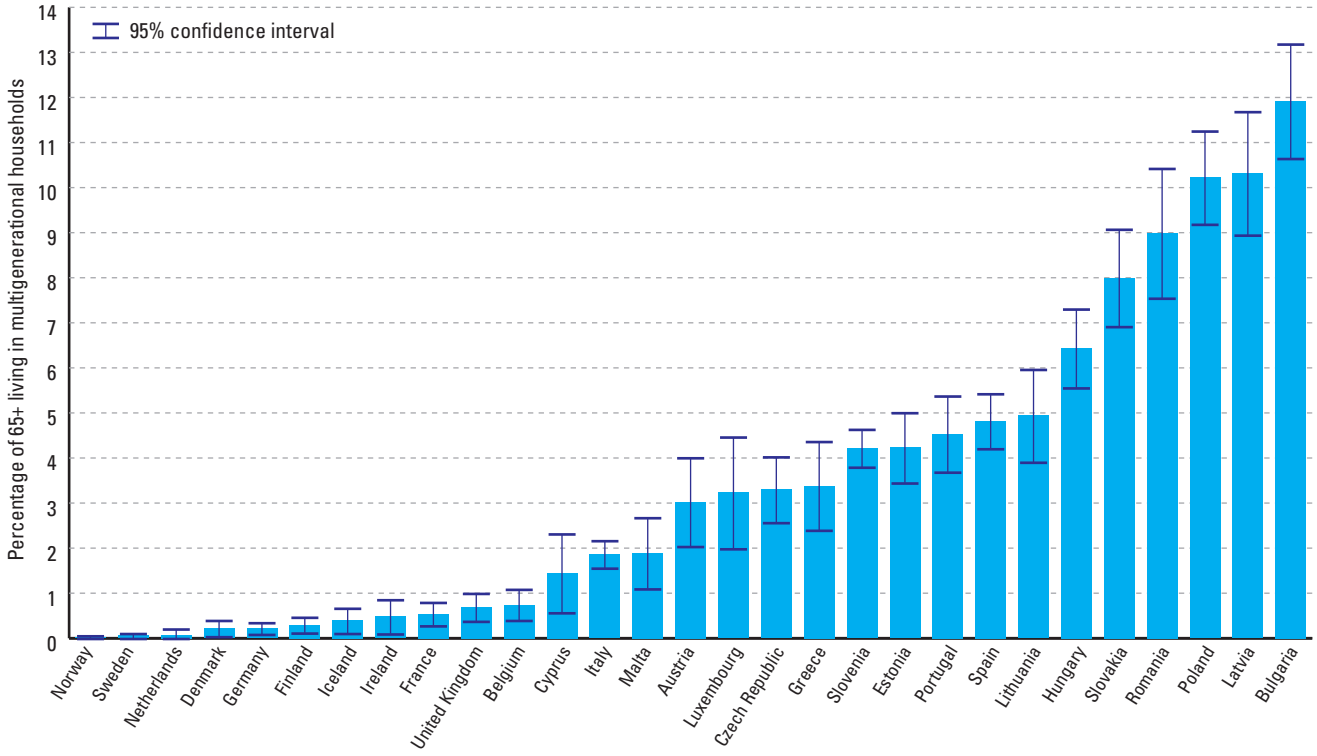
For definition of household types see Figure 2.1.

MULTIGENERATIONAL HOUSEHOLDS HAVE LOST THEIR TRADITIONAL ROLE IN MANY EU COUNTRIES

Share of 65 and older living in multigenerational households

To what extent is mutual support within the family a social norm? An important living arrangement in the context of care provision and intergenerational solidarity are multigenerational households. The prevalence of multigenerational households may give an indication of the mutual support between different generations of a family, although families who do not live under one roof may still live nearby within the same community. Furthermore, families that live together may find it easier to cope with difficulties in older age.

Figure 2.3: Share of 65 and older living in multigenerational households, 2010



Source: Own calculations based on EU-SILC 2010 (release date March 2012). Note: Data for Cyprus and Ireland refer to EU-SILC 2009 (release date August 2011).

- Eastern European countries have the highest share of people aged 65 and older living in households with at least two younger generations of their family. On the other hand, multigenerational households seem to be much less common in Northern European countries such as Norway, Sweden, the Netherlands, Finland, as well as Germany.
- Data from the Austrian micro-census in 2001 show that 80% of all Austrian families consist of at least 3 generations and one third of them even belong to a four-generational family (Richter, 2004: 187). Due to the rising life expectancy across Europe, contacts to family members of different generations are more and more likely which implies great potential for intergenerational support. Nevertheless, only a very small fraction does actually live together under one roof (only 3% in Austria).
- Although only a small share of older people live in multigenerational households, evidence shows that in times of economic constraints multigenerational households may be a coping strategy (Glick & Van Hook, 2011: 1149). In terms of care provision strategies, this might imply that support for informal carers becomes even more apparent.

Definitions

Multigenerational households are households where an older person aged 65+ lives together with his/her children and the grandchildren. In this definition, different from the other household types, the personal relationship was taken into account to construct the indicator.

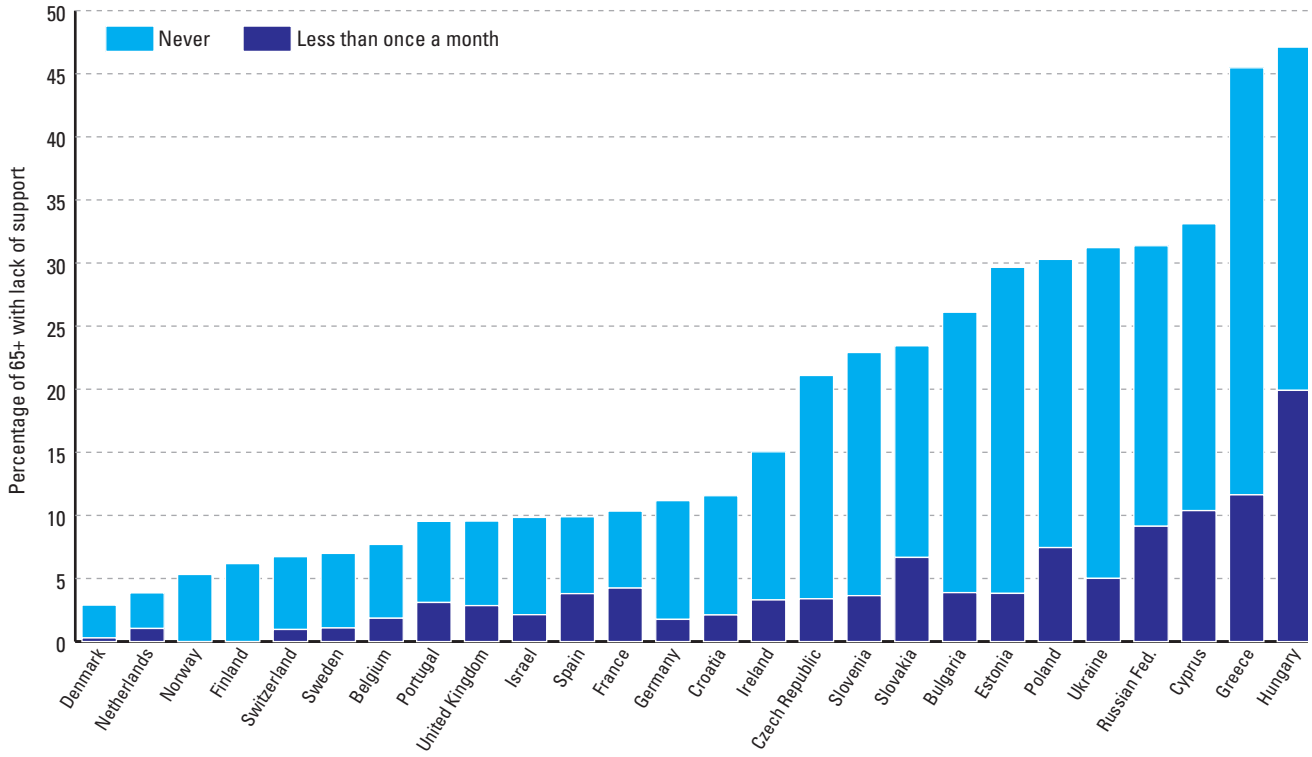
The confidence interval indicates – with a probability of 95% – the range within which the true figure is likely to lie. It is important to take this into account as sample sizes differ between countries.

WIDE GAP BETWEEN COUNTRIES WITH HIGHEST AND LOWEST RISK OF SOCIAL ISOLATION

Lack of social contact as indicator for risk of social isolation of the older population

Social isolation is characterized by the lack of contact with other people in normal daily living. It is assessed through data measuring the frequency of social contacts reported by individuals. Social isolation is both a symptom and a cause of psychological distress. It is one of the key determinants of subjective well-being.

Figure 2.4: Percentage of people meeting friends, relatives or colleagues less often than once a month or never within the population aged 65 or older, 2010



Source: Own calculations, based on the ESS5-2010 Edition 2.0

- Lack of social contact of the older population (aged 65 or over) ranges from 3-4% (the Netherlands, Denmark) to over 40% (Greece, Hungary). In 11 out of 26 countries at least one out of five older persons is affected by social isolation.
- In some countries such as Cyprus, Greece and Hungary, 10% or more of the older population say that they never meet friends, relatives or colleagues. This extreme degree of isolation is likely to have a negative impact on health and well-being, and may aggravate the need for public long-term care solutions.
- Social isolation increases with age, and is even more prevalent among the population aged 80 or over in all countries. In Cyprus, Estonia, Greece, Hungary and Poland over 40% of those aged 80 or older are affected by non-existing or very rare social contacts.
- The indicator measures contacts outside the household. Thus, the lack of social contacts is expected to hurt people living alone even more.
- The social isolation of the older population is also confirmed by evidence based on alternative data sources (EU-SILC 2006 Special module on Social participation) (see Lelkes, 2010).

Definitions

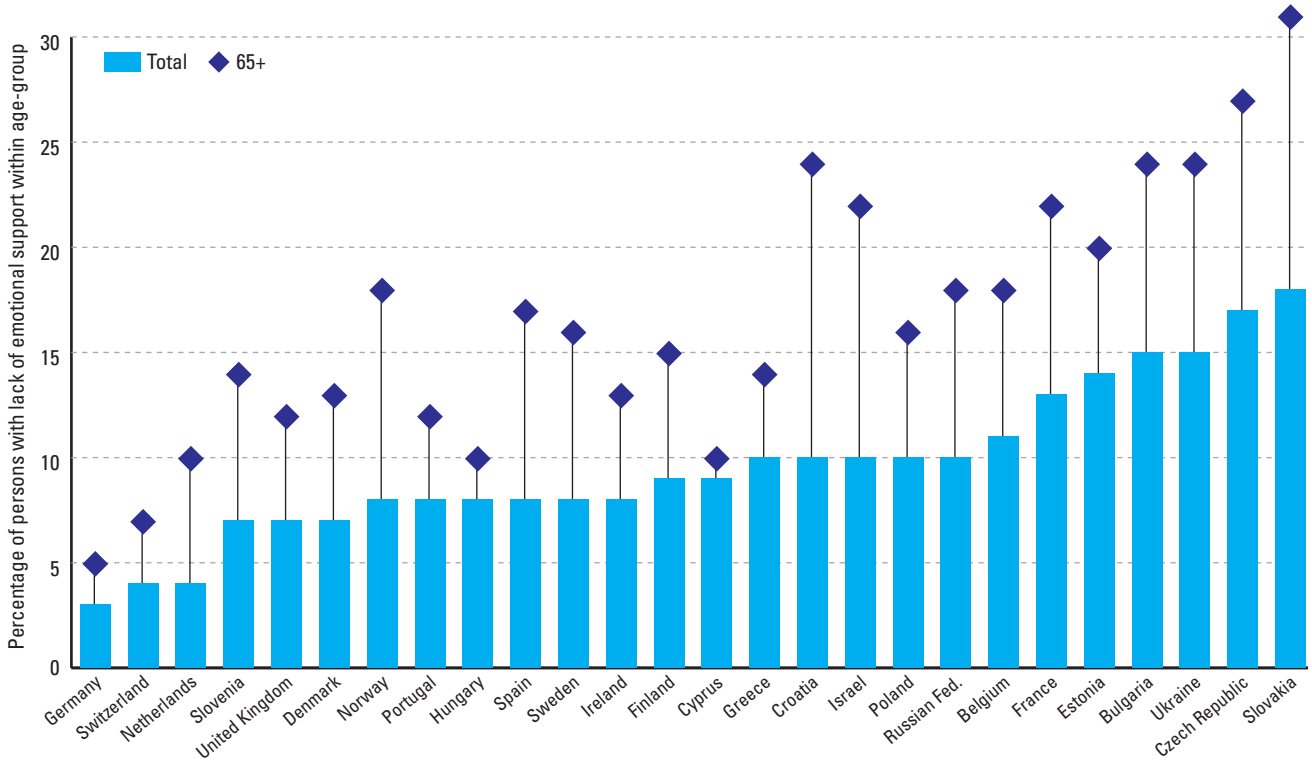
The indicator measures the share of people aged 65 or older who meet socially with friends, relatives or colleagues "never" or "less than once a month". "Meet socially" implies meeting by choice, rather than for reasons of either work or pure duty.

LACK OF EMOTIONAL SUPPORT AFFECTS OLDER PEOPLE MORE

Lack of emotional support

Social isolation can also arise from the lack of a friend who could provide emotional support. This definition refers to the qualitative aspect of personal relationships, as assessed by the individual.

Figure 2.5: Lack of emotional support: having no one to discuss personal matters with, 2010



Source: Own calculations, based on the ESS5-2010 Edition 2.0

- Lack of emotional support affects older people much more than the total population in all countries. It tends to increase with age, often due to job loss or retirement, the death of friends or spouse and the growing difficulties of replacing these relationships.
- Lack of emotional support, measured by the lack of anyone to discuss personal matters with, affects more than 1 out of 10 old-age persons in the majority of countries, and reaches 25% in the Czech Republic and Slovakia.
- The two indicators of social isolation highlight different facets of social isolation: while 9% of older people are isolated in terms of rare meetings and equally 9% are affected by having no one to discuss personal matters with, only 3% are affected by both of these, suggesting a limited overlap between the two measures[1].
- There are cultural differences as countries tend to differ in the way people keep connected. Although in Greece and Hungary, a high number of older people are isolated in terms of personal social contacts (as shown in Figure 2.4), most of them have someone with whom they can talk about their private affairs. In contrast, in the Czech Republic, Slovakia and Croatia, older people tend to be isolated in terms of having no one to talk to about their private affairs rather than in terms of personal contact.
- In some countries, both indicators of social isolation suggest that a high share of older people (at least one in five persons) is affected. These countries include Bulgaria, the Czech Republic, Estonia, Ukraine and Slovakia.

(1) These figures refer to sample averages.

Definitions

The indicator refers to people who say that they do not have anyone with whom they can discuss intimate and personal matters. "Intimate" implies things like sex or family matters, "personal" could include work or occupational issues as well.

ACCESSING THE INTERNET – ARE OLDER PEOPLE WEB-EXCLUDED?

Evolution of the share of older people having regular access to the internet (total and by educational status)

This indicator provides information about the evolution of access of people aged 55 to 74 to the internet and on the frequency of its use. The internet can be a useful tool for maintaining social contacts and for healthy ageing of the old-age population, as a significant number of resources targeted at older people and/or their carers are already available on the internet (e.g. on how to access benefits)

Figure 2.6a: Share of 55-74 year olds that regularly access the internet, 2003 and 2010

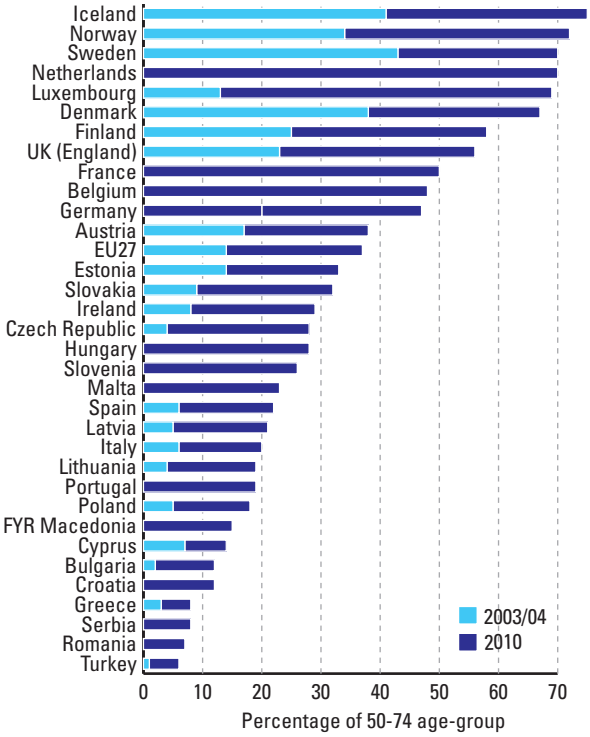
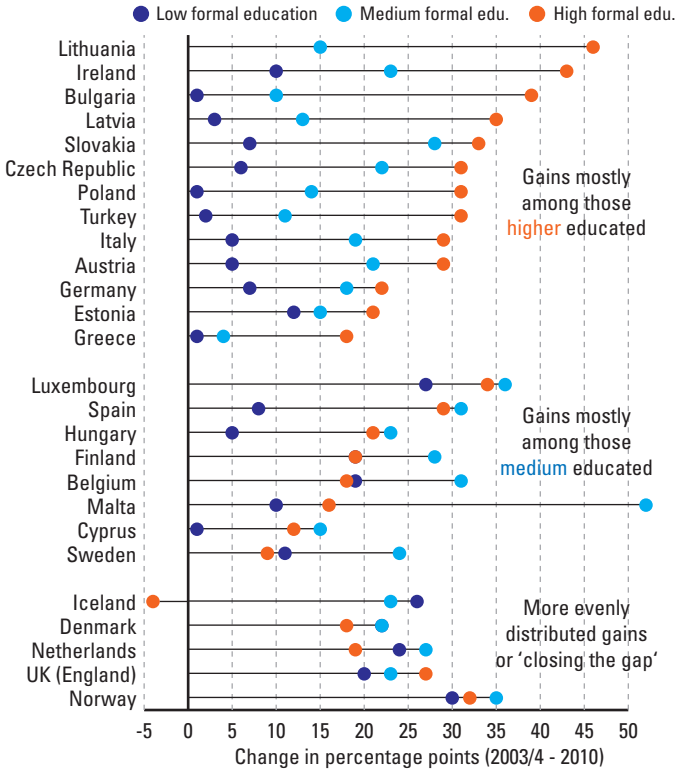


Figure 2.6b: Change in 55-74 year olds that regularly access the internet, by education, 2003-2010



Source: Eurostat, ICT Survey.
Notes: Frequency of Internet access: once a week (including every day).

- There are significant country differences in regular access to the internet in older age groups.
- The evolution of older age groups in accessing the internet between 2003 and 2010 (Figure 2.5a) points to the existence of a strong cohort effect underlying these figures.
- Close to 70% of Icelanders, Norwegians, Swedish, Dutch, Luxembourgers and Danish aged 55 to 74 regularly access the internet. These figures drop to around 35% among Austrians and less than 20% for a number of Eastern and Southern European countries (e.g. Cyprus, Croatia, Bulgaria, Serbia, Greece, Romania and Turkey). The potential for catching-up is therefore significant among these countries (Figure 2.5b).
- Those countries where internet access in the older age groups is presently the highest (cf. Figure 2.5a) are for the most part those where the gains have been more evenly distributed among education groups or where there was some 'catching-up' by those with low formal education (Figure 2.5b).
- For the majority of cases, however, the gains in accessing the internet were concentrated on those with higher education. This hints not only at the possibility of a cohort effect but also at the role of education in explaining country differences.

Definitions

Regular access to the internet is defined as accessing the internet at least once a week (including everyday) in a public place or in one's own home.

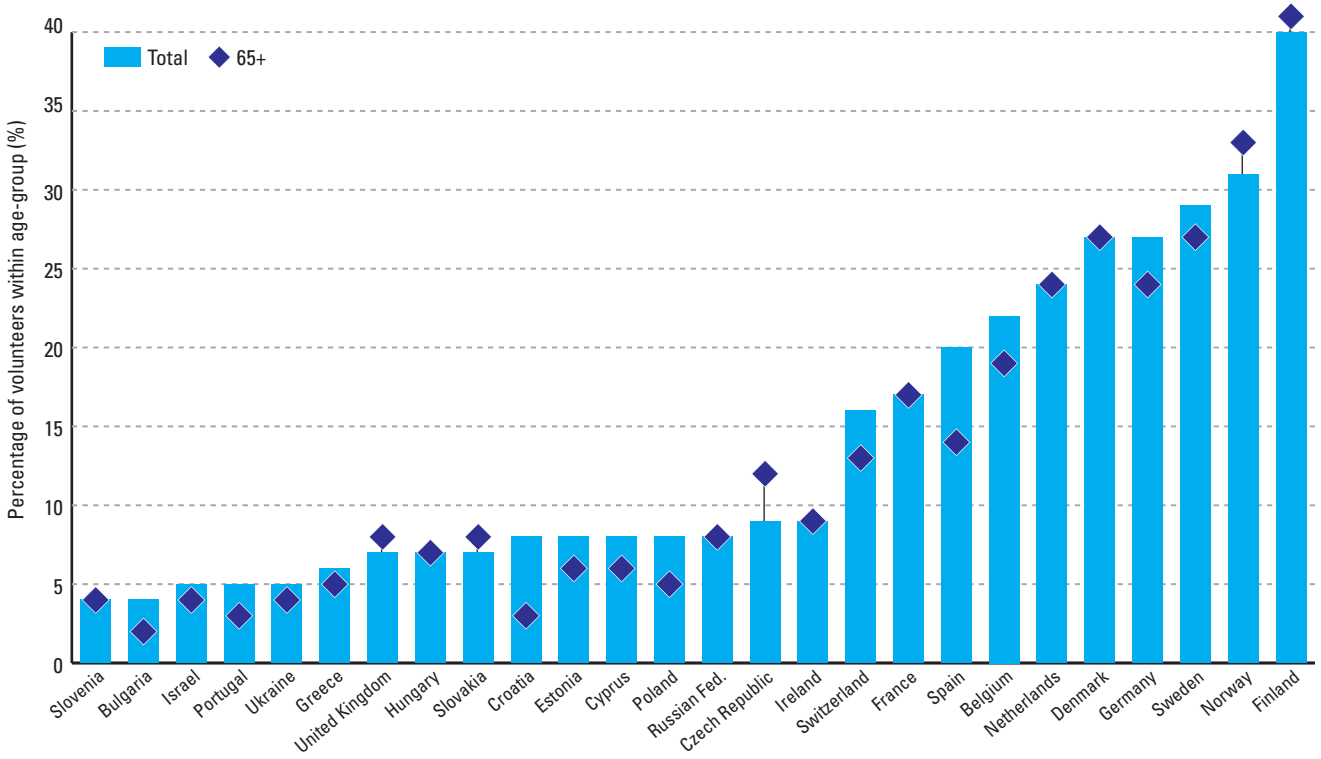
Education levels are defined using the International Standard Classification of Education (ISCED) (UNESCO, 2006) as: high (tertiary education, ISCED 5 or 6), medium (upper secondary education, ISCED 3 or 4), low (no formal education completed, primary or lower secondary education, ISCED 0, 1 or 2).

CIVIC PARTICIPATION: SOCIAL COHESION CONTINUES INTO OLDER AGE GROUPS

Civic participation

The extent to which people participate in formal and informal groups in society is an important dimension of social cohesion. In addition to the societal benefits arising from these activities, they tend to increase individual well-being. For both reasons, civic engagement is a key dimension of active and healthy ageing.

Figure 2.7: Working in a civic or political organization or association during the past 12 months, 2010



Source: Own calculations, based on the European Social Survey, ESS5-2010 Edition 2.0

- The older population tends to be less engaged in civic participation than the total population in countries with low levels of civic participation in general. In contrast, there is no such age pattern in Finland, Norway, Denmark and the Netherlands, namely countries with a high level of volunteering.
- Civic participation of the older population ranges from 2-3% in Bulgaria, Portugal and Croatia to 41% in Finland. In Denmark, Sweden, Norway and Finland over one in five older persons have been engaged in civic work during the past 12 months.
- East-European countries are characterised by relatively low levels of civic participation and tend to have a relatively small population engaged in political parties or action groups, as shown by our background calculations.
- Political participation tends to be less prevalent in the overall majority of countries than the non-political kind (Lelkes, 2010: Table 2).
- Older persons who are engaged in civic work are much less likely to suffer from social isolation (in the Czech Republic, Slovakia and Spain the prevalence falls to half or even less, according to own calculations). They also tend to trust others more and enjoy a higher level of subjective well-being.

Definitions

The indicator measures whether the individual has worked either (1) in a political party or action group or (2) in another organisation or association during the last 12 months. The survey question also emphasises the motivation behind, by referring to the improvement of things in the country or to help prevent things from going wrong.

The intensity or nature of this engagement is not explored in the survey.

Chapter 3:

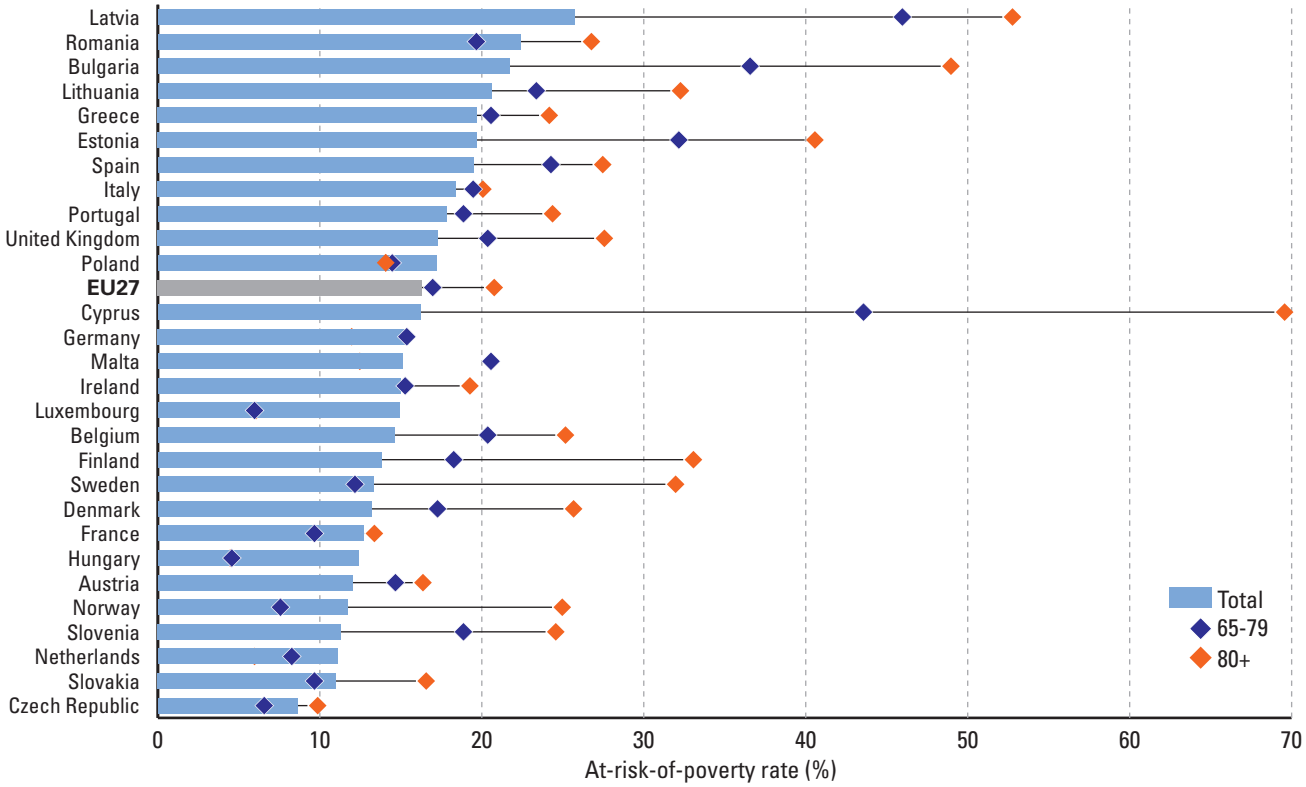
INCOME AND HOUSING SITUATION

ONE OUT OF FIVE OLDER CITIZENS IN THE EU ARE AT RISK OF POVERTY

At-risk-of-poverty rate by age groups

The income situation of older people is known to have a significant impact on their health and well-being for it may limit their access to basic goods and services including healthcare and long-term care. The indicator shows the proportion of people who are at risk of poverty, that is, whose household income is less than 60% of the national median. Here, poverty is defined in relative rather than absolute terms and is measured in reference to the standard of living in the country in which the individual lives. This, however, may differ significantly across countries depending on their general level of prosperity which should be kept in mind when interpreting the results.

Figure 3.1: At-risk-of-poverty rates of older age groups compared to the total population, 2009



Source: Own calculations based on EU-SILC 2009 (release date: August 2011)

- Across the EU about 18% of all older people (aged 65 and over) were at risk of poverty in 2008, which means that one in every five older EU citizens (or around 15 million people) had an income below the poverty line.
- Poverty among the older population tends to be higher than for the total population, but in a number of countries, such as Poland, Germany, Luxembourg, the Netherlands, Hungary, France and the Czech Republic, the opposite is the case suggesting that older people in these countries are relatively well protected against the risk of poverty.
- Among the older population, it is generally those aged 80 years or older who are most affected by poverty. The poverty risk for this age group varies widely across the EU ranging from 4% in Hungary to almost 70% in Cyprus, which is more than four times higher than for the total population.
- While low income is a key indicator of poverty and social exclusion, in order to better assess the living conditions of older people it is also important to measure other things such as the ability to afford certain goods, living in adequate housing, and the extent to which older people are included in community activities and have access to public services (see Figures 2.6, 2.7a and 2.7b).

Definitions

The at-risk-of-poverty rate measures the proportion of people living in households whose income is below the poverty threshold, which is set at 60% of the national median equivalised disposable household income (after social transfers and excluding direct taxes and social contributions).

Household income is measured on an equivalised basis (using the OECD modified equivalence scale) in order to adjust for differences in the size and composition of households.

Income is defined in monetary terms and excludes transfers such as publicly provided goods and services which might be particularly relevant for older people.

OLDER WOMEN LIVING ALONE ARE AT HIGH RISK OF POVERTY

At-risk-of-poverty rate among the old-age population by household type and gender

Poverty rates may not be uniform across different household types – for example those living alone may have less opportunity to pool resources – or across gender. This indicator captures the diversity of social situations across household types and gender, highlighting potential vulnerable groups.

Figure 3.2: At-risk-of-poverty rates of older persons aged 65 and older, by household type and gender, 2009

Source: Own calculations based on EU-SILC 2009 (release date: August 2011)

- A comparison of poverty rates by household type and gender reveals that women who live in single households have the highest poverty risk in the overall majority of countries (with the exception of Denmark, Ireland, Malta and the Netherlands).
- On average in the EU, 29% of older female single households are at risk of poverty representing 5.7 million older women. The corresponding figure for males is 21% (1.5 million men).
- The poverty risk of older women living alone is particularly high – over 70% – in the three Baltic States and Bulgaria, but also in Cyprus and Slovenia where more than half of them are exposed to poverty.
- Older people living in households comprising three or more adults are typically the least likely to be at risk of poverty, reflecting wider opportunities to pool resources.
- Couple households, which is still the dominant living arrangement for older people in Europe, are also less at risk of poverty than the average for the whole of the older population in most countries.
- The greater poverty risk for older women living alone means that they might be less able to afford long-term care out of their own pocket. Concomitantly, they might potentially have an increased need for formal care due to lack of support from close relatives. The fact that more than one-third of poor older households in the EU are made up of women who live alone (the proportion ranging from 22% in Greece and the Netherlands to 81% in Norway) shows that the numbers concerned are by far not insignificant.

Definitions

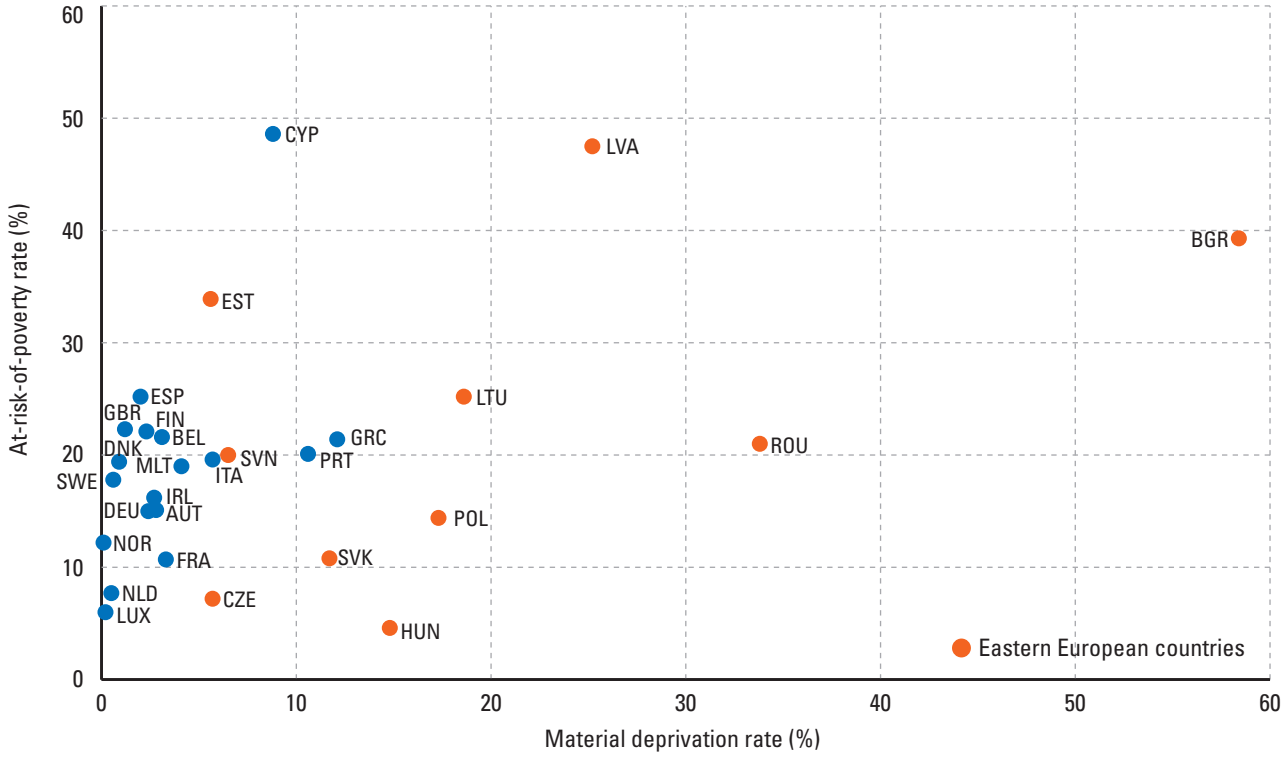
See Figure 3.1.

OLDER PEOPLE IN EASTERN EUROPE ARE MORE LIKELY TO LACK BASIC NECESSITIES

Material deprivation rate

The indicator shows the proportion of individuals and households who cannot afford certain goods considered by most people to be necessary. It measures exclusion by directly capturing people's actual standard of living in the country where they live. Moreover, whereas indicators based on current income (i.e. at-risk-of-poverty rate) are affected by transitory shocks, indicators on material deprivation can compensate for such limitations because they tend to be more stable over time and reflect the underlying circumstances of individuals and households.

Figure 3.3: Material deprivation rate and at-risk-of-poverty rate of older persons aged 65 and older, 2009



Source: Own calculations based on EU-SILC 2009 (release date: August 2011)

- The material deprivation rate of older people is considerably higher in Eastern compared with Western European countries where, with the exception of Greece and Portugal, the proportion of those affected remains below 10%.
- By contrast, more than half of Bulgaria's older population, around one-third of older Romanians and a quarter of older people in Latvia experience material deprivation.
- Even in Hungary, where the poverty risk of those aged 65 and over is the lowest in the EU, around 15% of its older citizens are materially deprived, which is more than twice above the EU average.
- The higher levels of material deprivation In Eastern European countries highlights that standards of living may vary significantly across Europe. For example, an older person who is relatively poor (see at-risk-of- poverty rate) in a rich country, say Belgium, tends to suffer considerably less material deprivation than someone living in Portugal despite the fact that the two countries have similar poverty rates.
- The worst situation is to be found in those countries (i.e. Bulgaria, Romania, Latvia, Lithuania) where older people face both a high level of poverty and material deprivation.

Definitions

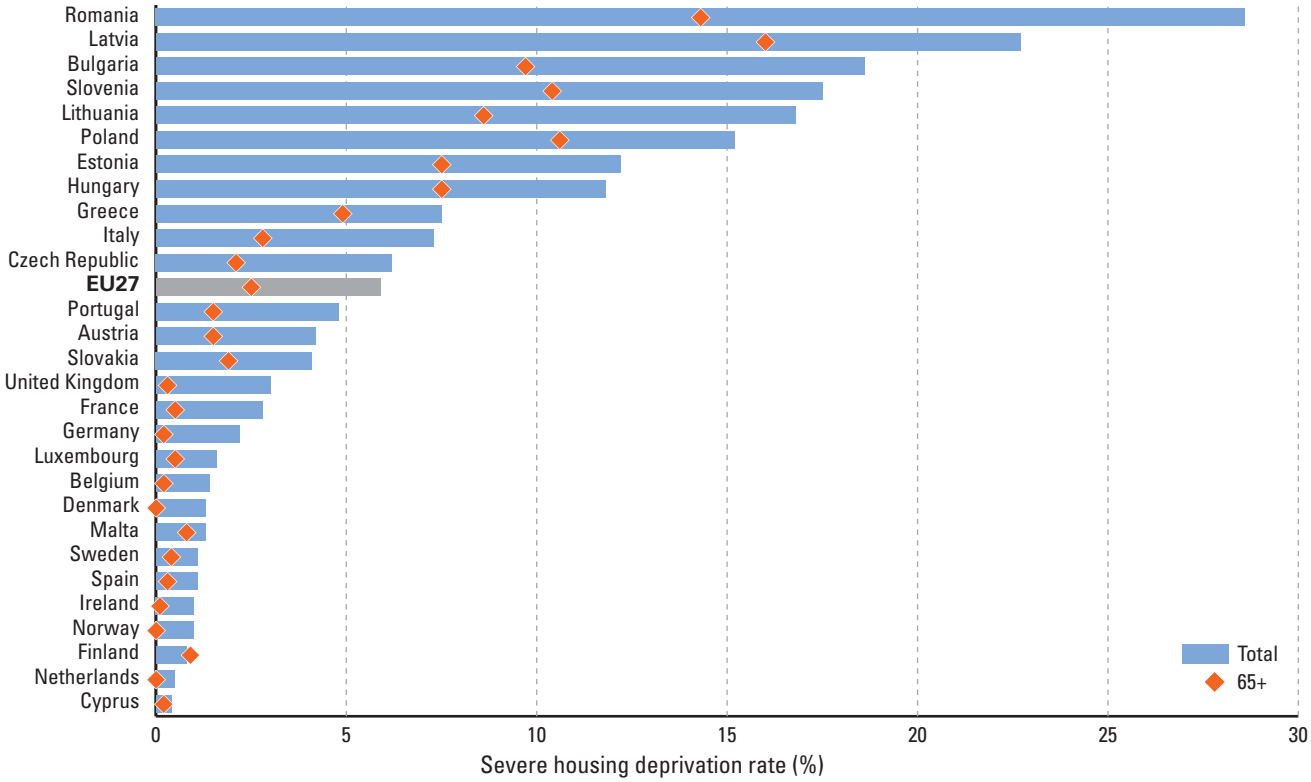
The material deprivation rate measures the percentage of the population that cannot afford at least three of the following nine items:

1. to pay their rent, mortgage or utility bills;
2. to keep their home adequately warm;
3. to face unexpected expenses;
4. to eat meat or proteins regularly;
5. to go on holiday;
6. a television set;
7. a washing machine;
8. a car;
9. a telephone

Severe housing deprivation rate of the old-age population

Living in adequate housing is a basic human need and central to people's well-being. The quality of housing, which refers to the physical characteristics of the dwelling and is measured here by the severe housing deprivation rate indicator, affects not only living standards, but also people's mental and physical health and even social relations. At the same time, housing deficiencies are a key element of deprivation.

Figure 3.4: Severe housing deprivation of older persons aged 65 and older, compared to the total population, 2009



Source: Own calculations based on EU-SILC 2009 (release date: August 2011)

- Severe housing deprivation among the older population is significantly lower than that of the total population in all countries except for Cyprus and Finland (the difference is, however, very small).
- On average in the EU, 6% of the total population lives in housing with poor amenities while the corresponding figure for the population aged 65 and older is 2.5%. While this average may seem small, it hides extremely important differences across Europe.
- In particular in some Eastern European countries the figures are by far not negligible. In Poland, more than 10% or around 560,000 older people live in bad housing conditions, while in Romania close to half a million are affected.
- The fact that severe housing deprivation of both the total and the older populations is higher in Eastern European countries indicates that the large country differences across Europe are mostly due to the generally worse housing conditions in these EU Member States.
- Living in inadequate housing, lacking for instance an indoor toilet and bathroom, can seriously limit the possibility of older people to be cared for in their own homes and might more likely result in them being institutionalised.

Definitions

The severe housing deprivation rate measures the percentage of the population living in a dwelling which is overcrowded (see definition in Annex) and has at least one of the following housing deprivation measures:

1. no bath/shower and indoor toilet in dwelling;
2. dwelling too dark, not enough light;
3. dwelling has leaking roof, damp walls/floors/foundation, or rot in window frames or floor.

HOUSING COSTS CAN BE A SUBSTANTIAL BURDEN ALSO FOR OLDER HOME OWNERS

Housing costs relative to disposable income

Housing costs can be a large component of households' expenditures, reducing the amount of disposable income that households can spend on other purchases.

Figure 3.5a: Housing costs as a percentage of disposable income (65 and older compared to the total population), 2009

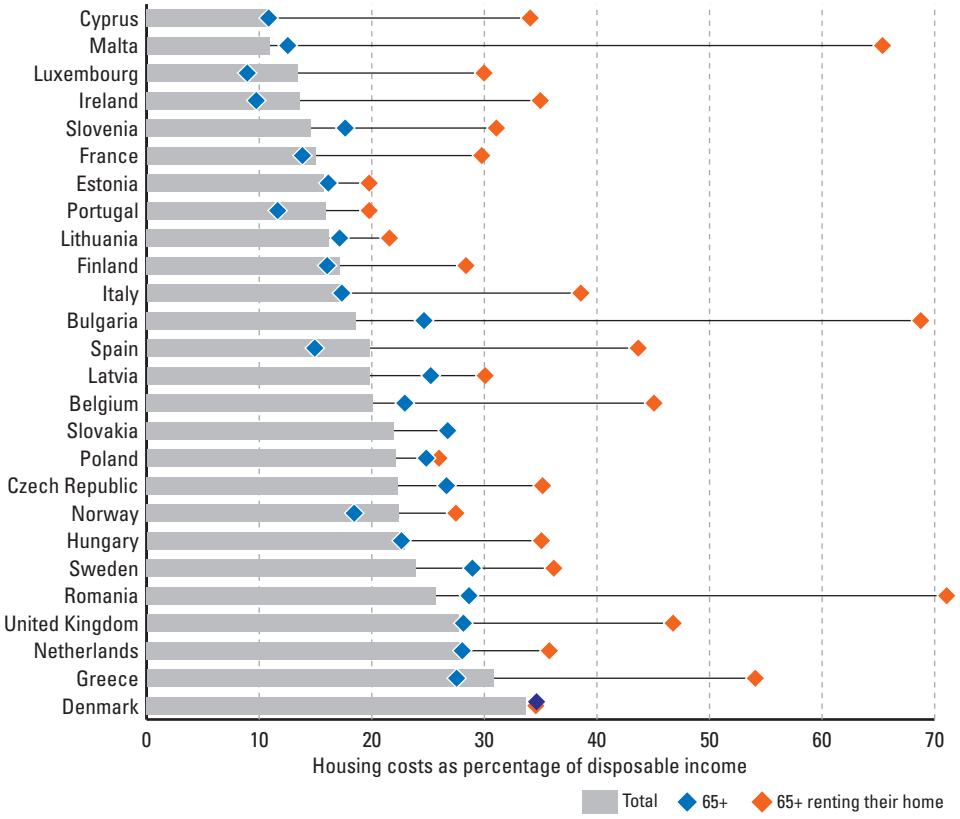
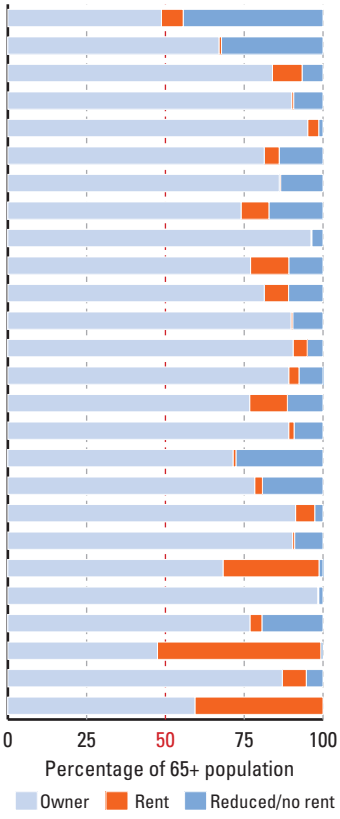


Figure 3.5b: Division of the 65 and older population by housing tenure (percentage), 2009



Source: Own calculations based on EU-SILC 2009 (release date: August 2011)

- Average housing costs relative to disposable income for those aged 65 and over do not differ significantly from the total population in general (Figure 2.5a).
- The limited variation between the total and 65+ population, however, is not the case for all countries. In many of the Eastern European countries there is a marked tendency, except in Hungary, Lithuania and Estonia, for housing costs of those aged 65 and over to be a larger share of disposable income. This is also the case for Sweden and Belgium.
- This is despite the fact that home ownership tends to be higher among the older population. As Figure2.5b illustrates, on average, some 75% of those aged 65 and over in the EU live in owner-occupied housing.
- Older people living in rented housing tend to have higher housing costs. In some extreme cases, such as Romania, Bulgaria, and Malta these amount to more than 60% of disposable income. At the same time, a very small proportion, less than 1% of the older population, lives in rented houses in these countries.
- It is also important to bear in mind that tenure itself has a tendency to vary with income, that is, a large proportion of those living in rented accommodation tend to have relatively low income and as a result also higher housing costs than those living in an owner-occupied dwelling.
- The relatively high housing costs for older people in Eastern European countries reflect that a large share of these consists of utilities and maintenance or repair costs.

Definitions

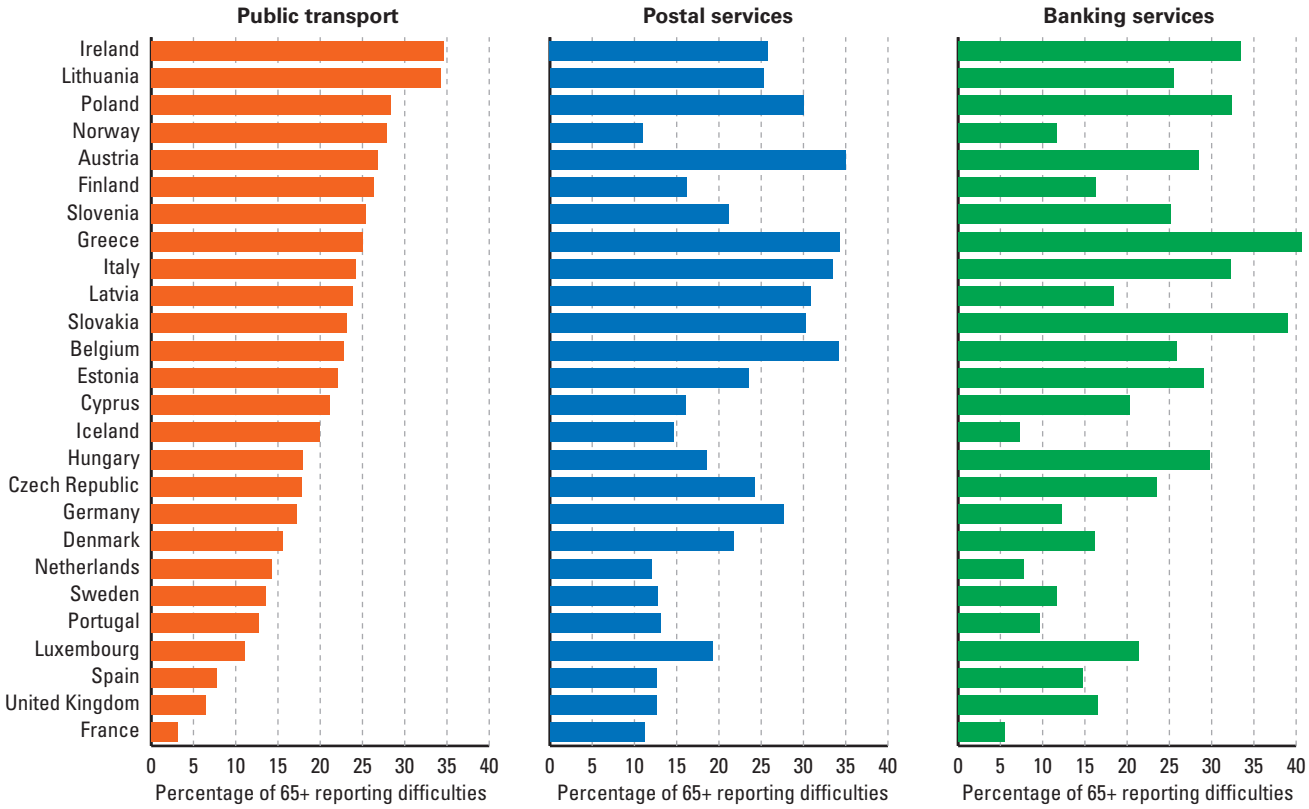
Housing costs refer to monthly costs connected with the households' right to live in the accommodation. It covers all the costs of accommodation, including the cost of utilities (water, electricity, gas and heating) and regular maintenance and repairs. Any housing allowances received are deducted from the gross housing costs as defined above to give the net amount paid.

ACCESS TO BASIC SERVICES IS NOT ALWAYS EASY

Accessibility of basic services among older people

For older people to lead an active, healthy and independent life and to be able to actively participate in society it is essential that they can easily access services which are considered by most people to be necessary or basic in everyday life. This indicator shows the percentage of older people who report difficulties accessing public transport, postal and banking services.

Figure 3.6: Percentage of older persons aged 65 and older reporting difficulties with access to public transport, postal and banking services, 2007



Source: Own calculations based on EU-SILC 2007 Special Module on Housing
Notes: Figures include those reporting "with great difficulty" or "with some difficulty".

- Older people in France, the Netherlands, Sweden and to a lesser extent in the UK, Spain and Portugal tend to have the least difficulties accessing basic services.
- In contrast, a relatively large proportion reports problems with access in Italy, Ireland, Poland, Greece, Austria, Slovakia as well as in the three Baltic countries.
- Of the three basic services, public transport (which includes bus, metro, tram or similar) seems to be the most problematic in terms of access in 9 of the 26 countries. In Norway, Finland and Lithuania, the proportion of older people reporting difficulties accessing this service is significantly higher than in the case of both postal and banking services.
- Whereas in Greece, Belgium, Austria, Germany, Italy or France sending or receiving ordinary and parcel post is considered by older respondents to be the most challenging, accessibility of banking services (i.e. withdrawing cash, transfering money and paying bills) fares relatively poorly in Spain, Hungary and the UK.

Definitions

Accessibility of services used by the household is assessed in terms of physical and technical access (i.e. distance, infrastructure, equipment) and opening hours, but not in terms of quality, price and similar aspects.

Besides physical and technical aspects, health conditions are also considered. If, for instance, the person has a disability and can hardly access a service which he/she needs as an individual and lives alone (or the household has no resources available to provide him/her support) in this case access to the service would be regarded difficult for the individual/household.

ACCESSING MEDICAL SERVICES IS IN MANY CASES A CONCERN FOR OLDER PERSONS

Accessibility of primary health care services among older people

Access to primary health care services is especially important to older age groups as they are more likely to have a need of medical services. This is not only the case for those older people who are being cared for at home and would need regular medical help, but also for the general old-age population that would benefit from access to preventive medical check-ups and mainstream health care

Figure 3.7a: Percentage of older persons reporting difficulties with access to primary health care services compared to the total population, 2007

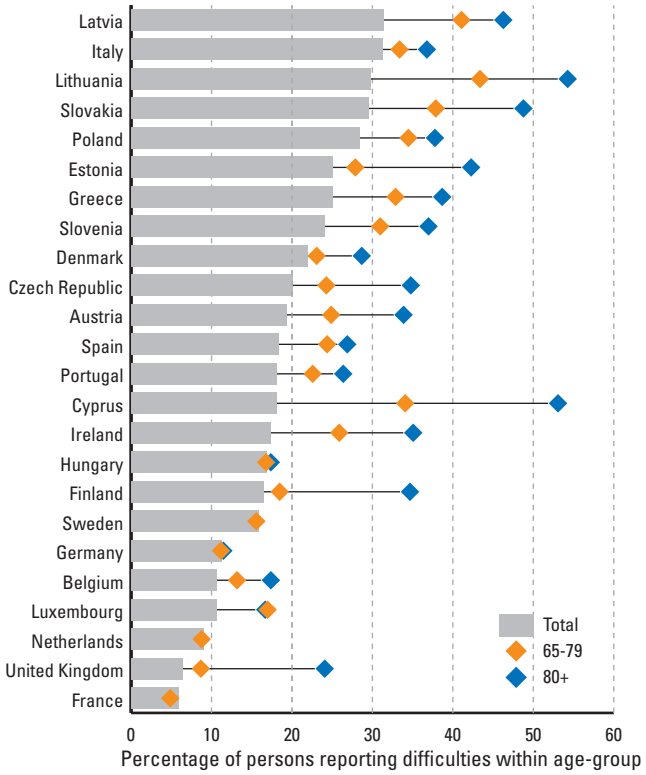
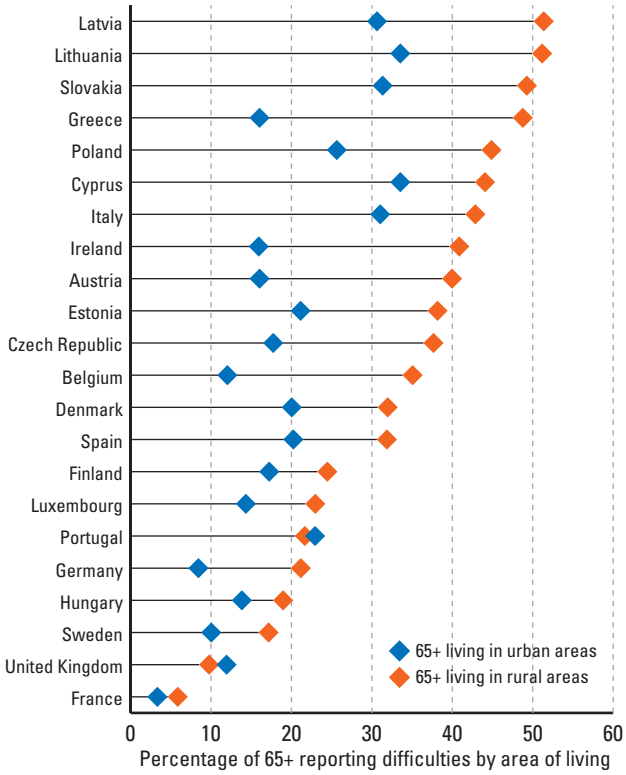


Figure 3.7b: Percentage of older persons living in urban/rural areas who report difficulties with access to primary health care services, 2007



Source: Own calculations based on EU-SILC 2007 Special Module on Housing
Notes: Figures include those reporting "with great difficulty" or "with some difficulty".

- As shown in Figure 3.7a, for the overall majority of countries more than 15% of the older persons report having problems of access to primary health care services.
- This is particularly the case for people aged 80 and over who have the most need for medical services, but whose access might likely be hindered by disability or other mobility constraints (especially problematic for those who live alone, which is often the case in this age group).
- Population density, or urban or rural residence plays a significant role in explaining differences in access to health care services among the population aged 65 and older. The proportion of those reporting problems of access is larger in rural than in urban areas in almost all countries with the exception of the UK and Portugal, although the difference is very small in the latter (Figure 2.7b). The difference is highest in Greece (over 30 percentage points) followed by Ireland, Austria and Belgium.
- Older people living in rural areas tend to be especially disadvantaged in Latvia and Lithuania where more than half of them report difficulties accessing primary health care services.

Definitions (see previous page)

Primary health care services refers to the general practitioner, primary health centre or similar.

Urban areas refer to densely populated or intermediate areas while rural areas refer to thinly populated areas (for detailed definitions see Annex).

Chapter 4:

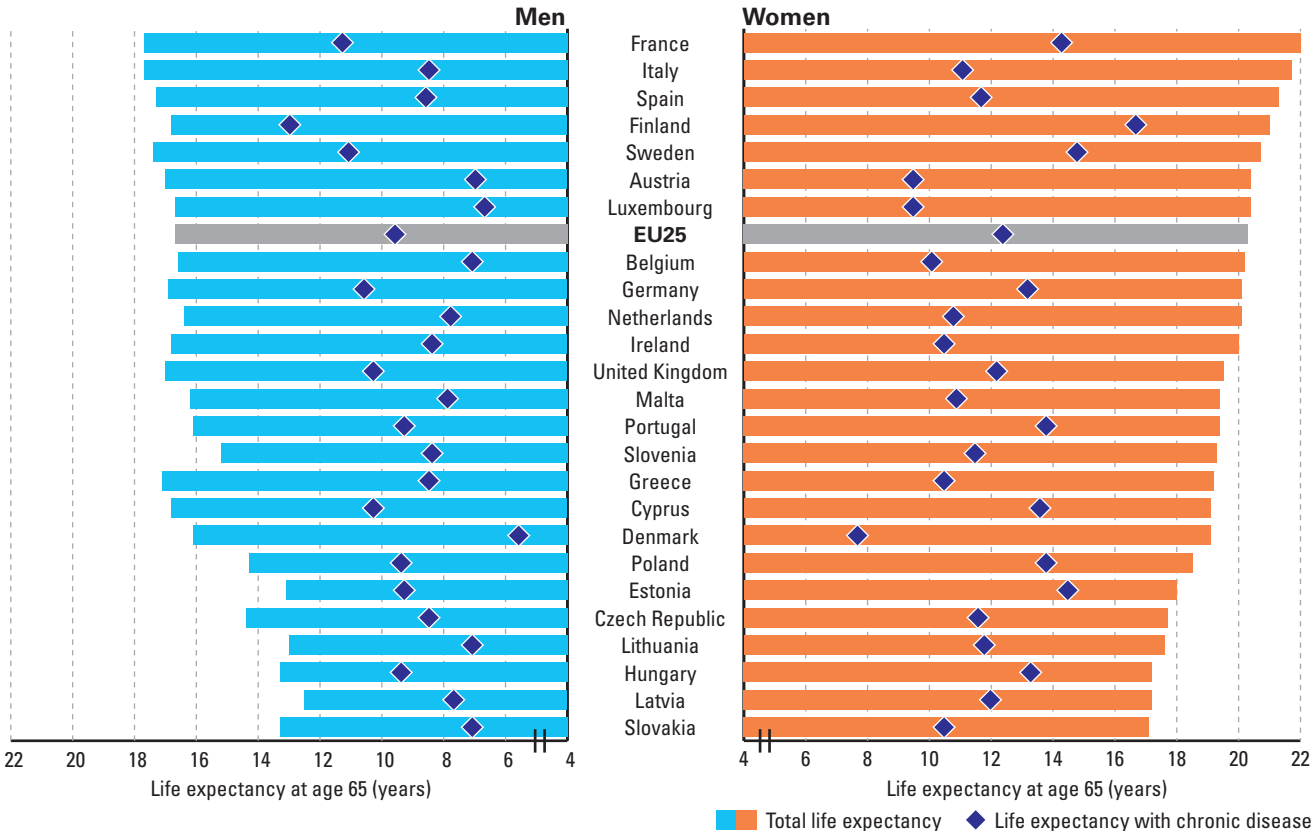
HEALTH STATUS, RISK FACTORS AND PREVENTION

THERE ARE LARGE DISPARITIES IN EUROPE FOR THE LIFE EXPECTANCY AT AGE 65 THAT IS SPENT WITH CHRONIC MORBIDITY

There are large disparities in Europe for the life expectancy at age 65 that is spent with chronic morbidity

Life expectancy at age 65 with chronic morbidity measures the number of years of overall (standard) life expectancy at age 65 that are lived with at least one self-reported chronic disease or condition. It provides a measure of how many years on average old-aged people may expect to live with a chronic condition that may imply the need for supportive services.

Figure 4.1: Life expectancy at age 65 versus life expectancy at age 65 with a chronic disease by gender



Source: European Communities (2008: Chapter 15).

- There are large disparities in the share of years of life expectancy at age 65 that are lived with a long-standing chronic morbidity, as measured by subjective health assessment. The difference between countries in the average number of years after 65 that are lived with chronic conditions is larger for women (12.4 years) than for men (9.6 years) and is greater than the differences in total life expectancy at age 65.
- Women spend a greater share of years after 65 with at least one chronic condition.
- An important observation from these estimates is that there is overall no apparent correlation between life expectancy at age 65 and the share of years that are lived with chronic conditions, as measured by subjective health assessments in Europe.
- However, the group of seven Eastern European countries at the lower end of life expectancy at age 65 has on average a higher share of number of years lived with chronic conditions compared with the remaining EU-25 countries for which data were available (63% versus 53% for men; and 71% versus 59% for women).
- These findings suggest that more can be done to address the health disparities in Europe that this indicator measures, and addressing these inequalities is a core concern of health policy in Europe (WHO/Europe, 2012c). Gaps in healthy ageing are especially important in a group of seven Eastern European countries, when compared to other EU Member States. However, because subjective scales that underlie the measurement of this indicator differ between countries, policy conclusions in a comparative perspective have to take into account larger sets of health indicators.

Definitions

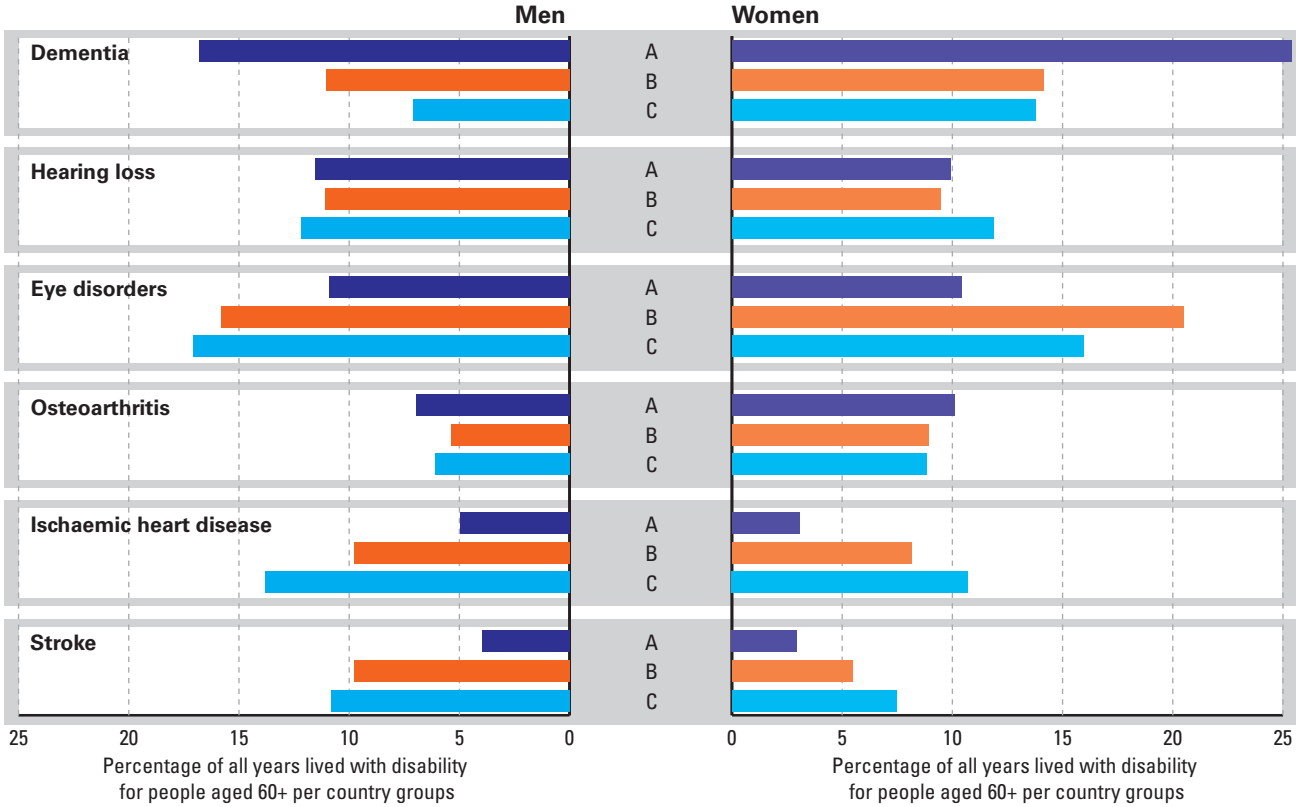
Prevalence of chronic morbidity is measured by the following question of the Minimum European Health Module: "Do you suffer from (have) any chronic (long-standing) illness or condition (health problem)? Yes/No". Data are based on the 2005 SILC survey. Life expectancy of years lived with chronic morbidity is calculated based on age and sex-specific prevalence rates.

FOR HIGHER AGE GROUPS, SIX LEADING CAUSES OF DISABILITY ACCOUNT FOR MORE THAN HALF OF THE BURDEN OF DISEASE DUE TO FUNCTIONAL LIMITATIONS

For higher age groups, six leading causes of disability account for more than half of the burden of disease due to functional limitations

Years lived with disability (YLD) measures the relative burden of disease from leading causes of functional limitations. This indicator provides information on the relative importance of selected causes of functional limitation.

Figure 4.2: Leading causes of years lived with disability by diseases and gender, percentage of all YLD for people aged 60+ (WHO Europe country groups)



Source: Own calculations based on WHO (2008a).

- In higher age groups, six leading causes of disability account for more than half of the burden of disease due to functional limitations in Europe: dementia; hearing loss; eye disorders; osteoarthritis; ischaemic heart disease; and stroke. However, there are important differences between the three groups "A", "B" and "C" of European countries, as defined by WHO according to their overall burden of mortality.
- These differences between country groups are more important for dementia, eye disorders, ischaemic heart disease and stroke compared with hearing loss and osteoarthritis. Addressing the burden of disease of these noncommunicable diseases is important for reducing the large health disparities between European countries (but also within countries) (WHO/Europe, 2006).
- Dementia, osteoarthritis, ischaemic heart disease and stroke account for the biggest differences in the relative burden of disease between men and women.
- At least ischaemic heart disease and stroke share the common risk factors that also affect other noncommunicable diseases: high blood pressure, physical inactivity, smoking, high blood cholesterol level, harmful use of alcohol, and overweight and obesity (see more below on the prevalence of risk factors at higher age groups) (WHO, 2009).
- But these risk factors are not limited to the individual level. Changing patterns of housing, transport, nutrition and social integration can also have major effects on the patterns of noncommunicable diseases over the life-course, and for older people in particular (WHO/Europe, 2012b).

Definitions

The years of life lived with disability (YLD) indicator measures years lived with functional limitations due to individual causes of disease as a proportion of the total number of YLD in the population.(1)

The indicator estimates the percentage of YLD for a specific age and sex group for three WHO country groups.

Europe A: countries with very low child mortality and very low adult mortality, which are mostly Western European countries.

Europe B: countries with low child mortality and low adult mortality. This is a diverse group of countries, many in Eastern and South-Eastern Europe, including 4 EU countries.

Europe C (low child mortality; high adult mortality): This is also a diverse group of countries, including among others 4 EU countries and the Russian Federation.

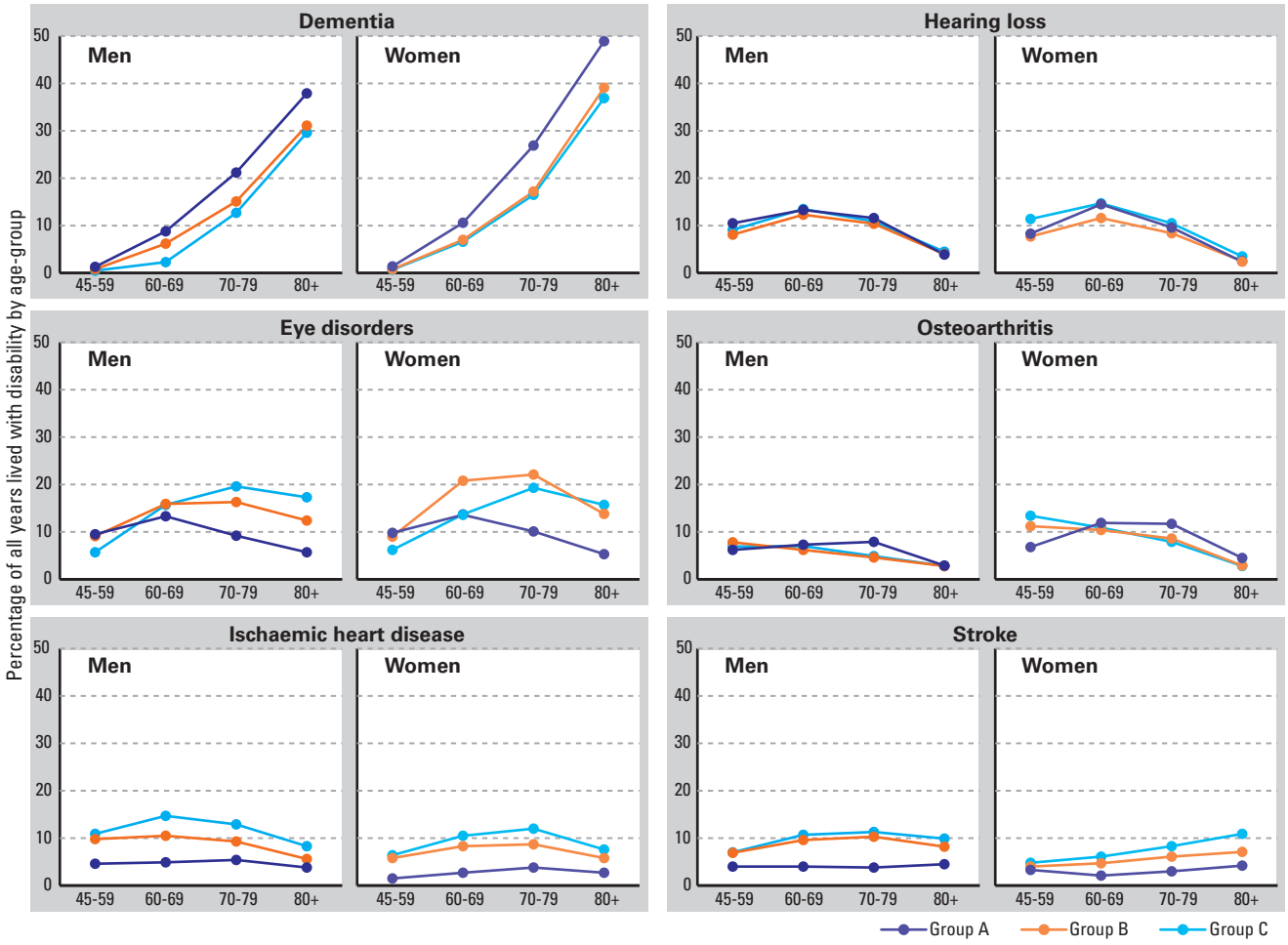
(1) For more details on country groups, estimation method and sources see the Annex and WHO (2008).

THE BURDEN OF DISEASE DUE TO FUNCTIONAL LIMITATIONS EVOLVES DIFFERENTLY IN OLDER AGE FOR THE VARIOUS LEADING CAUSES OF DISABILITY

The burden of disease due to functional limitations evolves differently in older age for the various leading causes of disability

The years of life lived with disability (YLD) by age group measures years lived with functional limitations due to individual causes of disease as a proportion of the total number of YLD in the population of a specific age group. The indicator estimates the percentage of YLD for a specific age and sex group for three WHO country groups (see definition above)

Figure 4.3: Years lived with disability by leading cause of disability and WHO Europe country groups, percentage of all YLD for people aged 60 and above, male and female, 2004



Source: Own calculations based on WHO (2008a).

- Disability due to dementia differs between country groups but steeply increases with age everywhere. Because the highest age groups are the fastest growing population segments in many countries (see Chapter 1), policies to support people with dementia, their families and informal as well as formal caregivers are now an integral part of policies of healthy ageing in many countries, but still need more attention in others (see Chapter 7).
- The share of disability from hearing loss peaks during the age of 60-69 years, for both men and women, in all country groups. The burden of disability from hearing loss is estimated taking into account partial restoration of hearing with the help of hearing aids. Improved access to diagnosis and hearing aids could therefore potentially contribute to lowering the relative burden of disease from hearing loss in the future, in particular for countries in group C.
- There is evidence that a sizeable share of burden of disease from hearing loss is avoidable through primary prevention. Moreover, a large percentage can be treated through early diagnosis and suitable management (WHO, 2012).
- After the age of 60, the relative burden of disability from eye disorders starts to diverge markedly between country groups in Europe. These disability estimates take into account corrections of eyesight by wearing glasses or contact lenses. The bulk of disability, however, is due to severe eye disorders like glaucoma or blindness. The differences between country groups point to differences in the prevalence of underlying diseases, such as diabetes, but partly also to differences in the access to early diagnosis and effective treatment of diseases of the eye (WHO, 2010).

Definitions

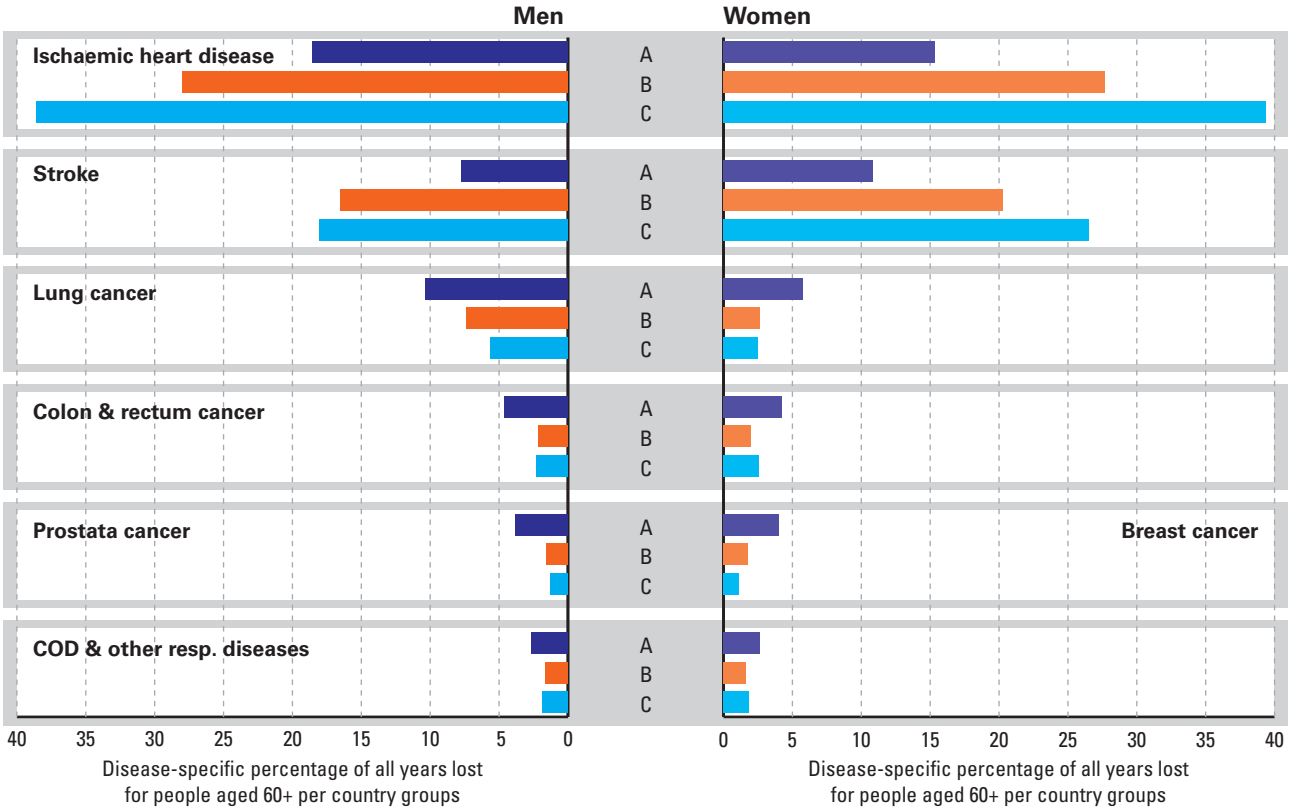
See Figure 4.2.

THE BULK OF LIFE YEARS LOST IN HIGHER AGE GROUPS CAN BE ATTRIBUTED TO SIX LEADING CAUSES OF MORTALITY

The bulk of life years lost in higher age groups can be attributed to six leading causes of mortality

Years of life lost (YLL) measures the relative burden of disease from leading causes of death. This indicator provides information on the leading causes of premature death among those aged 60 and older.

Figure 4.4: Years of life lost by causes of death and WHO Europe country groups, percentage of all YLL for people aged 60 and above, male, 2004



Source: Own calculations based on WHO (2008a).

- Six leading causes of death account for more than half of the burden of premature death in higher age groups in Europe: ischaemic heart disease; stroke and other cerebrovascular diseases; lung cancer; colon and rectum cancer; chronic obstructive pulmonary and other respiratory diseases; prostate cancer (male) and breast cancer (female).
- All six leading causes are non-communicable diseases; in fact more than 90% of all life years lost in Europe for people aged 60 years and older are due to non-communicable diseases, many of which share common risk factors, such as smoking, physical inactivity, nutrition, overweight and obesity or harmful use of alcohol (see the indicators on risk factors below) (WHO/Europe, 2006).
- Successful, evidence-based interventions exist to tackle each of these, and a more geographically even implementation could lead to a substantial reduction of health disparities in Europe (WHO/Europe, 2012d).
- Years of life lost are more concentrated on cardiovascular diseases for country groups B and C, while cancer plays a bigger relative role in country group A. In particular, there is a substantial higher relative burden of mortality due to lung cancer in group A.
- From a gender perspective, the share of burden of disease from ischaemic heart disease and from lung cancer is higher for men than for women, while mortality from cerebrovascular diseases in women is more important.
- There is concern that the burden of disease from lung cancer might increase in the future in country groups B and C, where prevalence of smoking has increased in recent years, not least among women.

Definitions

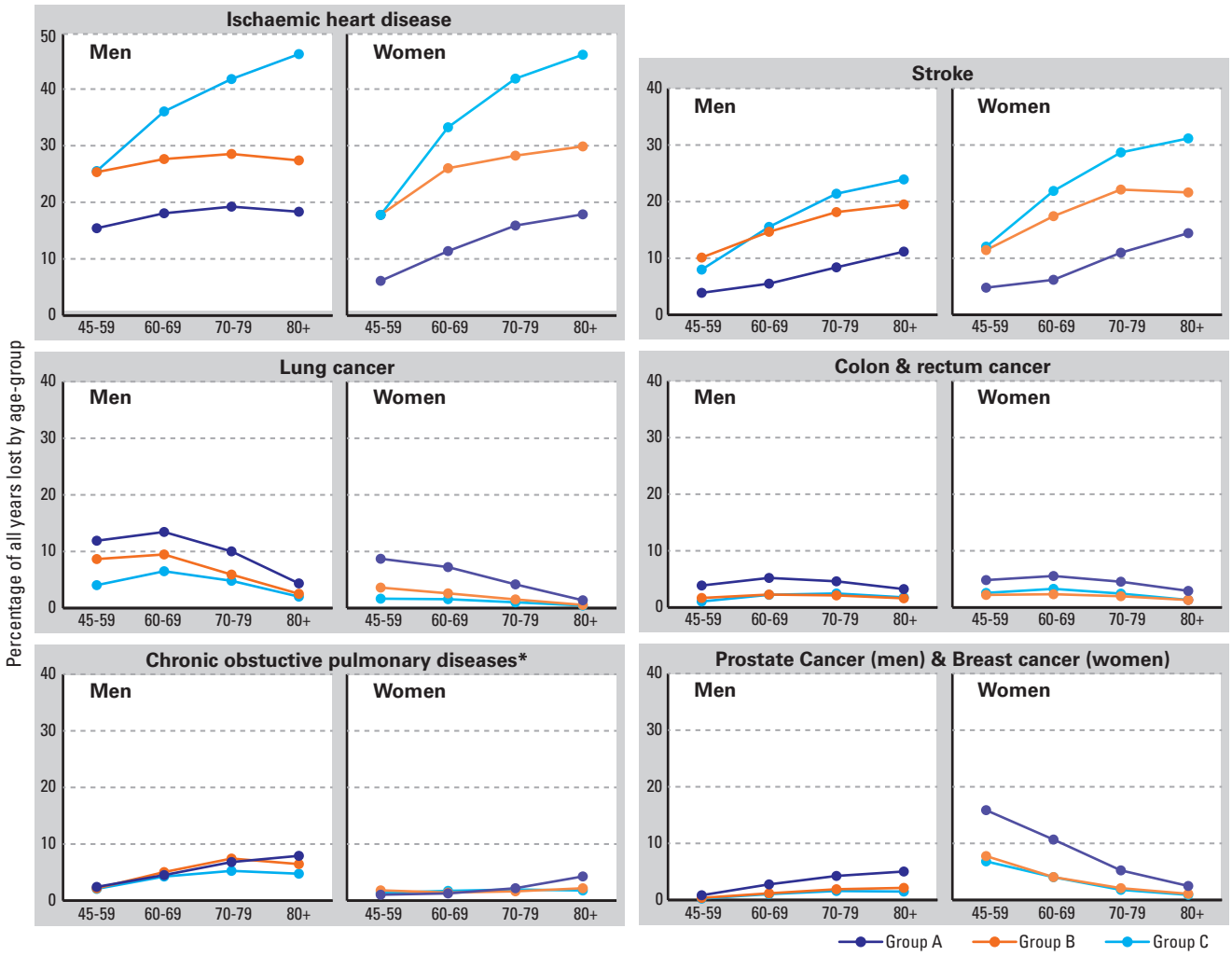
The years of life lost (YLL) indicator measures the cause-specific years lost as a proportion of the total YLL lost in the population due to premature mortality. The indicator estimates the percentage of total YLL for a specific age and sex group for three WHO country groups. Years of life lost (YLL) take into account the age at which deaths occur by calculating the hypothetical loss of years between the actual year of death and the age- and sex-specific life expectancy for Japan, which is currently the society with the longest life expectancy in the world. The estimates presented here use no additional discounting or age-weights (so-called "no-frills" DALY estimates). For the definition of country groups A, B and C see Figure 4.2 above.

IN HIGHER AGE GROUPS, MORTALITY FROM CIRCULATORY DISEASES DIVERGES MARKEDLY IN EUROPE

In higher age groups, mortality from circulatory diseases converges markedly in Europe

Years of life lost (YLL) by age groups measures the relative burden of disease from leading causes of death due to premature mortality for a specific age and sex group.

Figure 4.5: Years of life lost by ischaemic heart disease, age group and WHO Europe country group, percentage of all YLL per age group, male and female, 2004



Source: Own calculations based on WHO (2008a).

- For the six leading causes of mortality, the relative importance of years of life lost increases steadily with higher age groups, with the exception of lung cancer, colon and rectum, and breast cancer.
- For circulatory diseases, differences in the relative burden of disease between country groups are largest in the highest age group, pointing to the importance of policies for healthy ageing in Europe. In contrast, for lung cancer these differences vanish for the highest age groups, when the importance of this disease decreases substantially.
- For circulatory disease the divergence of the burden of mortality for higher age groups is especially striking between country group B and C. The relative burden or mortality per age group is similar for the age group of people aged 45 to 59, but grows much faster in countries in group C after that age.

Definitions

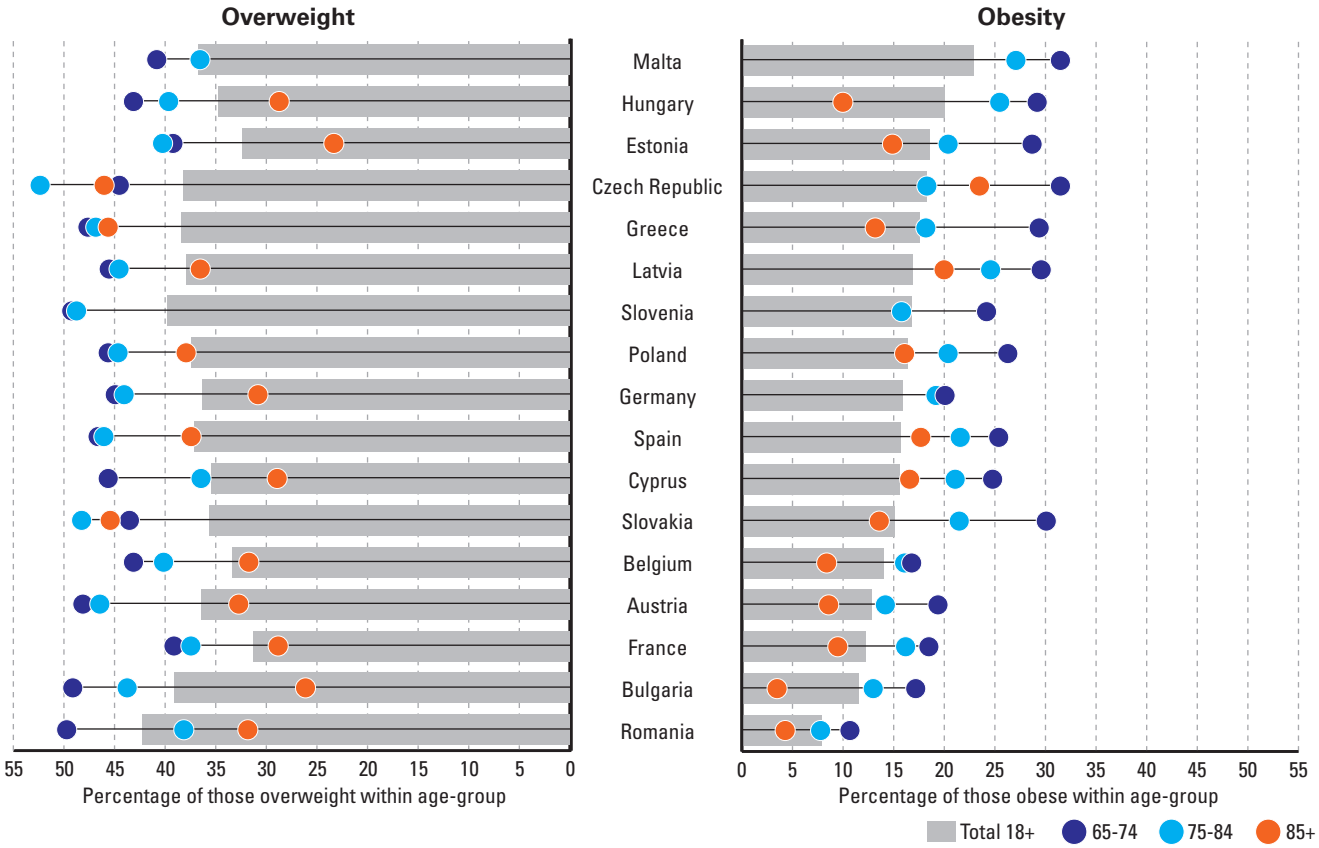
The years of life lost (YLL) indicator measures the cause-specific years lost as a proportion of the total YLL lost in the population due to premature mortality. The indicator estimates the percentage of total YLL for a specific age and sex group for three WHO country groups. (For the definition of country groups A, B and C see Figure 4.2 above).

OVERWEIGHT AND OBESITY: A GROWING PUBLIC HEALTH CONCERN IN EUROPE

Overweight and obesity: a growing public health concern in Europe

The prevalence of overweight or obesity by age groups measures the share of the population that is overweight or obese, as estimated by the body mass index calculated on the basis of self-reported data collected through national health interview surveys. As one of the major risk factors for cardiovascular disease, diabetes and cancer, obesity is a primary factor behind noncommunicable diseases.

Figure 4.6: Share of the population that are overweight, based on body mass index (in percent), 2009 or latest year available



Source: Eurostat [online database] European Health Interview Survey

- The prevalence of overweight is higher in the age groups above 55 years compared with the average of the adult population for the sample of countries shown below. Prevalence of overweight is close to or above 40% for those between 65 and 75 years of age.
- Overweight and obesity are substantially less prevalent among those aged 85 and above. Overweight is especially pronounced in Estonia, Bulgaria and Romania, while obesity is common in Romania, Bulgaria and Hungary.
- There is an East-West gradient in overweight and obesity for the adult population, including the higher age groups. This is, however, less pronounced for obesity, with Romania and Bulgaria at the lower end of the obesity spectrum.
- However, a substantial number of persons in the highest age groups are at risk of malnutrition, which can contribute to developing frailty, if not adequately addressed (WHO, 2002b).
- In Europe, there has been a three-fold increase in the prevalence of obesity over the last two decades. However, the trend is most alarming in today's children and adolescents, because many of them are passing the obesity epidemic into adulthood thus creating a growing health burden for the next generation (WHO/Europe, 2008).

Definitions

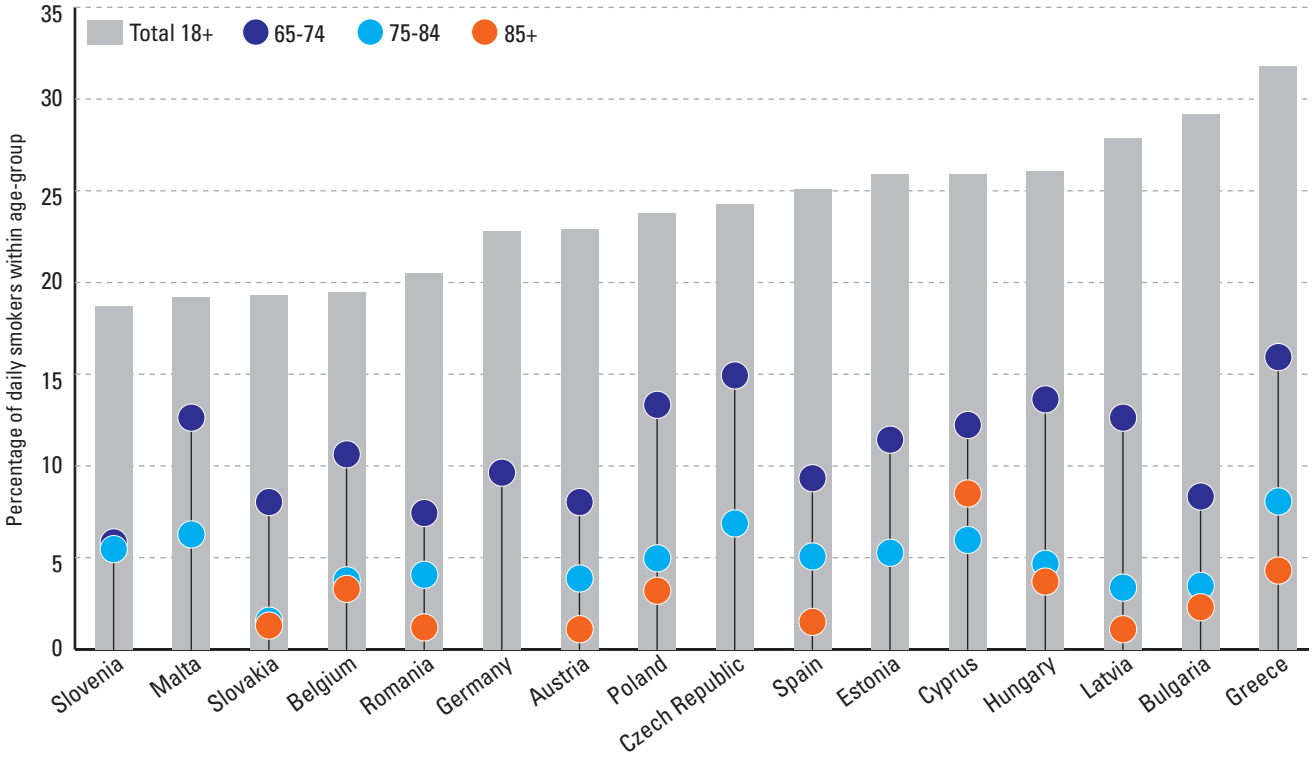
Persons who report a body weight and height that corresponds to a body mass index (BMI) between 25 and 30 are classified as overweight; those with a BMI of 30 and above as obese. As with other estimates based on self-assessed health, the comparability between countries is limited. Moreover, estimates based on self-reported measures tend to underestimate the prevalence of overweight and obesity compared with estimates from health examination surveys.

DAILY SMOKING IS NOT AS PREVALENT IN HIGHER AGE GROUPS AS AMONG YOUNGER PEOPLE

Daily smoking is not as prevalent in higher age groups as among younger people

Smoking prevalence is measured by the share of the population that smokes daily per age group, estimated on the basis of national health interview surveys. Tobacco use is a risk factor for six of the eight leading causes of death in the world: ischaemic heart disease, cerebrovascular disease, lower respiratory disease, chronic obstructive pulmonary disease, diarheal disease, tuberculosis and trachea/bronchus lung cancer. It is also a risk factor for stroke and colon/rectum cancer, among others.

Figure 4.7: Share of the population that are daily smokers (in percent), 2009 or latest year available



Source: Eurostat [online database] European Health Interview Survey

- For selected countries with available data, the smoking prevalence is visibly lower for persons aged over 65 when compared with younger age groups, becoming marginal among those people over 85 years in most countries for which data are available.
- Of the five countries shown above with the highest self-reported daily smoking prevalence, the majority are new Member States to the EU, with the important exception of Greece.
- Compared to Slovenes, almost twice as many Greeks up to age 64 report smoking on a daily basis.
- There is evidence that to quit smoking has beneficial health effects at all ages, including in older age groups, and there are effective policy measures to reduce overall as well as age-specific smoking rates in the population. Some of these measures are included in the WHO Framework Convention on Tobacco Control (WHO FCTC), such as protection from exposure to tobacco smoke, cessation support, packaging and labelling, prohibition of tobacco advertising, promotion and sponsorship and raising taxes and prices. The role of health professions in providing cessation support is also a key example, as they are seen as role models, highly respected and a trusted source of information and are also in contact with a higher percentage of the population, particularly those in older age groups.

Definitions

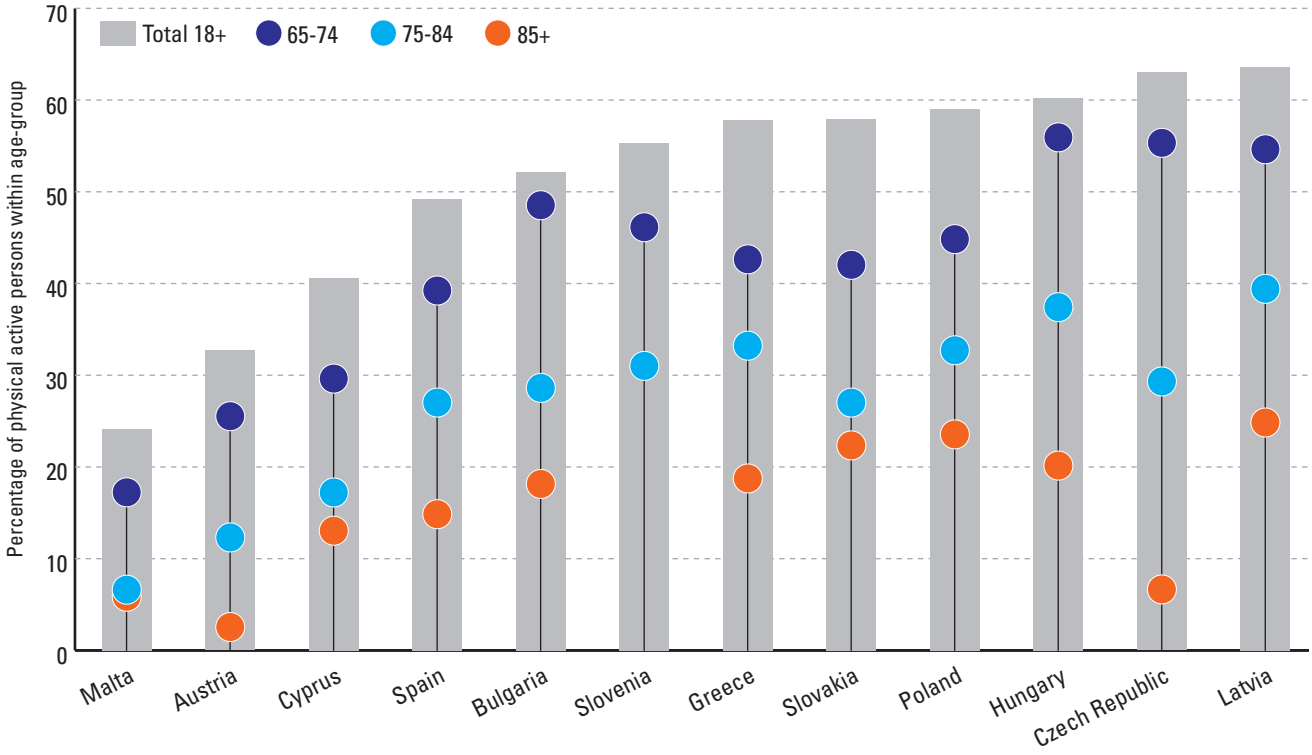
This indicator is a prevalence estimate of self-reported daily smoking from the European Health Interview Survey data collection of Eurostat.

TO REMAIN PHYSICALLY ACTIVE BECOMES MORE DIFFICULT IN THE HIGHEST AGE GROUPS

To remain physically active becomes more difficult in the highest age groups

Physical activity is measured by the share of the population that undertakes at least 30 minutes of physical activity per day, estimated on the basis of national health interview surveys. Physical activity is one of the strongest predictors of healthy ageing. Regular moderate physical activity promotes mental, physical and social well-being and helps to prevent illness and disability. Those who are physically fit when they enter old age tend to stay healthier for longer.

Figure 4.8: Share of the population that undertakes at least 30 minutes of physical activity per day (in percent), 2009 or latest year available



Source: Eurostat [online database] European Health Interview Survey

- Physical activity tends to decrease sharply as people grow older, with the largest decrease occurring when people are in their 70s.
- In the majority of countries in the sample shown below, the level of physical activity in the age group of 55-64 is still close to, or even higher than for the adult population on average. A significant drop of physical activity levels takes place in the age groups when most people are usually in retirement (age group of 65 years and older).
- Perhaps most surprisingly, the share of older people that stay physically active after 65 years does not seem to be correlated with the overall share of physically active adults of all age groups, nor with the share of those who are physically active in the age group of 55-64 years.
- These large variations across countries, in particular in the gaps between physical activity levels in the age groups before and after retirement age, suggest that more can be done to support more older people to stay physically active.
- For older people, physical activity can improve respiratory and muscular fitness, as well as bone and functional health, and reduce the risk of non-communicable diseases, depression and cognitive decline. Physical activity is also crucial for lowering the risk of injuries. For older people, taking part in physical activity can also be linked to increased opportunities for taking a more active part in the community. (WHO/Europe, 2012b).
- The sample of countries for which prevalence estimates for physical activity are available, is currently limited, which calls for a strengthening of the reporting base, given the importance of this indicator for public policies and healthy ageing.
- Policies to promote physical activity are frequently a cross-cutting concern, including a number of government departments, and successful implementations are found in particular at the local government level (WHO/Europe, 2004; 2007).

Definitions

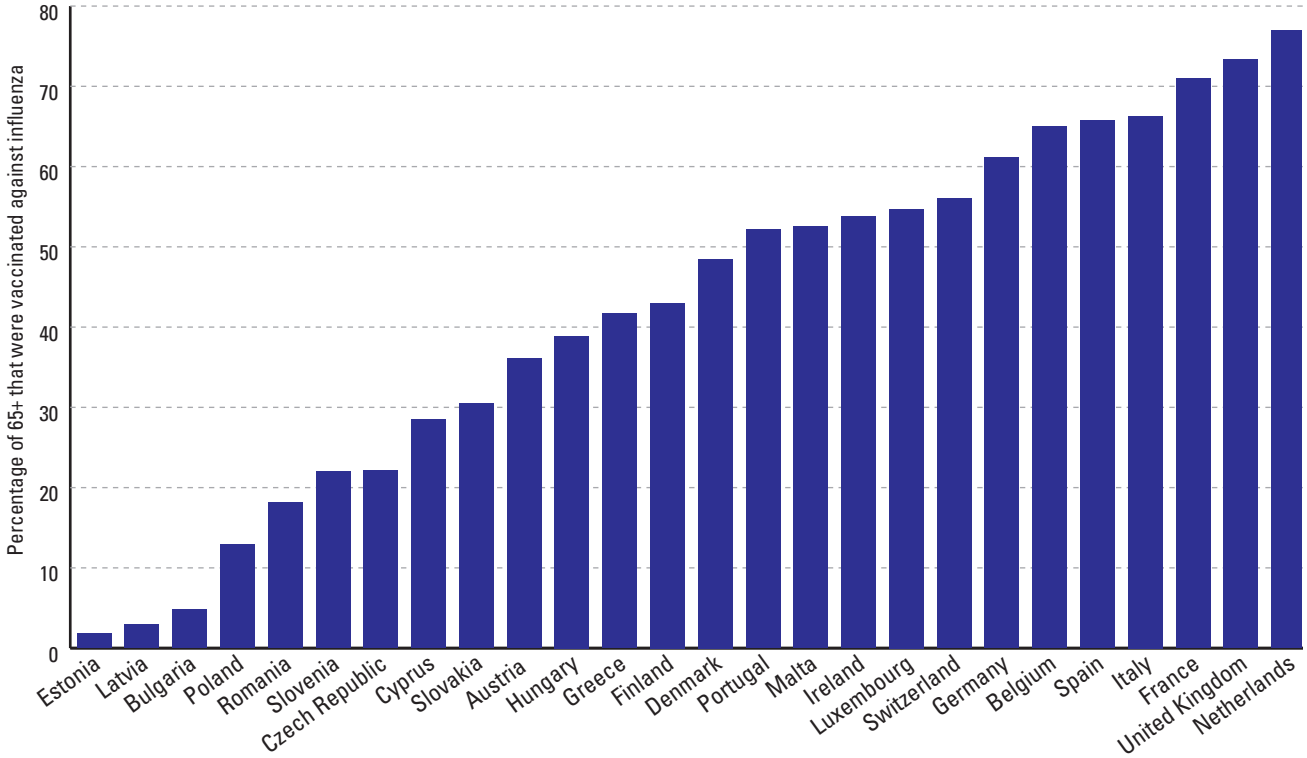
This indicator is a prevalence estimate from the European health interview survey data collection of Eurostat for self-reported physical activity of at least 30 minutes per day.

COVERAGE OF INFLUENZA VACCINATION CAN BE IMPROVED FOR OLDER AGE GROUPS

Coverage of influenza vaccination can be improved for older age groups

The share of the population that was vaccinated against influenza during the past 12 months measures influenza vaccination rates (population aged 65 and over, based on national administrative data). According to WHO recommendations, annual influenza vaccination is a safe and effective measure that can benefit all age groups. Vaccination is especially important for people at higher risk of serious influenza complications, including for older persons (including those in institutions) and persons with underlying medical conditions.

Figure 4.9: Share of the population over 65 that were vaccinated against influenza during the past 12 months, 2009 or latest year available



Source: OECD Health Data 2011 [online database]. Paris, Organisation for Economic Co-operation and Development, 2011; European Health Interview Survey [online database]. Brussels, Eurostat, 2012.

- Vaccination coverage is still relatively small in a number of EU12 countries, but also relatively low in Austria and Greece.
- Some countries have made considerable progress in increasing seasonal influenza vaccination coverage of older people, but in most European countries coverage still remains today well below the 2010 WHO target of vaccination coverage of 75% that was recommended by the World Health Assembly in 2003.
- Although usually a mild and self-limiting disease, influenza can cause life-threatening complications including pneumonia and bronchitis or exacerbation of underlying conditions (such as pulmonary or cardiovascular diseases), resulting in hospitalization and death.
- Older people in particular are vulnerable to developing severe diseases, which may result in prolonged and costly rehabilitation and recovery. During seasonal influenza epidemics, people aged 65 years or older account on average for more than 90% of influenza-related deaths (WHO, 2011).

Definitions

Reported vaccination rate, based on national administrative records.

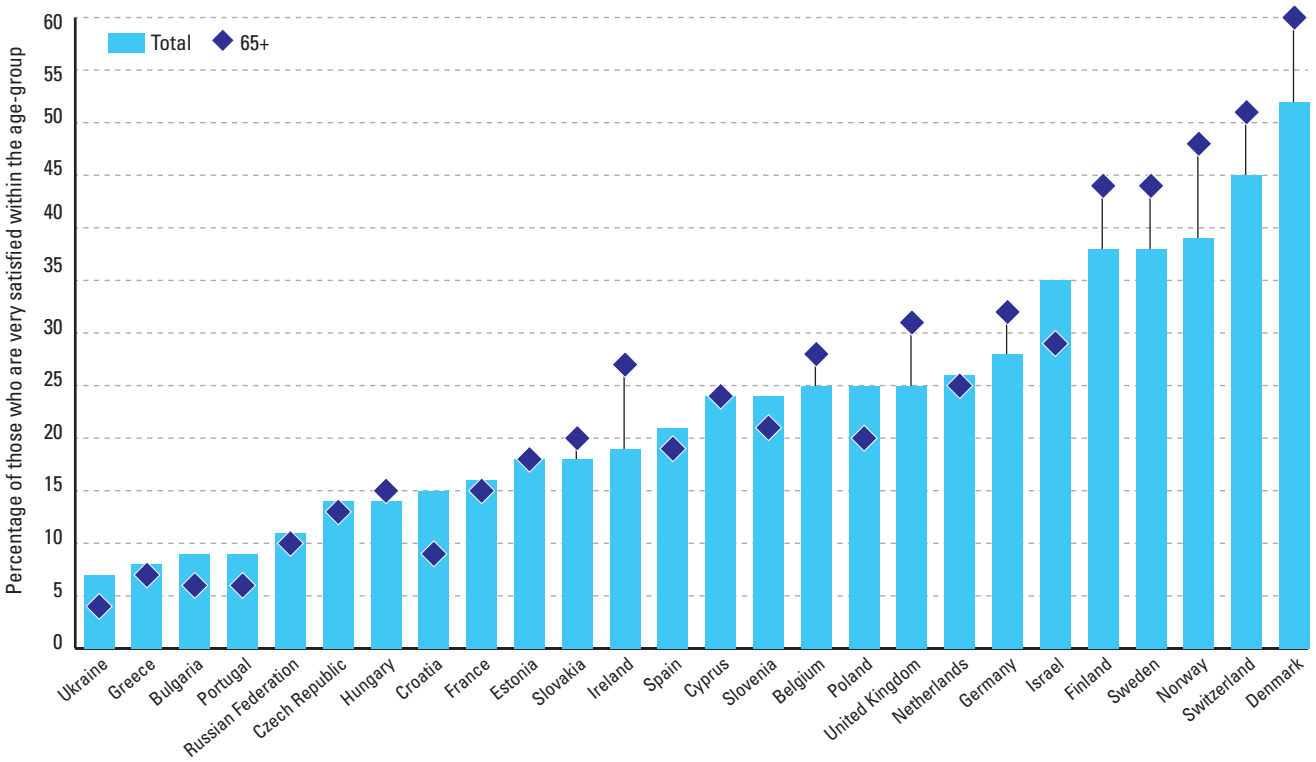
Note: For Austria and Germany, the population is aged 60 and over.

LIFE SATISFACTION: BLISS IN OLD AGE IN COUNTRIES WITH HIGH SUBJECTIVE WELL-BEING

Life satisfaction in old age

Self-reported life satisfaction is a key measure of subjective well-being, and provides a measure of the subjective evaluation of an individual's life as a whole. It is a useful complement to objective measures of living standards (e.g. poverty).

Figure 4.10: Share of those who are very satisfied across European countries, among the total and old-age population, 2010



Source: Own calculations, based on the European Social Survey, ESS5-2010 Edition 2.0

- There is a strong divide across Europe in terms of subjective well-being: in the 'best world' of Norway, Finland, Sweden, Switzerland and Denmark, nearly every second older person is very satisfied, while in Ukraine, Bulgaria, Portugal, Greece and Croatia their share is below one in ten.
- There is a clear age differential in countries with higher well-being: in these nine countries (Israel is an exception), the elderly are more likely to be very satisfied than the population average. In these countries, those aged 65+ are likely to have a longer and healthier life, but also to have access to more generous social services to cater for their needs.
- In many countries with low levels of subjective well-being (Ukraine, Bulgaria, Portugal, Greece, the Russian Federation, Czech Republic, France and Hungary) there is little difference by age, signalling a general social 'misery'. In the Czech Republic, France, Greece, Hungary and the Russian Federation, the difference is not statistically significant (at 5% level).
- According to an analysis based on Gallup World Poll, cross-country differences can be explained by both income and social context variables. In various alternative models, the combined effects of a few measures of the social and institutional context (e.g. food inadequacy, perception of corruption, freedom to choose) exceed that of income (Helliwell, Barrington-Leight et al. 2010).

Definitions

The indicator is based on self-reported life satisfaction. People are asked that "All things considered, how satisfied are you with your life as a whole nowadays?" This question is answered on a scale of 0 to 10, where 0 means extremely dissatisfied and 10 means extremely satisfied.

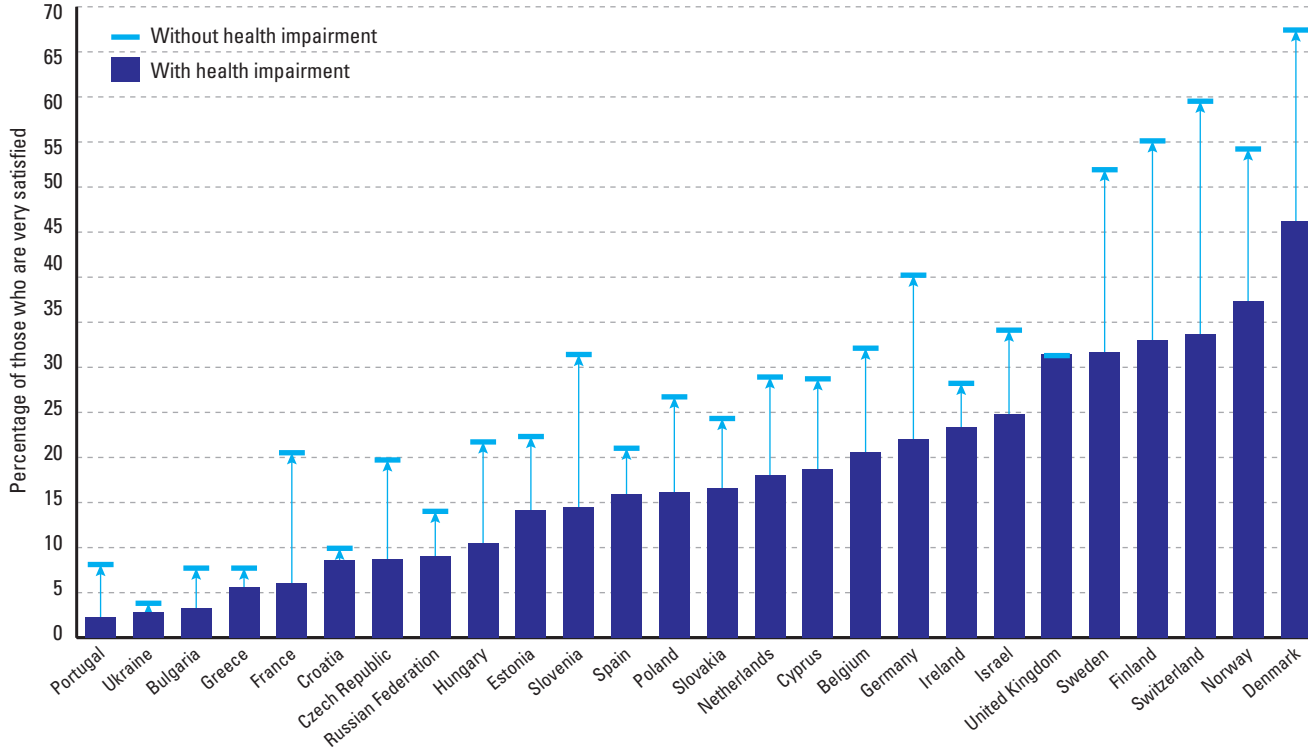
"Very satisfied": self-reported life satisfaction scores of 9 and 10 on a scale of 0 to 10.

HEALTH IMPAIRMENT REDUCES LIFE SATISFACTION

Health impairment and life satisfaction among the older population

This figure assesses to what extent health impairment (a key issue in old age) affects subjective well-being, by comparing the latter across people with different health conditions.

Figure 4.11: Share of those who are very satisfied with life within the age group 65 and older, by health impairment, 2010



Source: Own calculations, based on the European Social Survey, ESS5-2010 Edition 2.0

- Health problems take their toll: older people with health impairments are less likely to be very satisfied in nearly all countries. Thus, healthy ageing is a key aspect of happiness in old age.
- The well-being gap is particularly large in Bulgaria, the Czech Republic, Hungary, Slovenia, Latvia and Portugal, where the difference between the two groups is over twofold.
- In many countries (including Ukraine, Greece, Croatia, the Russian Federation, Spain, Slovakia, Ireland, and the UK) the difference between the two groups is not statistically significant, due to the large width of the confidence interval.
- The share of the older people who claim that they have some health impairment ranges from 26% in Ireland to 72-73% in Ukraine and the Russian Federation. This highlights the importance of health problems. Note, however, that a self-assessed health condition is affected by cultural standards, but more importantly from a policy point of view, by lifestyles and by (public) health and care services.
- Overall, a key aspect of promoting happiness in old age is preventing health impairment, long-term illnesses and mental health problems.

Definitions

The survey question explores whether the individual thinks he/she is hampered in daily activities by any long-standing illness, disability, infirmity or mental health problem. In our measurement of health impairment, we merged the answer categories 1 (yes a lot) and 2 (yes to some extent) together.

"Very satisfied": self-reported life satisfaction.

Chapter 5:

INFORMAL CARE

WHO CARES? IT'S A WOMAN'S WORLD – EXCEPT FOR THE OLDEST OLD

Gender distributions in providing informal care in older age groups

This indicator displays the share of older women providing informal care to an older relative or friend. They make the 'female face' of informal care explicit and point out the age groups in which gender-specific support policies might be most effective.

Figure 5.1a: Share of women and men providing informal care by age group and country (in percentage of female and male population)

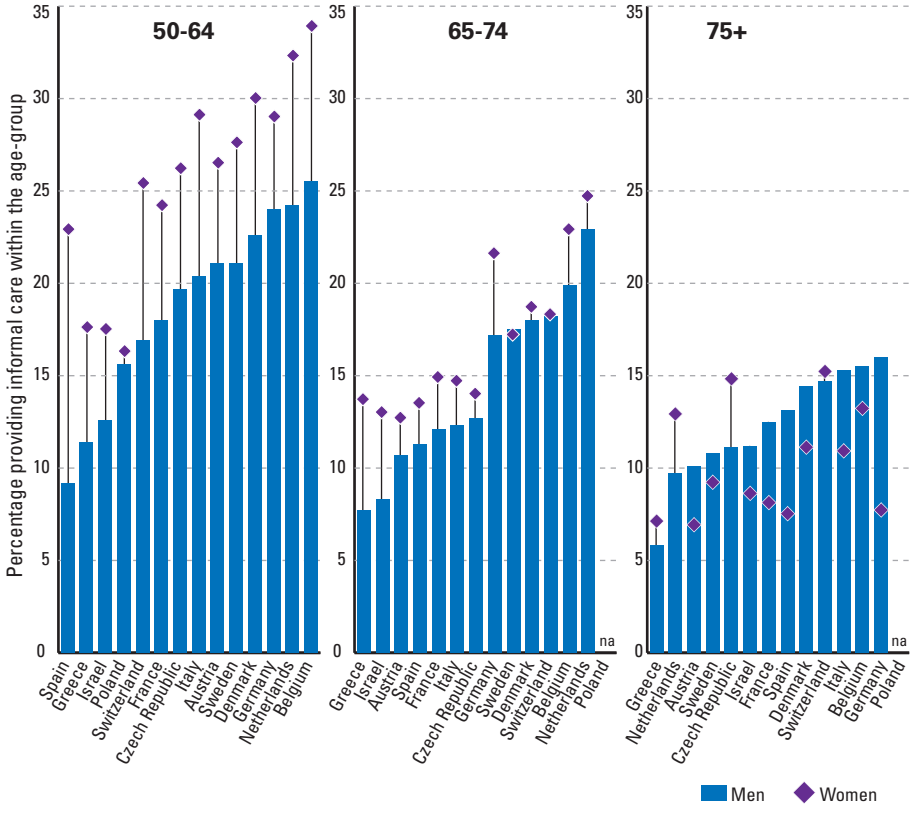
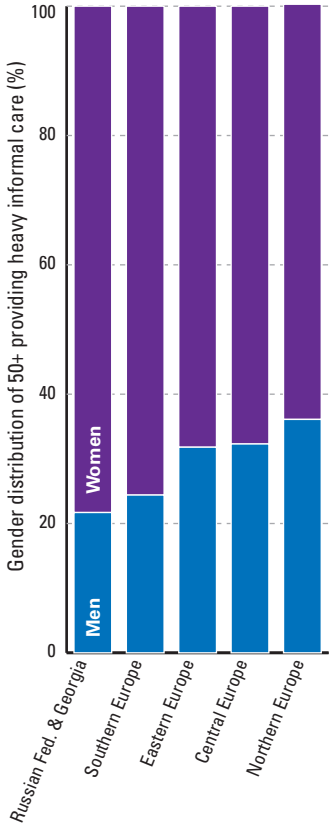


Figure 5.1b: Gender distribution of people providing heavy informal care (≥ 20 hours a week) to someone outside the household by country clusters, age group 50 and older



Source: Own calculations based on SHARE 2nd wave 2006/2007, except for Israel (SHARE 1st wave, 2005/2006); and Georgia, Russia, Norway, Estonia, Bulgaria and Romania (GGS 1st wave, 2005).

Notes: Informal care provision for Georgia, Russia, Norway, Bulgaria and Romania refers to personal care provided to someone outside the household. 'Central Europe': AT, DE, BE, FR, CH. 'Southern Europe': IT, ES, EL. 'Eastern Europe': CZ, PL, RO, BG. 'Northern Europe': DK, SE, NL, NO.

- In almost all countries women shoulder the largest part of informal care provided for older age groups. With higher age, however, the share of male carers increases, and men become more likely to be informal carers than women in most countries in the oldest age group (75 years and older) (Figure 5.1a). For example, in Spain, among the youngest old (50 to 64 years) differences are highly pronounced, with more than one in five women being an informal carer, as compared to only one in ten men. These differences, however, become reversed in higher age groups.

- Heavy informal care to someone outside the household – defined as more than 20 hours per week – is predominantly provided by women: indeed, more than six out of ten 'heavy' carers in the age group 50 and older are female. This is true for Southern, Central, Eastern and Northern European countries, and Georgia and Russia (Figure 5.1b).

- While these numbers need to be complemented with other, contextual data (e.g. living arrangements, number of children), they still give important insights into the dynamics of informal caring of men and women in old-age.

Definitions

The indicator in Figure 5.1a refers to informal care Type 1 a, excluding those who indicated to care for a younger relative (e.g. children, grandchildren, nieces or nephews):

- Providing personal care, practical household help or help with paperwork to someone living outside the carer's household, AND/OR
- Providing personal care to someone living inside the carer's household

Note: There is no defined minimum amount of informal care provided (e.g. informal care is considered only when provided for at least 1 hour a week) unless specified otherwise. If specified, time limits only refer to informal care provided to someone living outside the carer's household.

The indicator in Figure 5.1b refers to heavy informal care Type 1 c (outside the household) for a minimum of 20 hours per week:

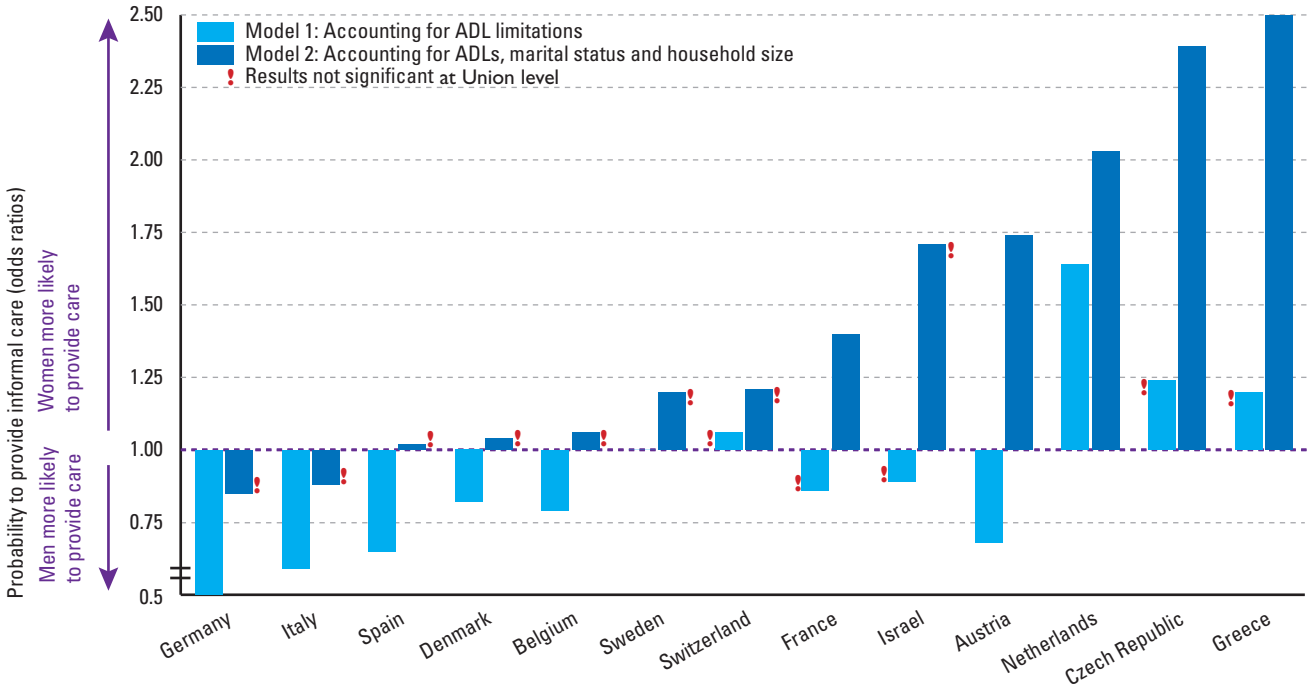
- Providing personal care, practical household help or help with paperwork to someone living outside the carer's household.

PROBABILITY OF MEN AND WOMEN TO PROVIDE INFORMAL CARE

Probability of men and women to provide informal care

Using statistical modelling techniques the higher prevalence of male informal carers in the oldest age groups (75 years and over) is investigated further. The role played by health condition, marital status and living arrangements is taken into consideration to explain possible gender differences in the provision of care among old-age people.

Figure 5.2: Probability (odds ratios) to provide informal care to someone inside or outside the household of women compared to men in the older age groups (75 and older)



Source: Own calculations based on SHARE 2nd wave (2006/07), except for Israel (SHARE, 1st wave, 2005/2006).

- Informal carers are predominantly women – and in particular daughters, daughters-in-law or wives (cf. Hoffmann & Rodrigues, 2010) – except for the oldest age group (75 years and over), when men catch up with or even outnumber women in providing informal care (see Figure 5.1a). However, this could be partly explained by the fact that men are more likely than women to live with their partners or spouses in very old age; and partners or spouses are in turn more likely to care for each other (cf. Del Bono et al., 2009).
- This indicator provides evidence that the effect of 'male caring' in the oldest age group is indeed partly due to women living alone more often in older age than men (see also Chapter 2). The likelihood of providing informal care increases for women in all countries when marital status and household size are accounted for, albeit not significantly ($p<0.1$) for all countries.
- Two important policy messages can be drawn from this finding: firstly, women continue to be the main resource for informal care also among the very old. Secondly, men are also highly prone to provide informal care, but only if they live together with their partner or spouse.

Definitions

Logistic regression models are used to infer the likelihood of providing informal care by women compared to men.

The first model (displayed in blue) investigates gender differences in the likelihood to provide informal care controlling for limitations with activities of daily living (ADLs) – as an indicator of health status, while the second model (displayed in red) additionally controls for marital status (living with partner/spouse or not) and household size.

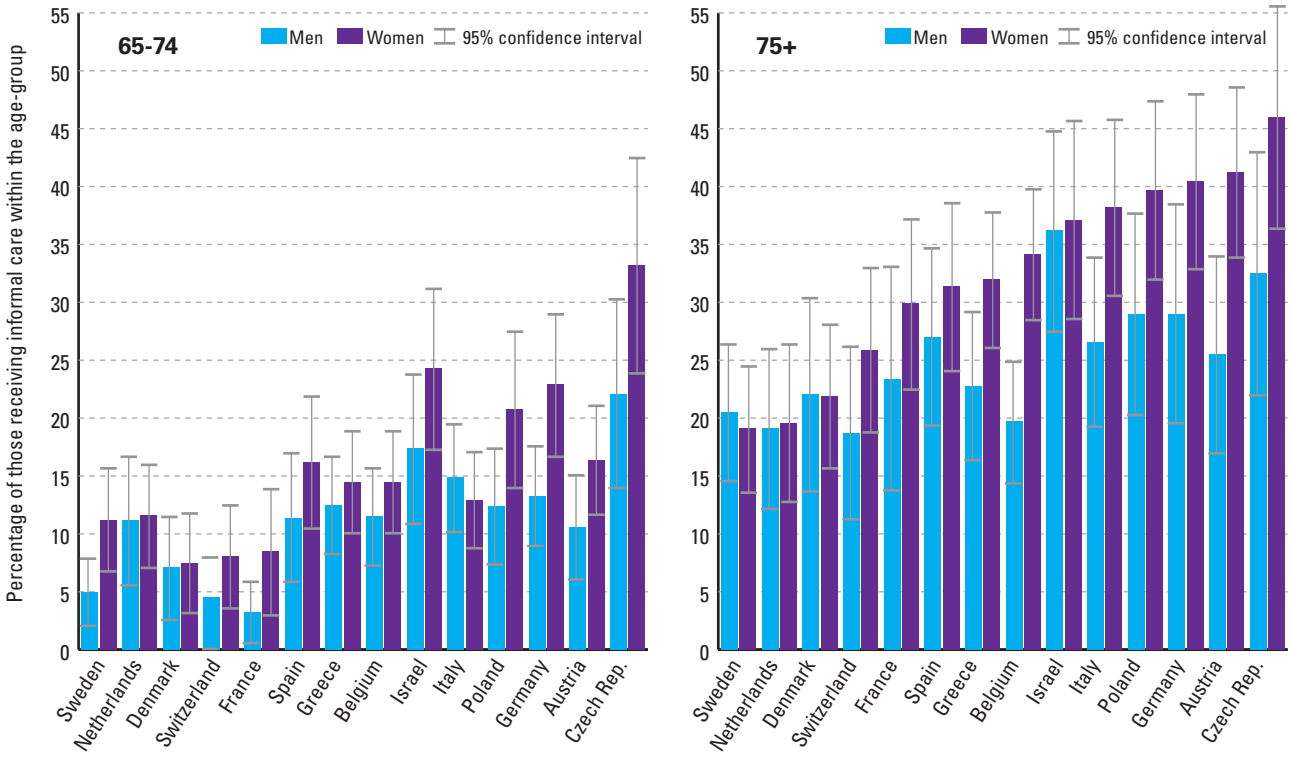
Informal care refers to Type 1 a (see Figure 5.1a), excluding informal care to younger relatives such as children, grandchildren, nieces or nephews.

WOMEN IN NEED, MORE THAN MEN

Gender differences in receiving informal care

This indicator depicts differences between men and women in receiving informal care from people inside or outside the household. The numbers point to a higher need for support among older women, compared to men of the same age groups.

Figure 5.3: Share of women and men in different age groups receiving informal care (minimum 1 hour per week) from people inside or outside the household



Source: Own calculations based on SHARE 2nd wave (2006/07), except for Israel (SHARE, 1st wave, 2005/2006).

- Older women spend a greater share of their older lives suffering from chronic health problems than men (see Chapter 4). This also has an impact on their need for support from their family members and friends: As displayed in Figure 5.3, women receive more support from informal carers (co-residing or not) than men in almost all countries and age groups.
- Gender differences in support received from informal carers are highest in the oldest age group (75 years and over) and in those countries where informal caring is generally more widespread, such as the Czech Republic, Austria, Germany, Poland, and Italy. In countries where a smaller share of older people receive informal care, such as in Sweden, the Netherlands, and Denmark, gender differences are less pronounced. In short, a clustering pattern of countries in the North-West versus countries in Southern-Eastern parts of Europe and Israel can be found.
- Future research should shed more light on whether higher levels of informal care support among women correspond to their own preferences, or are due to other factors such as lack of access to services or information deficits.

Definitions

Informal care is defined as receiving informal care **Type II a** for a minimum of 1 hour per week:

- Receiving personal care, practical household help, or help with paperwork from someone living outside the person's household, AND/OR
- Receiving personal care from someone living inside the person's household.

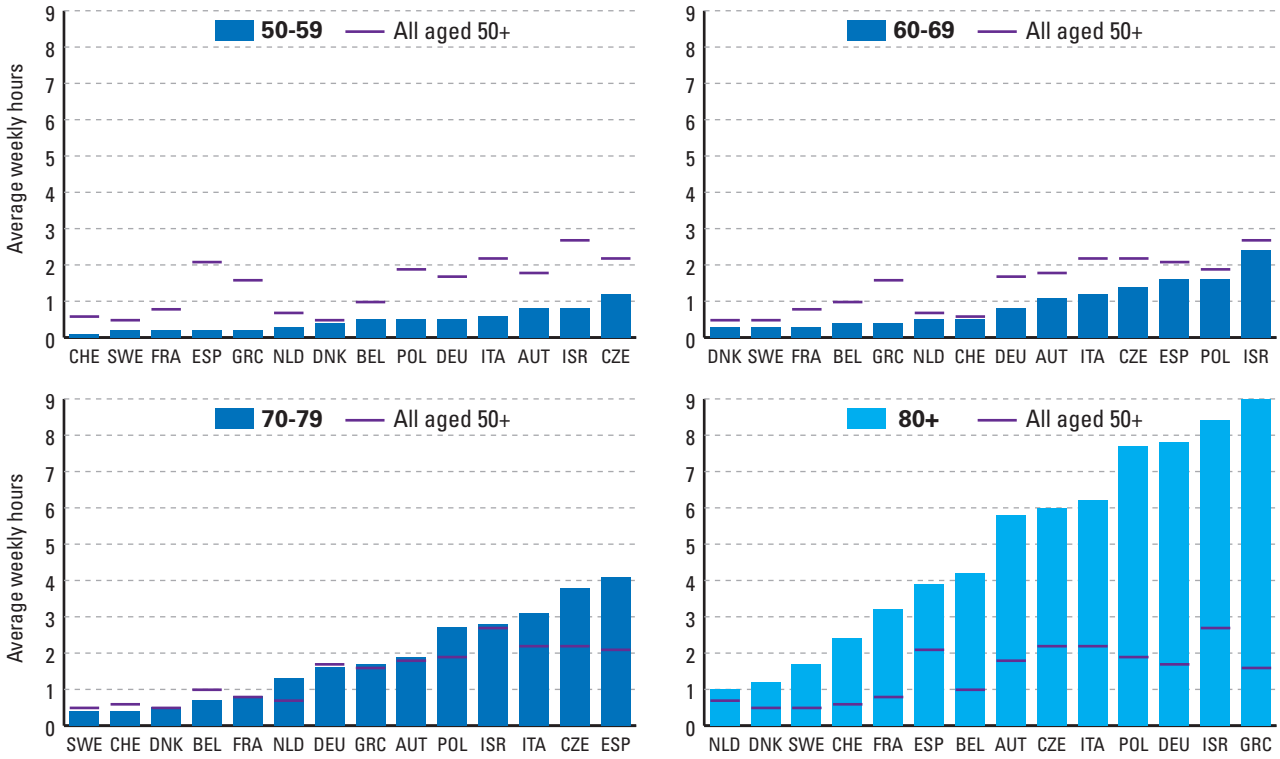
There is no defined minimum amount of informal care provided (e.g. informal care is considered only when received for at least 1 hour per week) unless specified otherwise. If specified, time limits only refer to informal care received from someone living outside the carer's household.

FAMILY CARE AS A FAMILY AFFAIR – MOSTLY IN 'FAMILY-ORIENTED' WELFARE STATES

Intensity of informal care

This indicator measures average intensity of informal care received by older persons of different age groups. This provides an estimation of the degree to which care needs are met by informal carers.

Figure 5.4: Average weekly hours of informal care received from people outside the household, by age groups



Source: Own calculations based on SHARE 2nd wave (2006/07), except for Israel (SHARE, 1st wave, 2005/2006).

- Intensity of informal care is much more pronounced and already evident in earlier age groups in countries where the state traditionally leaves a comparatively larger part of LTC provision in the realms of the family (Bolin et al., 2008a). In fact, intensity of informal care in the oldest age group is more than six times higher in Greece, Germany and Poland, compared to the Netherlands and Denmark (cf. Figure 5.4). In the latter countries, older people with higher care needs are more likely to be cared for by formal care services or in institutions (cf. Chapter 7).
- What is common to all countries displayed is that the intensity of informal care received increases with age, due to a generally higher need for LTC in the highest age groups.
- In Southern and Eastern European countries the intensity of informal care may be even higher, given the fact that co-residential personal care is more common in these countries (Figure 5.8), and co-residential carers tend to provide more hours of informal care. Given the lack of data on the intensity of informal care *within* the same household, the effect of multi-generational households, however, cannot be taken into account (see also Chapter 2).
- As life expectancy increases, intensity of informal care in older age groups could be expected to increase further as the result of policies that aim to support informal care in the context of "ageing in place" (OECD, 2005); or that take informal care into consideration when it comes to receiving public benefits. In the Netherlands for example, 'customary care' (i.e. informal care that can be provided by relatives) is considered before a person is entitled to access formal care services.

Definitions

The indicator measures the average number of hours of informal care per week received by older people from someone outside their household (e.g. a relative, friend or neighbour), including 0 hours of care. Informal care refers to **Type II b** (outside the household):

Receiving personal care, practical household help, or help with paperwork from someone living outside the person's household.

Average hours refer to the total population in that age group and not just to those receiving care.

LIGHT CARING BY MANY, HEAVY CARING BY A FEW

Relationship between intensity of informal care and the share of carers in the population

This indicator complements the picture on intensive care by associating the amount of informal care provided with the share of carers aged 50 years and older in the population. This makes it possible to better understand the complexities of informal care provision as well as set them in a comparative perspective.

Figure 5.5: Average amount of informal care to someone outside the household vs. percentage of informal carers in the population aged 50 and older

Source: Own calculations based on SHARE 2nd wave (2006/07), except for Israel (SHARE, 1st wave, 2005/2006).
Notes: The vertical axis measures the average number of hours of informal care provided to someone outside the household; the horizontal axis measures the share of informal carers in the population 50+.

- The degree to which relatives become engaged in carrying out informal caring duties differs largely (Figure 5.5, vertical axis): on this measurement, Scandinavian countries fare lowest. This indicates a negative relationship between the share of carers in the population and the intensity with which informal care is provided on average.
- Looking at the numbers of carers in the population aged 50 years and older (Figure 5.5, horizontal axis), it is evident that Nordic countries such as Denmark and Sweden, but also the Netherlands and Belgium, rank highest when it comes to the involvement of families in providing help.
- By contrast, in Italy and Spain, but also Greece, Israel and Poland, only a small part of the population aged 50 and older takes on caring duties, but they do so on average for more hours per week. This means that more burdensome caring duties are shouldered by a few in these five countries.
- Had co-residential care been considered too, the picture of intensive caring in Southern European regions would have been even more skewed, as multigenerational households are highly common in those countries (see Chapter 2).
- The findings could point to a possible complementary dynamic of formal and informal care in Northern European countries. There, older people's family members and friends show a higher engagement in providing care, possibly because heavier tasks are delegated to formal care services (see Chapter 7). In Southern and Eastern European countries coverage with formal services is scarce, thus informal carers may be confronted with a starker choice between becoming full-time carers (possibly forfeiting employment) or not caring at all, although evidence remains inconclusive in this respect (Bolin et al., 2008b).

Definitions

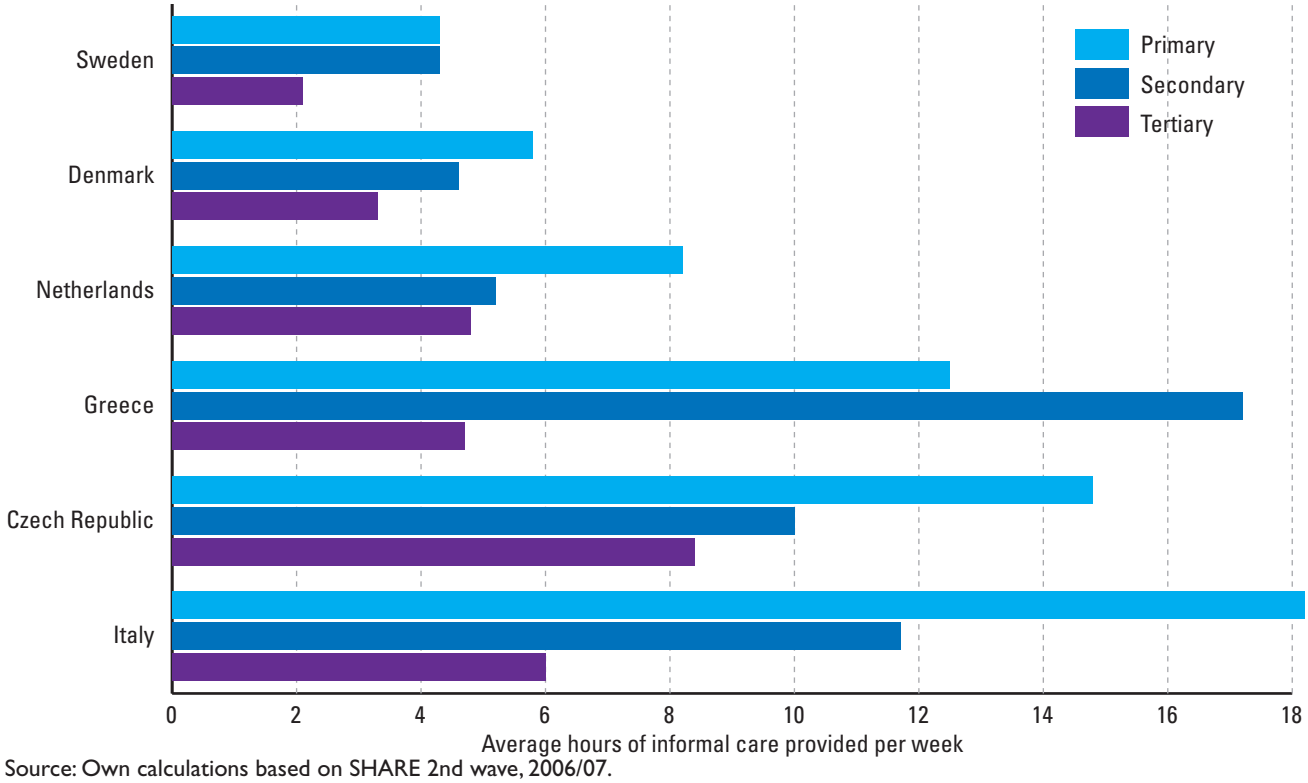
Informal care is defined as in **Type I c** (see Figure 5.1b) (outside the household), with the time limit excluding 0 hours of informal care on the vertical axis.

THE SOCIO-ECONOMIC GRADIENT OF INFORMAL CARE

Provision of informal care by people with different educational levels

This indicator measures how many hours of informal care are being provided by people with basic education, compared to people with secondary and those with tertiary education. This allows an estimation of the role played by socio-economic differences in the intensity of informal care provided.

Figure 5.6: Average hours of informal care provided per week by those aged 50 and older to someone outside the household, by education



Source: Own calculations based on SHARE 2nd wave, 2006/07.
Note: Results for countries where the intensity of care provision for people with neither secondary nor tertiary education was not statistically significantly different from those with basic education, are not shown.

- Lower socio-economic status has been associated with a higher likelihood to provide more hours of informal care (Motel-Klingebiel et al., 2005). This indicator demonstrates that people with basic education, compared to people with secondary or tertiary education, provide higher amounts of informal care in Sweden, Denmark, the Netherlands, Greece, Czech Republic and Italy.
- The gradient between people with basic and people with tertiary education is largest in the Czech Republic and Italy – the countries where the amount of hours of informal care per week is on average the highest for these six countries. On the other hand, differences in the provision of care are relatively small in Sweden and Denmark, where on average the lowest amounts of informal care are provided.
- The reasons for the socio-economic differences in the likelihood to provide informal care may be found in the specific features of long-term care policy design. For example, in countries where cash benefits are provided (e.g. in Italy) lower socio-economic groups may use these to top up their household income and provide informal care themselves. Also, when the amount of formal care services may be limited (e.g. in Greece; the Czech Republic), or people have to pay a high share of costs out of their own pockets, they may also prefer to provide informal care themselves on top of formal services.
- Moreover, these factors may make informal carers from lower income groups more likely to drop out from the labour force, and face restrictions in moving up the social mobility ladder.

Definitions

Informal care refers to **Type I c** (outside the household) (See Figure 5.1b). Average hours of informal care provided per week to someone outside the household are measured, excluding 0 hours of care. Education levels refer to the ISCED: basic education refers to ISCED levels 1 and 2, secondary education refers to levels 3 and 4, and tertiary education refers to levels 5 and 6.

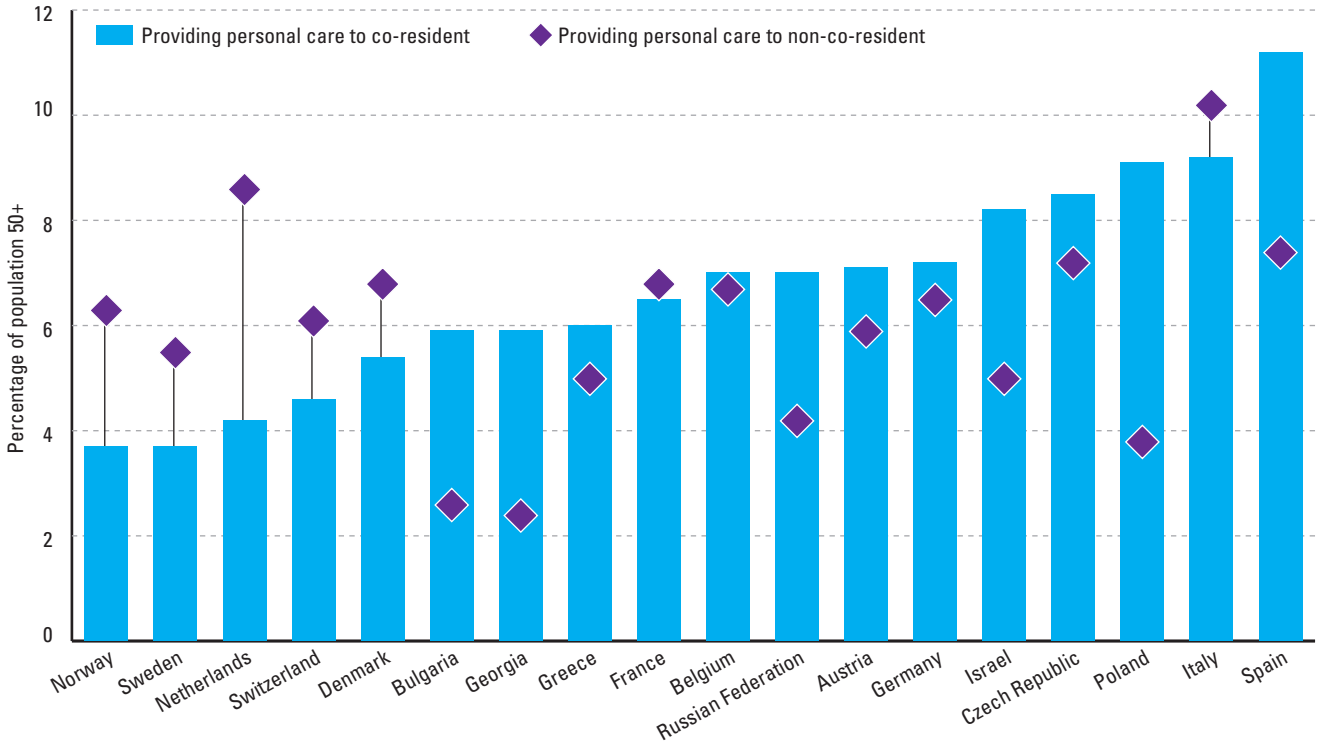
Bonferroni's method ($p \leq 0{,}01$) has been used to test differences between basic and secondary education, and between basic and tertiary education.

CLOSE TO MY HOME, CLOSE TO MY HEART: CO-RESIDENTIAL CARE

Providing informal personal care to co-residing vs. non-co-residing persons

This indicator displays the share of persons providing 'heavy' care (i.e. personal care) to a friend or family member in the same household, compared with those doing so for an externally living family member or friend. Co-residential care is often associated with more burdensome caring duties and it is thus of interest to take a closer look at those informal carers.

Figure 5.7: Share of people in the population 50 and older providing informal personal care to a co-residing and non-co-residing person



Source: Own calculations based on SHARE 2nd wave 2006/2007, except for Israel (SHARE 1st wave, 2006); and for the Russian Federation, Georgia, and Bulgaria (GGS, wave 1, 2005).
Notes: Shares of informal carers may not be added up, as there may be overlaps between the two groups of carers, for persons providing both co-residential care, and non-co-residential care.

- Not surprisingly, co-residential care is most common in countries where both multi-generational households (see Chapter 2), as well as intensive informal care to persons outside one's own household (cf. Figure 5.4) are common (see e.g. Poland, the Czech Republic, Austria and Italy).
- There is a North-West / South-East gradient in the prevalence of co-residential care provided: in Spain, Italy, Poland and the Czech Republic about one in ten persons provide heavier care (i.e. personal care) to a family member or friend living within the same household, whereas in Norway, Sweden and the Netherlands this is the case for less than one in 20 persons in the age group 50 years and over.
- In some countries personal care is provided as frequently *within* the same as *outside* one's household (e.g. Italy, Belgium, France), whereas in others it is much more common to provide informal care to persons *within* the same household rather than elsewhere (see e.g. Bulgaria, Georgia, Poland, or Spain). In the Nordic countries, by contrast, care provided to someone *outside* one's own household is much more common than co-residential care.
- Visibility of co-residential carers is often hampered by difficulties in measurement of the actual amounts of informal care provided to a co-residing family member, and the challenges in reaching these carers. Yet, given that these persons often shoulder the largest 'burden of care' and suffer a high risk of dropping out from the labour market (cf. OECD, 2011: 111), it is highly important to ensure the availability of e.g. respite care services or care leaves (cf. section on care leaves in this Chapter, Figures 5.11 to 5.14) for this group of informal carers.

Definitions

Informal care refers to personal care as defined in Type I b:

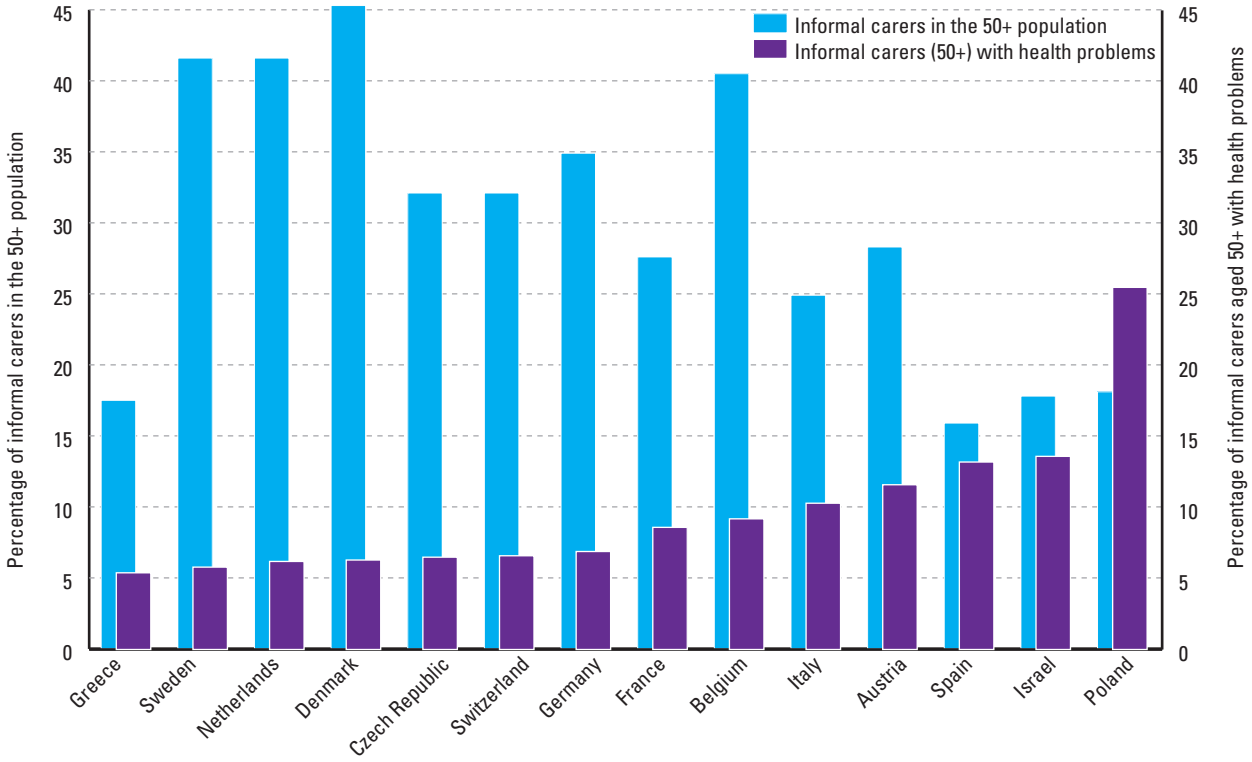
- Providing personal care to someone living outside the carer's household, AND/OR
- Providing personal care to someone living inside the carer's household.

HEALTH LIMITATIONS AMONG INFORMAL CARERS

Prevalence of health problems among people providing informal care

This indicator shows the number of informal carers in the age group 50 years and older who suffer from physical limitations themselves. This illustrates the health condition of carers.

Figure. 5.8: Share of informal carers (minimum 1 hour per week) in the age group 50 years and older suffering from at least one limitation in ADL



Source: Own calculations based on SHARE 2nd wave 2006/2007, except for Israel (SHARE 1st wave, 2006).

- Informal carers have been shown to frequently suffer from health problems, especially in countries where caring duties tend to be more intense (cf. OECD, 2011; Hoffmann & Rodrigues, 2010). Apart from physical problems (Figure 5.8) these carers also have been shown to suffer from mental health problems, particularly if informal care is provided for a large number of hours per week (cf. OECD, 2011:99f.).
- There seems to be a slightly inverse relationship between the share of carers in the population and the share of informal carers who suffer from physical limitations themselves (Figure 5.8). In other words, in countries where informal care is distributed among many (cf. Figure 5.5), these carers are also less sick, except for Greece.
- Given the long-term consequences on countries' health and long-term care systems it ought to be in the interest of policy-makers to identify the reasons for informal carers' health problems at an early stage, in order to prevent them from becoming dependent themselves in older age.

Definitions

Informal care refers to providing informal care **Type I a** (see Figure 5.1a) for a minimum of 1 hour per week. The time limit refers only to care provided outside the household.

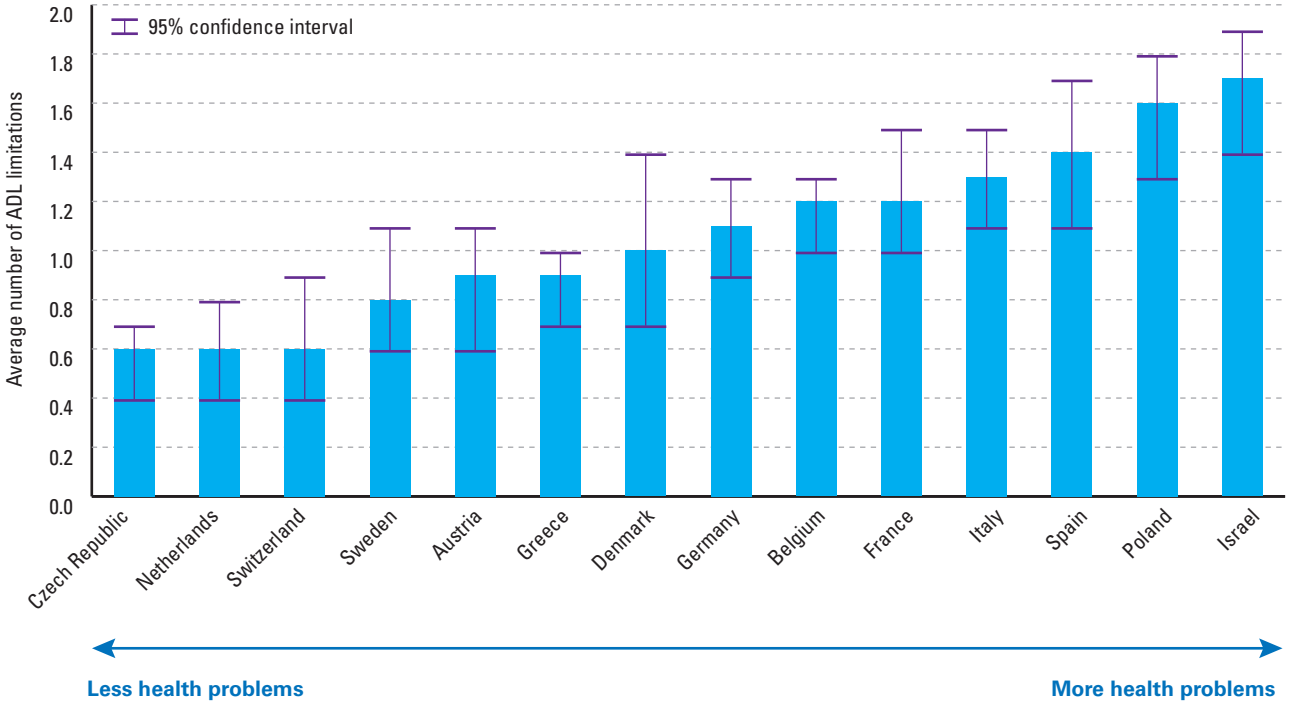
Health problems are defined as suffering from one or more limitations with activities of daily living (such as getting dressed, bathing, eating, getting in and out of bed, using the toilet).

HEALTH STATUS OF THE AVERAGE INFORMAL CARE RECIPIENTS CAN VARY

Average number of limitations with Activities of Daily Living (ADL) of informal care recipients

While in some countries informal care is (also) targeted to people with severe health problems, in others informal care remains 'light'. This indicator demonstrates these differences by measuring the average number of health problems of people receiving informal care.

Figure 5.9: Average number of ADL limitations of care recipients aged 65 and older (including people without health problems)



Source: Own calculations based on SHARE 2nd wave 2006/2007, except for Israel (SHARE 1st wave, 2006).
Note: The number of observations is small (n<100) for the Netherlands, Denmark, Switzerland, and the Czech Republic.

- In countries where the provision of formal LTC services is rather scarce (see Chapter 7), family members more often step in to support older people with higher needs of care – as reflected by the number of self-reported health problems in Figure 5.9. In Israel, Poland, and Spain people in need of care on average suffer from at least one limitation in activities of daily living (such as getting dressed, eating, or using the toilet). By contrast, in the Czech Republic, the Netherlands, Switzerland and Austria people aged 65 years and older who receive informal care seem to be healthier on average.
- Yet, no single measurement of health status is without its faults, and the number of people receiving informal care has not been taken into account in Figure 5.9. For example, the share of people relying on informal care is relatively large in the Czech Republic (cf. Figure 5.10) yet people report to be in better health as shown above. On the other hand, average intensity of informal care in this country is relatively high, especially for the very old (cf. Figure 5.4).
- In other countries, such as the Netherlands, the share of older people receiving care is comparatively small (cf. Figure 5.10), and older people's care needs seem to be lighter, too.
- Generally speaking, in countries where informal carers take on large amounts of caring duties (i.e. replacing formal care services) it is important to ensure not only that sufficient respite services are available, but also that the quality of care provided is adequate to the demands of people with severe needs in old age.

Definitions

Informal care is defined as in **Type II a** (see Figure 5.3) for a minimum of 1 hour per week. The time limit refers only to care received from someone outside the household.

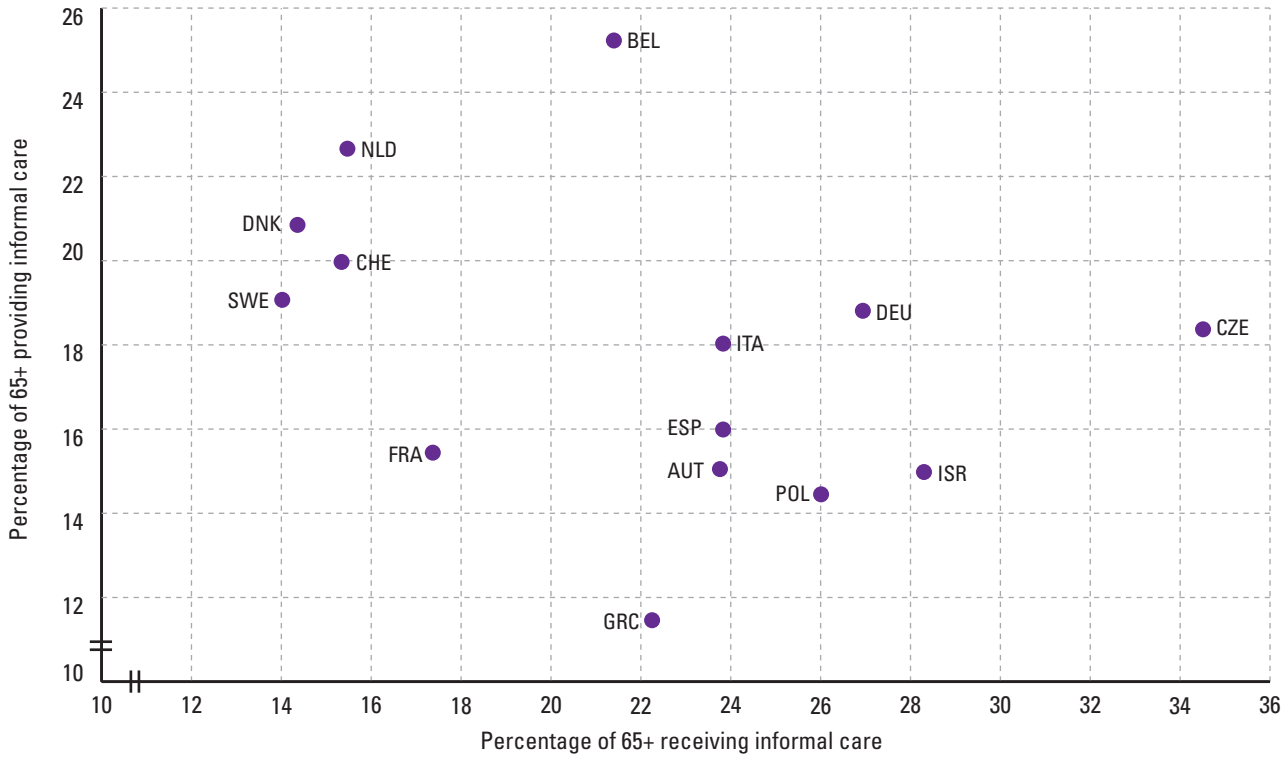
Health problems are defined as suffering from one or more limitation with ADL (for a definition see Fig. 5.6).

HELPING EACH OTHER: HEALTHY AND ACTIVE AGEING IN THE NORTH

Providing and receiving informal care among older people

This indicator shows the share of persons in the population 65 and older providing informal care in relation to the share of persons in this age group receiving informal care. This gives some insights into patterns of intra-generational solidarity in Northern, Continental, Southern and Eastern European countries.

Figure 5.10: Relationship between the share of informal carers and the share of informal care recipients among those aged 65 years and older



Source: Own calculations based on SHARE 2nd wave.

- As previously shown (cf. Chapter 2) the degree of social isolation of older people varies largely across countries. In line with these findings, patterns of intragenerational solidarity (i.e. older persons helping each other) also seem to be stronger in some countries than in others, although there is only a relatively weak association between the shares of informal carers and care recipients in the population aged 65 years and over across countries (Figure 5.10).
- However, it is interesting to take a closer look at two groups of countries: firstly, countries in which there is a relatively small group of older people *receiving* informal care, but a relatively large group of older people *providing* informal care, e.g. Denmark, Sweden, the Netherlands and Switzerland (left side). Secondly, there are countries in which there is a comparatively larger group of older people *receiving* informal care, yet only a small part of the older population *providing* informal care, e.g. Greece, Poland, Austria and Spain (right side).
- This might point to the fact that older people in the first group show higher levels of *intra*-generational solidarity, i.e. providing support to each other, while also maintaining a better health status in old age. Conversely, in Austria, Greece or Poland the degree of *inter*-generational solidarity may be higher and older people may receive informal care from younger age groups instead.
- Yet, as only the 65 and over age group is included, more data would be required to confirm these findings, and shed light on the actual patterns of intergenerational help in different countries. This would, at the same time, serve as a useful indicator about social cohesion and time transfers across generations.

Definitions

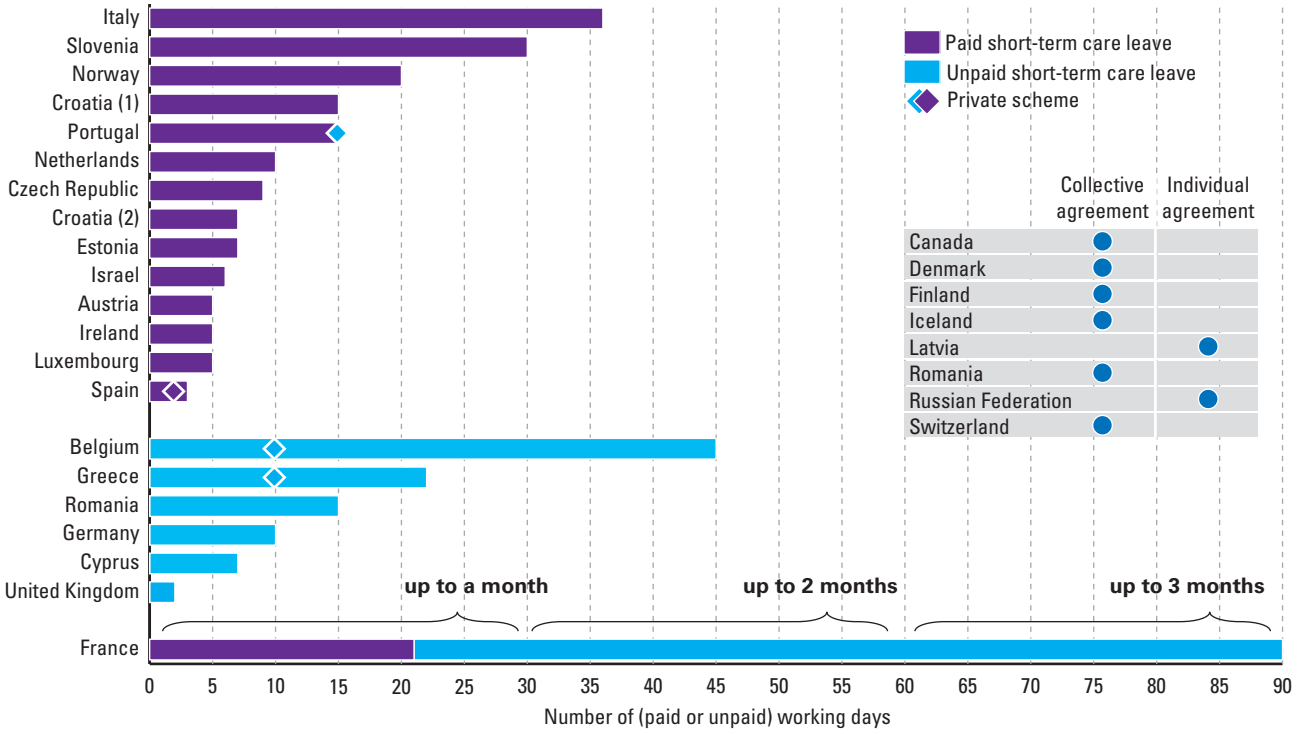
'Receiving informal care' (horizontal axis) is defined as in **Type II a** (see Figure 5.3) for a minimum of 1 hour per week, and 'providing informal care' (vertical axis) is defined as in **Type I a** (see Figure 5.1a) for a minimum of 1 hour per week. The time limit refers only to care received from/provided by someone outside the household.

CARE LEAVES – IMPORTANT TO RECONCILE PAID WORK AND BEING A CARER

Time off for dependants

This indicator provides an overview of the duration and design of short-term leaves from work to take care of older dependent relatives or friends. Care leaves help to reconcile care responsibilities and paid work.

Figure 5.11: Number of paid or unpaid working days per year that are granted as care leaves



Source: OECD, 2011; Moss, 2011; Leave Network; National legislation.

Notes: In Slovenia, Luxembourg, the Czech Republic, Spain, Norway and Estonia the number of working days is granted per case, not per year. Austria refers to one, Germany to two average working weeks per year. Croatia (1) applies if the carer is the co-resident spouse; Croatia (2) applies if the carer is another family member.

- There is a large variety of approaches to granting short-term care leaves as time off to care for (older) dependants in the UNECE region. In those countries where care leaves are usually granted for a specified period, these are provided as statutory rights. Others such as Canada, Denmark, Finland, Iceland, Romania and Switzerland grant short-term care leaves only under collective agreements. In Latvia and Russia individual agreements with employers are possible.
- In Greece, Spain, Portugal and Belgium, public sector employees enjoy more generous provisions than employees in the private sector to take care of dependent older people. In fact, in Greece entitlement for (unpaid) leave of absence is twice as long for civil servants, and in Belgium it is more than four times longer than for private employees. In Portugal, the length is the same (15 days) for both, but leaves are paid for public employees.
- Also, the rules to take care leaves are often combined with a number of eligibility criteria, e.g. the relationship with the person cared for: in Croatia, the length of a care leave differs for people who care for their co-resident spouse compared to other family members. In other countries, e.g. France (and Canada, cf. Figure 5.13), the leave can be taken by more than one carer. The United Kingdom refrains from defining a strict length and instead lays down that the emergency leave should be of 'reasonable' length (~two days).
- While it is interesting to see that the length varies from only two days (e.g. Spain) to three months (e.g. France), little data is available on actual take-up of care leaves by employees.

Definitions

The difference between short-term and long-term care leaves is made in cases where a country has two different provisions (e.g. Spain, Italy) for (i) emergency and (ii) longer leaves. In cases where only one type of entitlement exists (e.g. Poland, Sweden, Norway) these are considered to be 'longer leaves' if they exceed a period of 20 days, and 'shorter leaves' if they do not exceed a period of 20 days.

The numbers refer to statutory entitlements for short-term leaves for working carers to care for older dependent persons, in working days per year unless stated otherwise (see Annex).

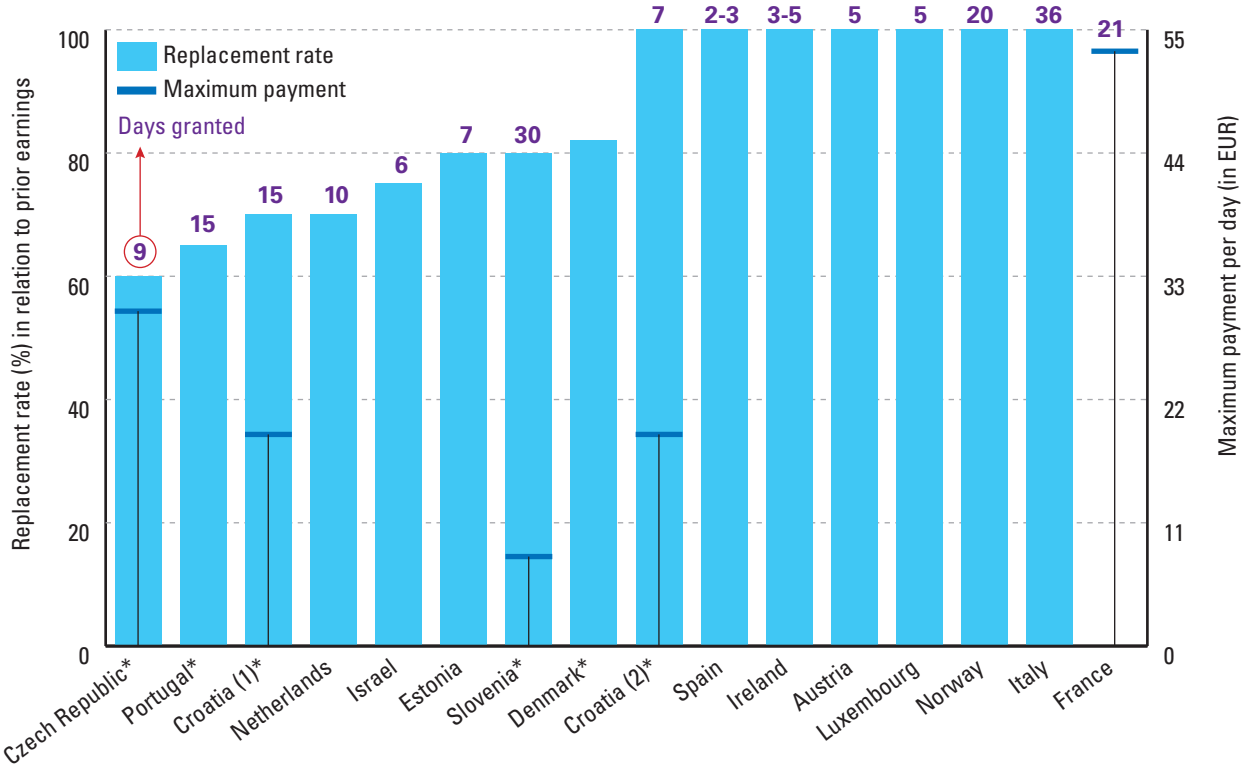
All countries displayed grant short-tem care leaves as statutory rights.

GENEROSITY DURING SHORT-TERM LEAVES DIFFERS WIDELY

Paying carers during time off to care for dependants

This indicator provides an overview of generosity of pay for working carers during short-term leaves to care for older persons.

Figure 5.12: Replacement rates (of previous gross average earnings) and maximum payments in Euro per day during short-term care leaves



Source: OECD, 2011; Moss, 2011; Leave Network; National legislation.
Notes: In France payment refers to payment per day during the first 21 days of leave. Croatia (1) refers to the replacement rate for the co-resident spouse, Croatia (2) refers to the replacement rate for other relatives. In Denmark, the replacement rate amounts to 82% of the sick pay ceiling. Exchange rates: In the Czech Republic a maximum of 777 CZK per day are paid (1 CZK=0,0039 EUR, 26 June 2012). In Croatia there is a ceiling of a maximum of 4257 HRK per month (1 HRK=0,133 EUR, 26 June 2012).

- Generosity levels of payment during emergency leaves (cf. Figure 5.11) are highly diverse across countries: full payment is provided only in Italy (for 36 days), Norway (for 20 days), Croatia for co-residing spouses (for 7 days), Austria (for 5 days), Luxembourg (for 5 days) and Spain (for 2 days). In other countries a lump sum is provided such as in France (for 21 days), or minimum levels of payment are specified, like in Slovenia.
- Also, the level of payment may change during the duration of the leave: in France, for example, a leave can be taken for up to three months, but only the first 21 days are paid leave. Similarly, in the Netherlands the first day of a leave is paid at 100% while the remaining 9 days are paid only at 70% of previous earnings.
- Generally, it is striking that no clear pattern of generosity can be identified across countries. For example, Eastern European countries like the Czech Republic, Croatia and Slovenia provide rather broad benefits for working carers, whereas for other countries (e.g. Austria, Germany or France) there is large diversity regarding the generosity of pay during short-term leaves for carers. Nordic countries like Denmark or Norway rank among the most generous systems regarding short-term leaves.

Definitions

Replacement rates are calculated as average replacement rates of gross earnings, unless otherwise stated.

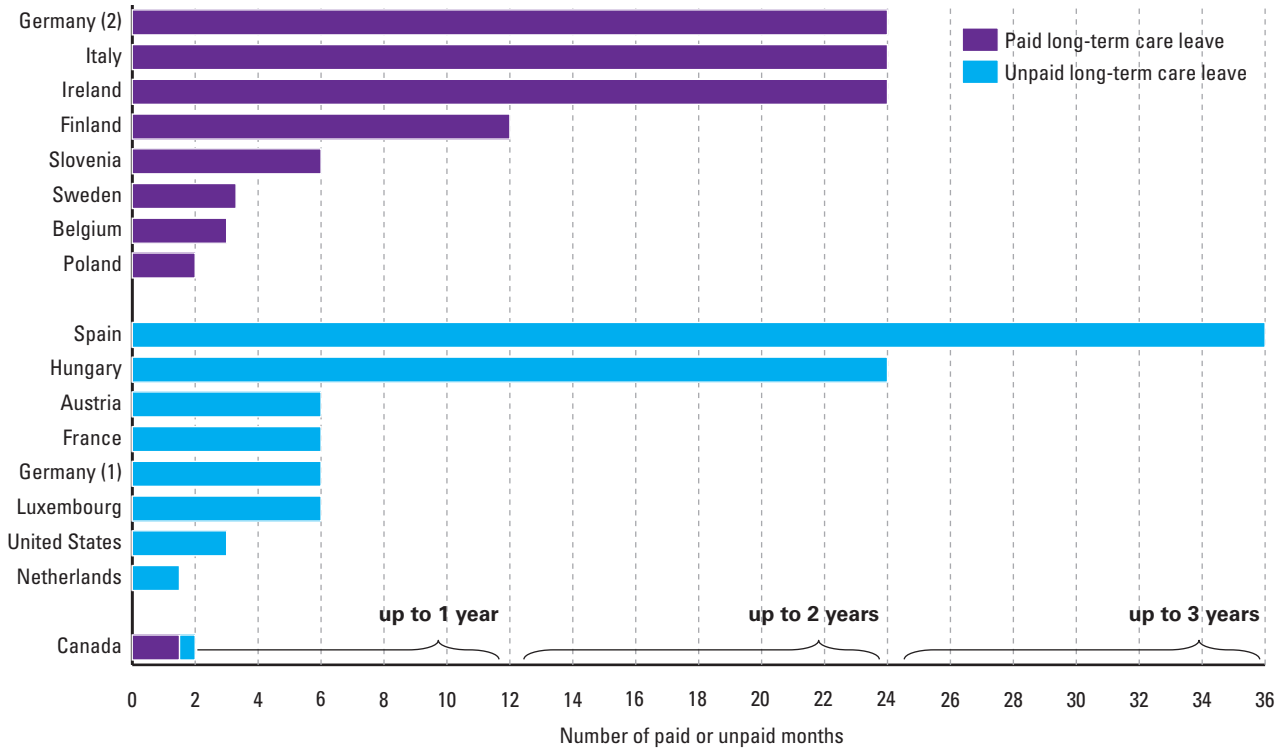
For further information on the individual countries cf. notes in the statistical annex.

LONG-TERM CARE LEAVES: KEEPING THE DOOR OPEN TO RETURN TO PAID EMPLOYMENT

Long-term leaves for working carers

This indicator provides an overview of care leave availability for longer periods for working carers. Supporting carers in reconciliation, e.g. by offering part-time care leaves, helps them to reduce the psychological burden associated with the difficulties in balancing paid work and informal care.

Figure 5.13: Maximum number of paid or unpaid months granted as longer care leaves to working carers



Source: OECD, 2011; Moss, 2011; Leave Network; National legislation.
Notes: Leaves may be granted once during working life or per case, depending on the country (see statistical annex). Germany (1) refers to provisions under collective agreements; Germany (2) refers to statutory provisions.

- As with short-term leaves, the generosity of care leaves over longer periods also differs markedly across countries (see Figure 5.14 below), as well as the duration and eligibility criteria to use such leaves. For example, in Poland longer leaves from work to care for older dependent relatives are granted for 60 days at full payment, whereas in Italy they can be granted for up to two years. In other countries like Ireland and Finland there are certain requirements regarding the minimum length of a leave, amounting to 13 weeks and 90 days, respectively.
- Some countries only provide leave entitlements under collective agreements: in Germany, for example, a recently introduced regulation foresees a 'shifted payment'. Under this arrangement, during the care leave the person receives 75% of his/her previous earnings. When returning to full-time work, however, employees continue to receive only 75% of their salary until they have recovered the payment received during leave.
- Certain countries also encourage working carers to reduce their working time rather than fully leave paid employment for informal care: the Netherlands, France and Luxembourg are such examples.
- Care leaves are often part of a broader set of public measures that help informal carers to remain integrated in the labour force, and reduce the social and health risks of informal care. Such a set of measures may also include e.g. day care centres, respite care or formal home care services.

Definitions

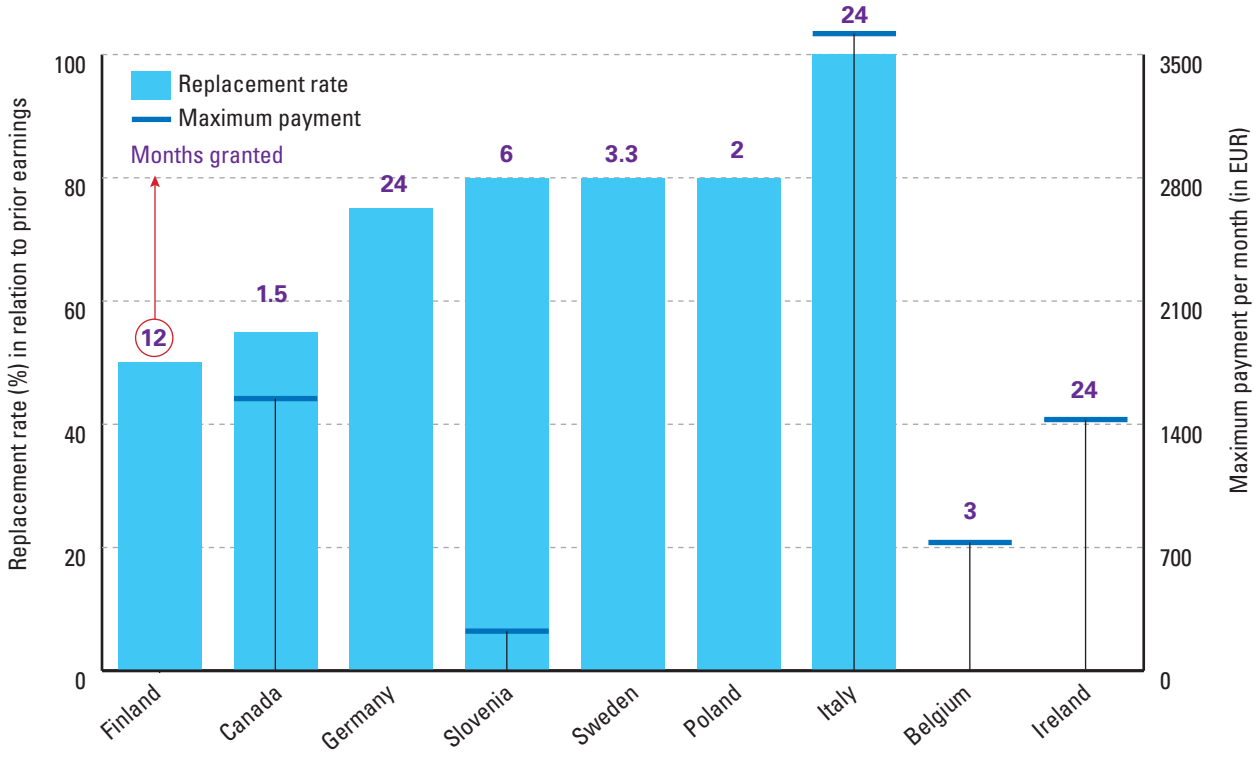
For further information on the individual countries cf. notes in the statistical annex.

KEEPING CARERS ATTACHED TO WORK – PAYMENTS DURING CARE LEAVES

Paying carers during long-term leaves from work

This indicator represents an overview of replacement rates and payment levels during longer leaves from work to provide informal care to dependent older people.

Figure 5.14: Replacement rates (of previous gross average earnings) and maximum payments in Euro per month during longer care leaves



Source: OECD, 2011; Moss, 2011; Leave Network; National legislation.
Notes: In Germany payment is granted only under collective agreements, and has to be recovered by the employee when returning to work. In Finland payment refers to 70% of unemployment allowance. In Belgium a lump sum is granted. In Canada there is a two-weeks waiting period before a payment is made. In Canada, care leave benefits are considered a part of taxable income.
Exchange rates: In Canada, the maximum benefit amounts to 468 CAD per week (1 CAD=0,777 EUR, 26 June 2012).

- As in the case of short-term leaves (cf. Figure 5.11 and Figure 5.12) generosity of payment during leaves from work for longer periods is also diverse across countries: the most generous regulations are found in Italy, where carers receive a full earnings replacement (up to a ceiling of 43,580 EUR per year) for a period of up to 24 months in case a family member is in serious need of support.
- Other countries like Belgium provide rather generous ways to leave work when caring for a family member: provisions exist under the so-called palliative care leave (up to 12 months), or the medical assistance leave (1 to 3 months), both of which are paid with a lump sum of 741,40 Euro per month. The benefit is reduced proportionally if a part-time solution is chosen by the employee.
- In a number of countries benefit entitlements during care leaves are tied to other benefits: in Finland, for example, 70% of unemployment allowance is paid during care leaves, and in Israel (cf. Figure 5.12) payments during short-term care leaves are provided as part of the sickness benefit entitlements of employees.
- Overall, it is important – both from an economic point of view as well as for the carer's well-being – to keep working carers attached to the labour market even if they have caring responsibilities over a longer period: payments to cover e.g. forgone income from a reduction of working time (like in Germany or the Netherlands) may thus be helpful tools to allow workers to reconcile work and care in the best possible way.

Definitions

Replacement rates refer to replacement from previous earnings. Payments refer to maximum payments per month, unless otherwise specified (see notes).

Chapter 6:

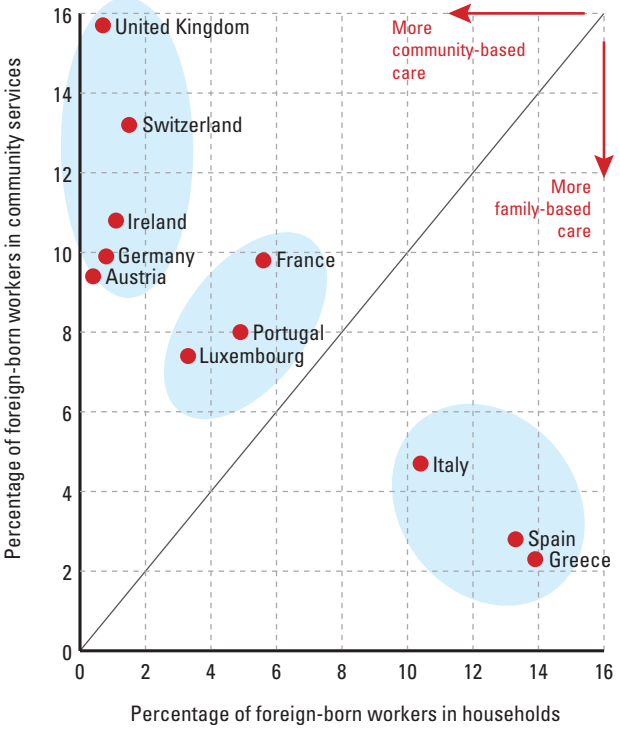
MIGRANT CARE WORK

WHEN MIGRATION "MEETS" AGEING: THE ROLE OF MIGRANT WORK IN LONG-TERM CARE

Prevalence of migrant work in community and household services

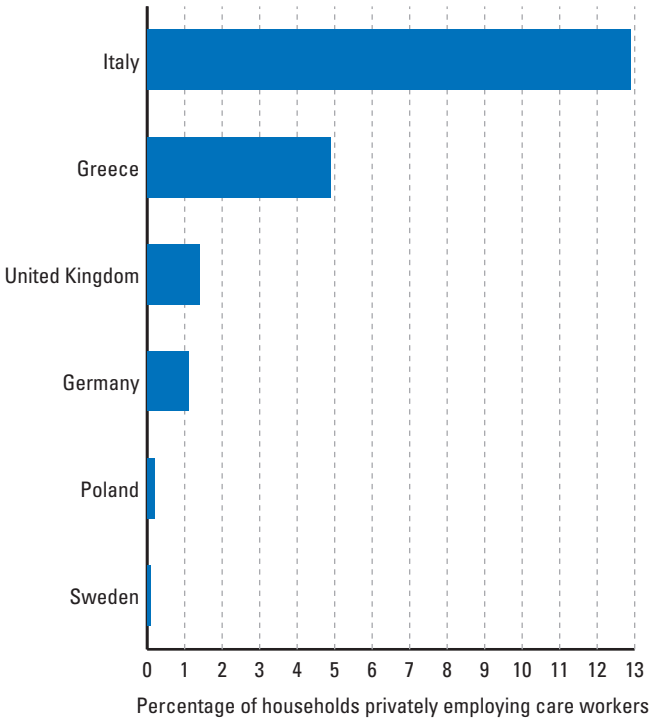
This measure indicates how much a welfare state relies on internal and external human resources to provide long-term care, and whether this process takes place at community or family level

Figure 6.1a: Share of foreign-born workers in community services vs. those privately employed by households in selected European countries (average 2005-06)



Source: own calculations based on Eurostat data (as reported by OECD, 2011)

Figure 6.1b: Prevalence of privately paid carers in households caring for older people (%, 2005)



Source: Eurofamcare data (Lamura et al. 2010).

- In many European countries – as well as in other developed areas of the world – migrant work has become an important component for the everyday provision of long-term care (despite the difficulties experienced by official statistics in capturing its real scope, see Definition box).
- Based on data collected from one of the few sources providing comparable data (Eurostat's Labour Force Survey), Fig. 6.1a above shows that the direct (legal) employment of care migrants by private households prevails in most Mediterranean countries (except for Portugal), while their presence as staff of "formal" service providers is stronger in liberal (Ireland and United Kingdom) and continental care regimes (Austria, Germany and Switzerland), with France and Luxembourg in an intermediate position.
- This situation is indirectly confirmed by the EUROFAMCARE data (Fig. 6.1b), which shows that the private employment of care workers by households to provide care to dependent older people is quite frequent in Mediterranean countries and almost absent in Eastern Europe or Scandinavia.

Definitions

Share of foreign-born workers in community services (Eurostat data): percentage of foreign-born workers who are employed by health and social care service providers, calculated on the total of all foreign-born workers.

Share of foreign-born workers employed by households (Eurostat data): percentage of foreign-born workers who are employed in private households, calculated on the total of all foreign-born workers.

Share of households privately employing care workers (Eurofamcare data): percentage of households that privately employ a home carer, calculated on all households providing care to a dependent older person.

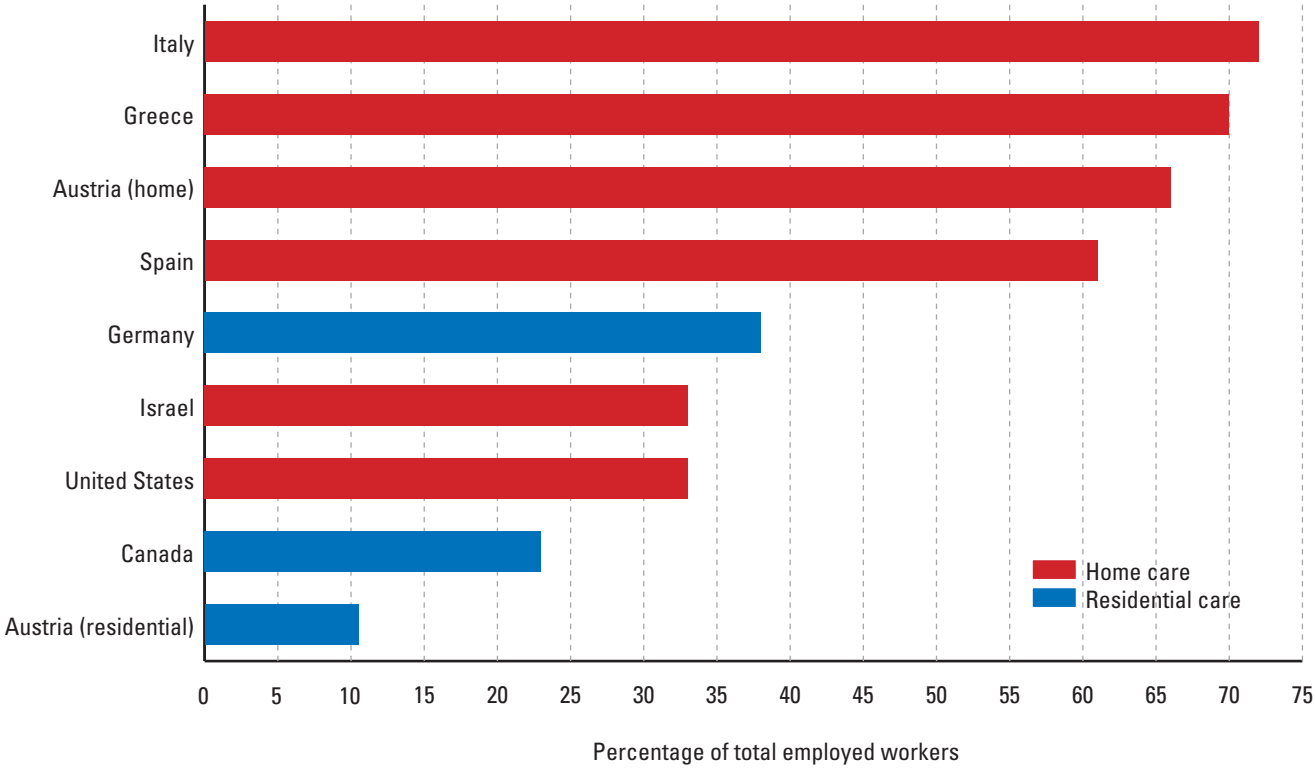
N.B.: Data provided here are survey-based. Therefore, they might underestimate the real scope and 'complexity' of this phenomenon, since in most countries the level of undeclared work among migrants employed in the care sector is relatively high, especially at the household level.

MOST MIGRANT CARE WORKERS ARE ATTRACTED BY THE HOME CARE SECTOR

Share of migrant work in residential and home care

This estimation indicates the prevalence of foreign-born workers in the two main areas of long-term care intervention: home and residential care.

Figure 6.2: Share of foreign-born workers employed in home and residential care in selected countries (% of all employed workers in each sector)



Source: Akinyosoye 2008; OECD, 2011; Iecovich 2011; Lamura et al. 2010; Lenhart & Oesterle 2007; Martinez Bujan 2010

- When we compare the situation in the home care sector with that in residential care settings, data show that the prevalence of migrant work seems to be generally higher in home care.
- This is probably partly due to the fact that figures concerning home care usually include the estimated number of migrants who are privately employed by households, a phenomenon often stimulated by the care allowances families receive from the national or local cash-for-care schemes.
- In turn, this also explains why the highest share of foreign-born workers in home care is reported for countries belonging to the Southern European rim (as well as Austria), which are characterised by what has been called the 'migrant-in-the-family' care pattern (van Hooren 2012). This situation has also been referred to as a phenomenon in which migrants tend to gradually substitute the family in its traditional role of main (informal) caregiver of its (mainly older) dependent members.
- The lower prevalence of migrant work in residential care is also partly explained by the stricter regulation and stronger professionalization that characterises this sector compared with home care services.

Definitions

Foreign-born workers in home care: measures the percentage of foreign-born workers who are employed by formal home care providers or by private households, calculated on the total of all workers employed in this sector.

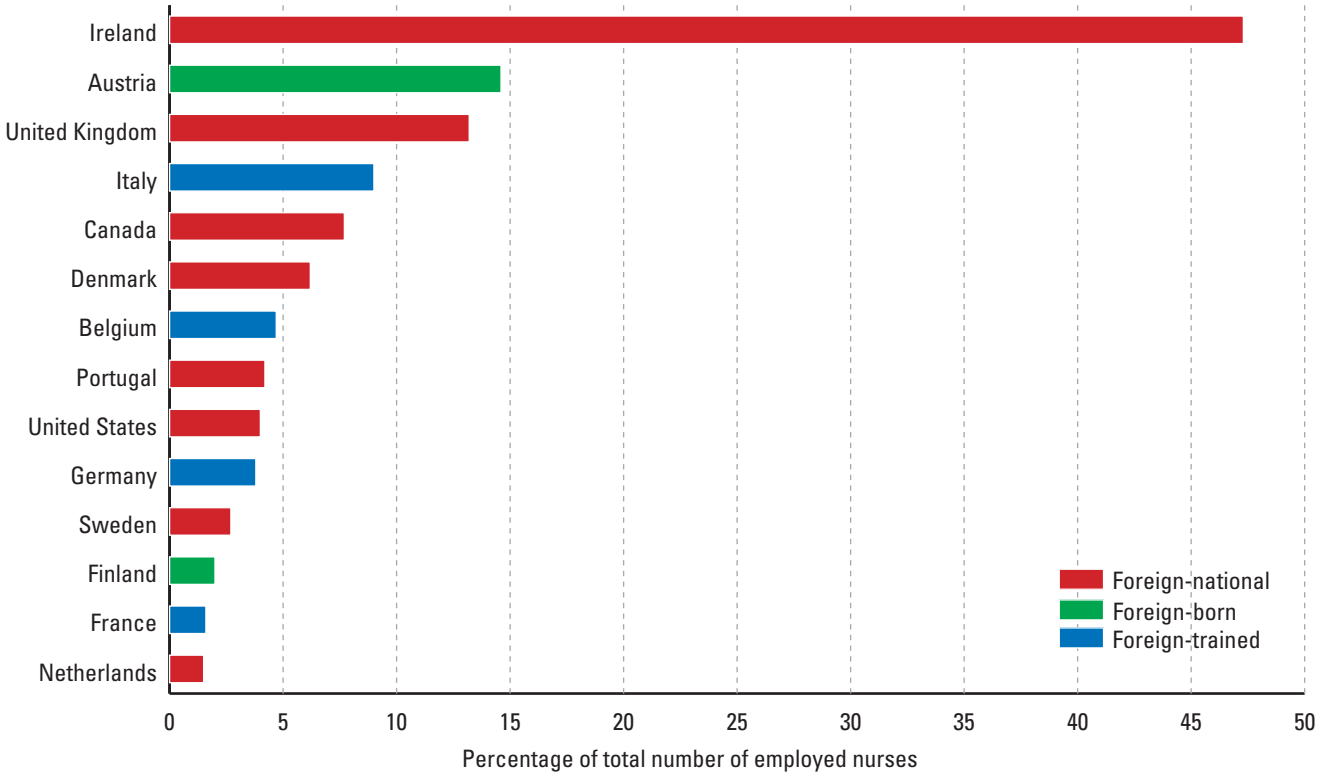
Foreign-born workers in residential care: percentage of foreign-born workers who are employed in residential care facilities, calculated on the total of all workers employed in this sector.

MIGRATION IN THE NURSING CARE SECTOR

Share of nurses with a migration background

This set of indicators reports the prevalence of nurses working in the long-term care sector who have a foreign-based training or a migration background.

Figure 6.3: Share of foreign-trained, foreign-national and foreign-born nurses employed in the long-term care sector in selected countries (% of all employed nurses)



Source: OECD, 2011:174 ; Rostgaard, Chiatti & Lamura 2011; Wismar et al., 2011:28.

- Another area in which the role of migration is currently growing is that of nursing care. As Figure 6.3 clearly shows, in most European and North-American countries – across the different types of care regimes – the share of nurses who are foreign-trained, foreign-national (i.e. with a foreign nationality) or foreign-born (independently from their nationality) often exceeds or is close to 5% of all nurses employed in the long-term care sector (the Irish outlier being explained by the fact that many Irish nurses are trained in the UK).
- Being a much more formalised sector than other sub-areas of long-term care provision (such as for instance domestic or home care), data reliability is much higher, as is also the level of control on flows by nursing care authorities and trade unions. This situation represents a factor which tends to keep the number of non-national professionals employed in this field at a low level. This is true especially in countries characterised by a strong professionalization of the nursing sector, such as for instance the Scandinavian ones, France and the Netherlands, where efforts have been made to ensure care quality through targeted efforts to tackle care staff shortages and training.

Definitions

Foreign-trained nurses: nurses who have acquired their professional skills in a foreign country.

Foreign-national nurses: nurses who have a foreign nationality.

Foreign-born nurses: nurses who were born abroad (irrespective of their current nationality).

All three indicators above are calculated as a percentage of the total number of employed nurses.

THE SAME OLD STORY: FEMALE, MIDDLE-AGED AND LOW-PAID

Characteristics of migrant care workers

This table provides an insight on the main features characterising migrant care workers in most relevant destination countries. These data contribute to gaining a better understanding of the major dynamics underlying this underinvestigated and still critical phenomenon of current LTC provision.

Table 6.1: Profile of migrant care workers in selected countries

Country	Gender	Age	Main countries of origin	Level of education	Working conditions (contract type, pay etc.)
Austria	Mainly female	Mainly middle-aged	Czech Republic, Hungary & Slovakia	Usually higher than the required one	Both regular and undeclared
Canada	Mainly female	Mainly middle-aged	Philippines & Asia	Usually higher than the required one	Mostly regular
Denmark	Mainly female	Mainly middle-aged	Second-generation migrants from Turkey	Usually higher than the required one	Mostly regular
France	Mainly female	Mainly middle-aged	North-Africa	Usually higher than the required one	Usually regular
Germany	Mainly female	Mainly middle-aged	Poland, Czech Republic, Slovenia	Usually higher than the required one	Sometimes undeclared
Greece	Mainly female	Mainly middle-aged	Bulgaria, Poland and Albania	Usually higher than the required one	Often undeclared
Italy	90%	Also older age	Ukraine, Romania, Poland, Philippines	Often highly-skilled	Often undeclared and underpaid
Ireland	Mainly female	Mainly middle-aged	Philippines and Poland	Usually higher than the required one	More often employed in private, low-paid sector
Israel	Mainly female	Mainly middle-aged	Philippines	Usually higher than the required one	Usually regular
Spain	Mainly female	Mainly middle-aged	South America and Morocco	Usually higher than the required one	Often undeclared
United Kingdom	Mainly female	Also younger age	Asia & Central Europe	Usually higher than the required one	One third earns below the minimum wage
United States	90%	Mainly middle-aged	Central America	Usually higher than the required one	Often undeclared

Source: OECD, 2011: 175; Di Santo & Ceruzzi 2010: 10-11; Fujiama & Colombo 2010: 31-32; Lutz & Palenga-Moellenbeck 2010: 420-421; Simonazzi, 2009.

- Data confirms that long-term care remains in most countries a low-pay, middle-aged-women based task, even (more) when migration comes into the picture.
- In all countries a 'feminization' of care is the rule and, as the table above clearly shows, women represent the overwhelming majority of migrant care workers too.
- In most cases these belong to the middle-aged group, although in the UK younger carers are also present while in Italy also a significant group of older ones exists.
- A further, cross-nationally common feature is that the countries of origin of many care migrants are geographically close or historically bound to the destination country (see also Fig. 6.4).
- An addition, this general trend is that migrant care workers often possess a qualification which is higher than the one that is normally required for the care work they perform. This circumstance is often combined with an undeclared position on the labour market, especially in less regulated and less professionalised welfare states (such as for instance the Mediterranean), and much less in more formalised care regimes (such as for example those belonging to the Nordic Scandinavian model).
- These characteristics should be carefully considered when planning future care staff strategies, especially in the light of current financial constraints and the ageing of the care workforce.

Definitions

Regular: possessing both a residence and working permit and a legal work contract.

Undeclared: either without a residence permit, a working permit or a legal work contract.

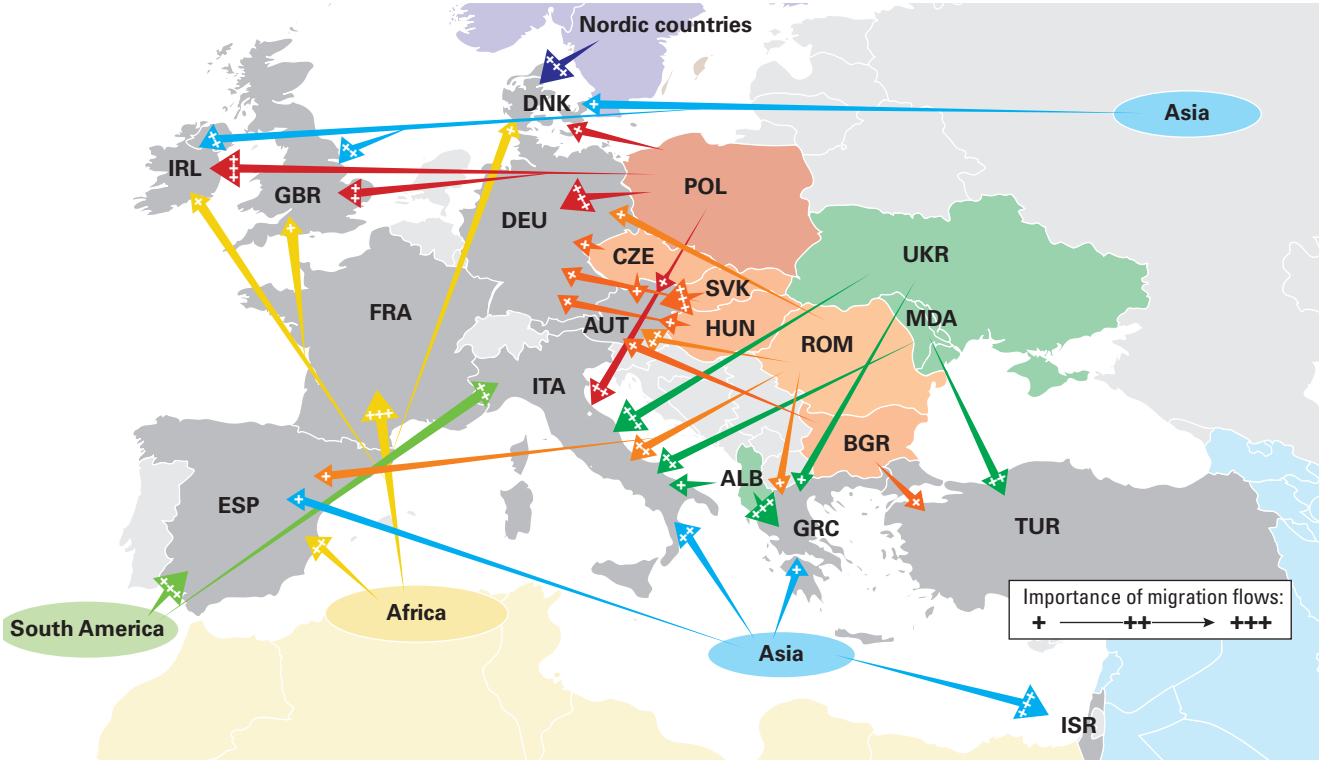
INTERNATIONAL FLOWS OF MIGRANT CARE WORKERS IN EUROPE

The role of geographical proximity and historical/cultural bonds

Countries of origin and destination of migrant care workers

This graph offers an overview of the main flows of care migration in Europe.

Figure 6.4: Main countries of origin and destination of migrant care workers in Europe



Source:

- Figure 6.4 above visualises the main flows of care migration taking place on the European continent. As anticipated in Table 6.1, most of these migratory movements are the result of a condition of geographical proximity between countries of destination and of origin and/or historical and cultural bonds between them. This is clearly the case for the Czech, Slovakian or Hungarian care migrants in Austria (often on a rotating, fortnightly rhythm), the North Africans in France, the Polish and Czech nurses in Germany, the South Americans in Spain as well as – to recall a well-known example outside Europe – the Mexicans in the US.
- Another issue that is worth mentioning concerns the 'cascade' (or chain) effect which takes place in terms of migrant carers, as these sometimes fill in the care gaps created in the countries of origin of those migrants who left for other destinations. This phenomenon – that is also often referred to as 'care drain' (Lutz & Palenga-Möllenbeck 2012) concerns for instance Romanians (of Hungarian origin) who migrate to Hungary to care for older people there, whose children migrate themselves to care for older Austrians. A similar pattern applies also to Ukrainians providing care in Poland while Polish carers move to Italy and Germany.
- The main components of this care drain effect are: a poorer informal care available to both migrants' left-behind children and older parents (in countries where formal LTC services are usually less developed); mental diseases often affecting return migrants after years of an unhealthy life abroad (Tosltokorova, 2007); and loss of training investments (Anonymous 2008).

Definitions

Care drain: impact on care migrants' countries of origin in terms of reduced informal support to younger and older generations, higher costs on care systems and lower returns on educational investments.

THE ROLE OF MIGRANT CARE WORK DEPENDS ON THE COMBINED EFFECT OF DIFFERENT POLICY AREAS

The interaction of care, migration and labour market regimes

This table provides an overview of how selected European countries feature with regard to these three main fields of policy intervention, and their impact on care migration.

Table 6.2: Role of care, migration and labour market regimes for migrant LTC work in selected European countries

		LTC regime				Migration regime		LTC labour market regime		Role of migrant LTC work	
		Family-based	Private cash-for-care	Private services	Public services	Rather unmanaged	Rather managed	Low-skilled	Professio-nalised	Regular (by LTC providers)	Irregular (by house-holds)
Transition	Poland	●	○	○	●	●	○	●	○		+
Mediterranean	Portugal	●	○	○	●	●	○	●	○		+
	Greece	●	○	○	○	●	○	●	○	+	++
	Spain	●	●	○	●	●	○	●	○		+++
	Italy	●	●	○	●	●	○	●	○		+++
Continental Bismarckian	Austria	●	●	○	●	●	●	●	●	++	+++
	Germany	●	○	●	●	○	●	○	●	++	+
Liberal - Beveridge	Ireland	●	●	○	●	○	●	●	●	+	++
	United Kingdom	○	●	●	●	○	●	●	●	++	+
Mixed	France	○	○	●	●	○	●	●	●	++	
	Netherlands	○	●	●	●	○	●	○	●	+	
Nordic	Denmark	○	○	●	●	○	●	○	●	+	

Source: Da Roit & Le Bihan (2010 and 2011); Fujisawa & Colombo (2009); Larsen & Rand (2011); Lamura et al. 2010 ; Lutz 2008; Rostgaard, Chiatti & Lamura 2010; Simonazzi 2008 and 2009.
Notes: +: means 'weak role of migrant LTC work'; + +: means this role is 'strong'; + + +: means this role is 'very strong'.

- The impact of the labour market regime on care migration is shown in Table 6.2, in combination with two other relevant policy areas: that of long-term care and that of migration itself.
- One of the emerging trends concerns countries characterised by a stronger role of public and professionalised long-term care services and a managed (i.e. regulated) migration approach (typical of the Liberal and Nordic – as well as, but to a lesser extent, Continental – care regimes). These countries share the common feature of a stronger prevalence of migrant work in the form of regular employment within community care services.
- On the opposite side, countries belonging to the transition and Mediterranean models – featuring a weaker role of public and professionalised LTC services, as well as an unmanaged (i.e. less regulated) migration regime – report, as already mentioned, a more frequent direct employment of migrant workers by private households.
- In some countries, the predominance of one or the other type of regime (especially in terms of LTC and labour market features) is not univocal, as different interventions might not always have an impact in the same direction (thus showing contradictory effects).
- Country-specific conditions might differ also between the (usually more professionalised) residential care sector and the home care segment (which often employs a less skilled and more difficult to manage LTC staff).

Definitions

Managed migration: LTC migration is usually high-skilled, regulated and controlled, migrants being mainly employed by LTC providers.

Unmanaged migration: LTC migration is usually low-skilled, regulated but not well controlled, migrants being mainly employed by private households.

Chapter 7:

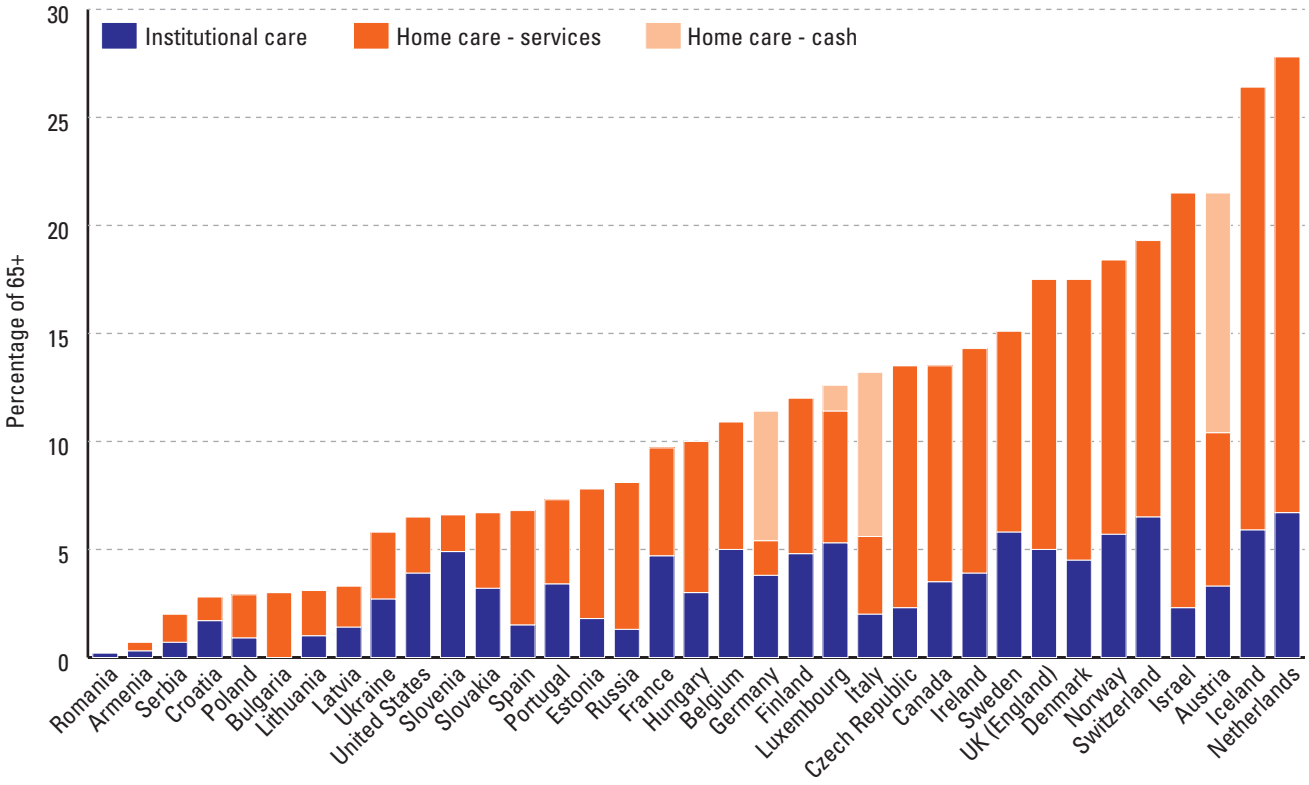
LONG-TERM CARE SERVICES

IN WHICH SETTING IS LONG-TERM CARE PROVIDED?

Provision of formal care to older people in different settings

This indicator shows the percentage of people aged 65 and older that receive care benefits (cash or in-kind) in different settings: in their own homes or in institutions. It depicts the different mixes of care and is one measure of relative system generosity.

Figure 7.1: People aged 65 and older receiving care benefits (cash or in-kind) in different care settings – 2009 or most recent year



Source: OECD Health Data and national sources (see Annex).
Notes: Belgium and Austria for 60+. France for 60+ for home care. Some of the national sources refer to age groups which may not coincide with the 65+ cut-off (see Annex). 'Home care – services' include those taking a combination of cash and in-kind services. Estimates for Italy 'home-cash' are a conservative approximation so as to avoid double-counting. Disaggregated data for Luxembourg and Germany are extrapolated from total beneficiaries.

- There are substantial differences in access to care services among countries of the UNECE region. While 5 out of 20 older people in Israel, Austria, Iceland and the Netherlands have access to formal care services or cash benefits, this percentage proportion is less than 1 in 20 in a number of Eastern and South-east European countries.
- It is important to distinguish between access to care services and cash benefits, which can also be used to pay or compensate for informal care. For example, a significant share of older people opt for cash benefits in Austria and Germany and use them to compensate their informal carers.
- In countries such as the Netherlands, Iceland, Norway and Denmark, older people receiving care in their own homes receive mostly in-kind services and not cash.
- The use of de-regulated cash benefits[1] has been linked to the hindering development of formal care services, either by incentivising informal care within the family or care provided by migrant care workers employed in the grey labour market (Simonazzi, 2009)

(1) This is meant to characterise cash for care benefits such as the Austrian, German and Italian examples, where no proof of expense or employment contract is required when the cash benefit is used to pay informal carers.

Definitions

'Institutional care' refers to care services and accommodation provided to users residing in nursing homes, retirement homes and service housing.

'Home care – services' is defined as benefits provided to dependent older people by care providers or bought by users with cash benefits.

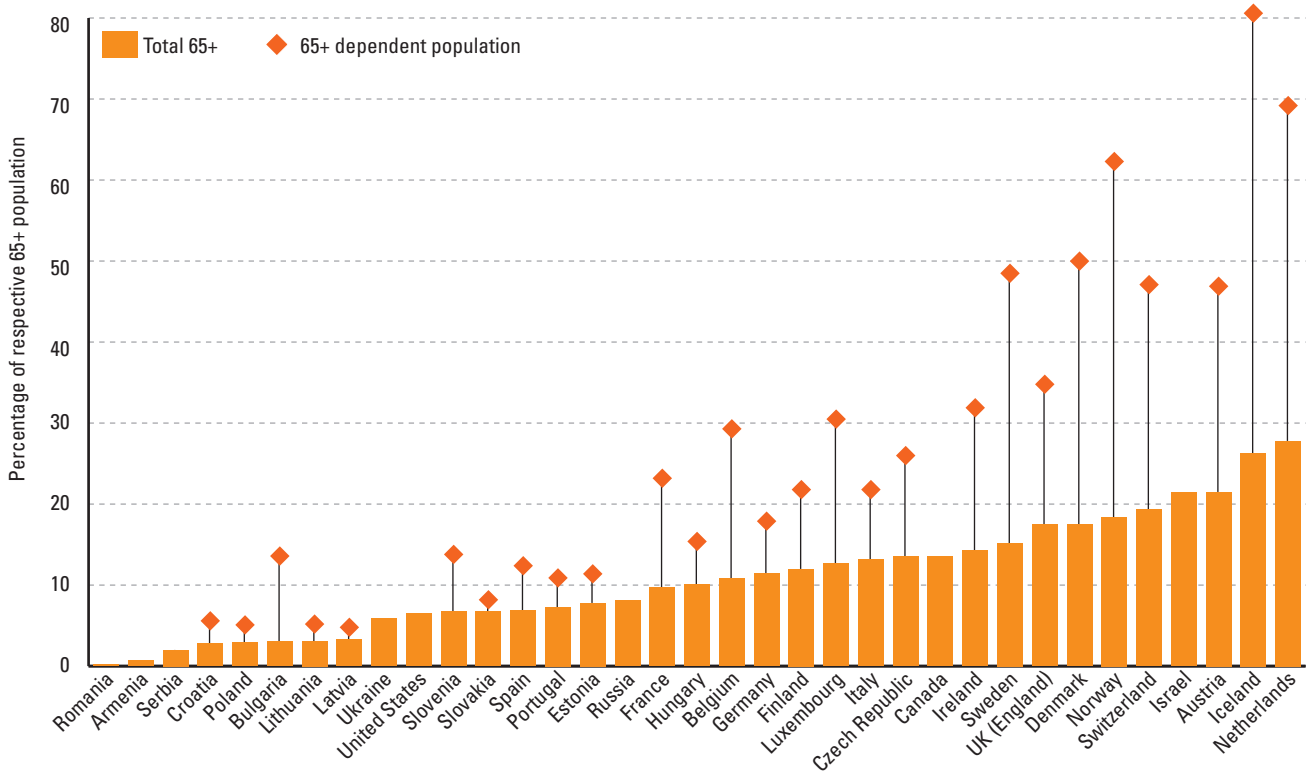
'Home care – cash' is defined as cash benefits provided to dependent older people that may be used to pay for informal carers or to hire personal assistants.

STARKER DIFFERENCES BETWEEN COUNTRIES IN DEPENDENT OLDER PEOPLE RECEIVING CARE

Provision of formal care to dependent older people

This indicator measures the share of people aged 65 and older that report limitations with Activities of Daily Living (ADLs) and receive care benefits (cash or in-kind) at home or in institutions. It provides a narrower definition of generosity than the provision of care to the total population aged 65 or older.

Figure 7.2: Dependent people aged 65 and older receiving care benefits (cash or in-kind) – 2009 or most recent year



Source: Own calculations based on EU-SILC, OECD Health Database and national sources.
Notes: See figure 7.1.

- The broad picture of ranking of countries remains, but individual countries' ranking often changes significantly when both ratios are compared (beneficiaries of care per dependent older people instead of all people aged 65 and older).
- For a set of countries the number of beneficiaries receiving care benefits surpasses those that have reported severe activity limitations (e.g. Austria, Denmark, Iceland, Ireland, the Netherlands, Norway, Sweden and Switzerland). This is a further indicator of the generosity of these systems.
- In countries such as Iceland, the Netherlands, Norway and Denmark 50% or more of dependent people receive publicly-funded care.
- At the other extreme are a number of Eastern European countries (e.g. Croatia, Poland, Latvia, Slovakia) where less than 10% of dependent older people receive care.
- While the definition of dependent people may vary across countries (i.e. it is based on self-assessed activity limitations) and includes people with more minor limitations, this indicator nevertheless points towards the potential level of unmet long-term care needs in many countries.

Definitions

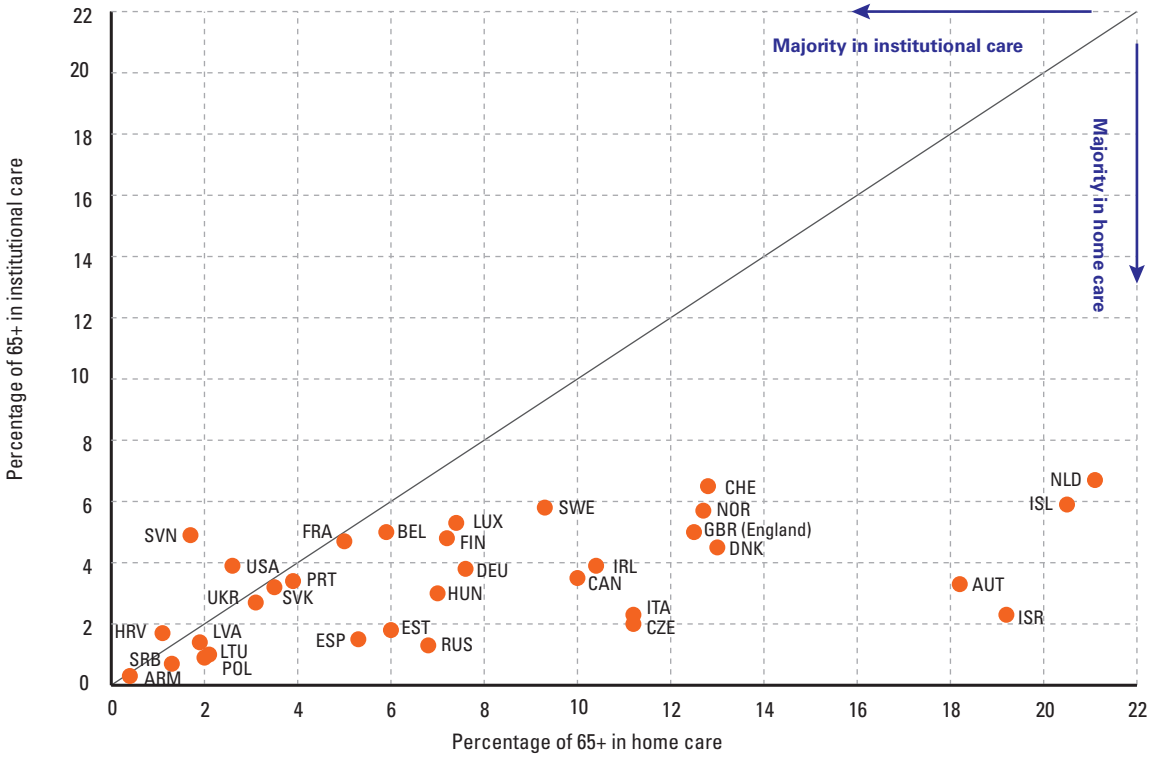
Dependent population in an age group is defined as one with self-reported severe or moderate limitations in Activities of Daily Living (ADL) for at least 6 consecutive months (limitations with ADL are not always the eligibility criterion to access care benefits, though).

(ADL) include: bathing, toileting, dressing, transferring, eating and having control over one's own bowels and bladder or managing incontinence independently.

Distribution of users of formal care by different care settings

This indicator measures the distribution of users of formal care by different care settings and thus provides a picture of 'ageing in place' policies (i.e. policies that allow dependent people to receive care in their homes for as long as possible).

Figure 7.3: People aged 65 and older receiving care benefits (cash or in-kind) in different care settings – 2009 or most recent year



Source: OECD Health Data and national sources (see Statistical Annex).
Notes: Belgium and Austria for 60+. France for 60+ for home care. Some of the national sources refer to age groups which may not coincide with the 65+ cut-off (see Statistical Annex). Italy (a) refers to *Indennità di accompagnamento*. United Kingdom refers to England only.

- Home care has become the predominant care setting in European countries and these care services seem to be the key to allow access to care for a wider share of the older population and are associated with more developed long-term care services.
- Care provided in institutions remains the predominant form of care in just a few countries (above all the United States) and nowhere does it account for more than 8% of those aged 65 and older.
- In countries such as France, the United Kingdom (England) or Slovakia, there is an equivalent number of beneficiaries receiving care in their own homes and in institutions.
- On the contrary, in the Netherlands and Iceland, for each old-age person receiving care in an institution there are at least three being cared for in their own home.
- The preponderance of home care in most European countries could be considered as a signal or at least as a facilitator of healthy ageing, as older people that remain in their homes are also more likely to continue to be engaged and participate in their communities.

Definitions
See Figure 7.1.

FORMAL AND INFORMAL CARE: SUPPLEMENT OR SUBSTITUTION?

Correlation between informal care received and the availability of care services

These indicators measure the correlation between formal and informal care, providing an indication of the relation between the use and intensity of informal care provided and the availability of care services.

Figure 7.4a: Association between informal care received and availability of care services

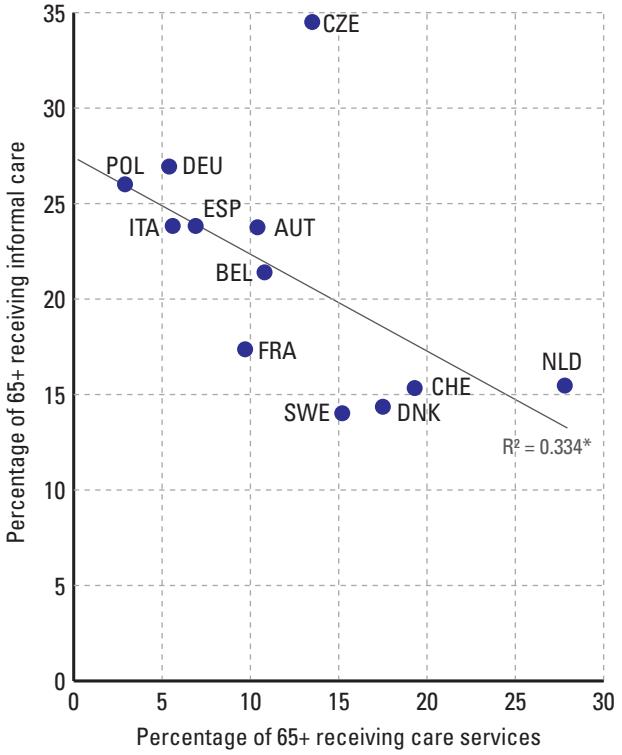
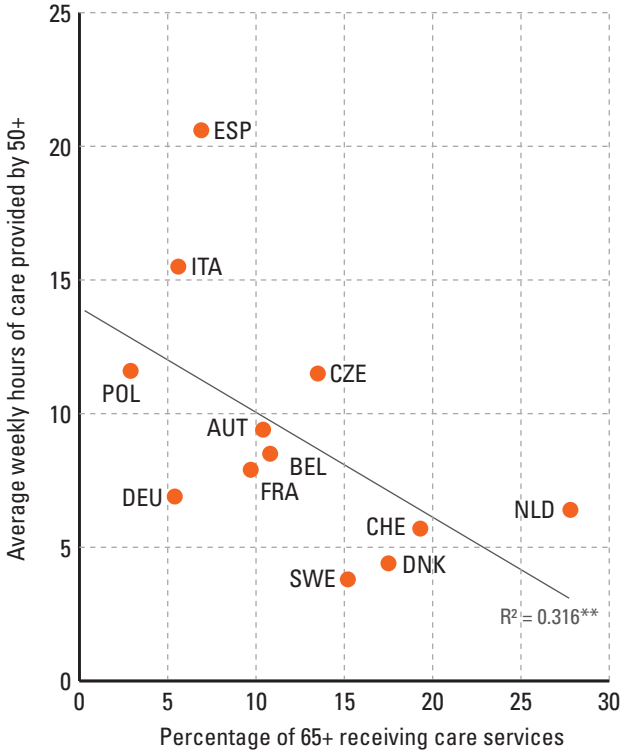


Figure 7.4b: Association between intensity of informal care provided and availability of care services



Source: Own calculations based on SHARE (2nd wave), Österle & Bauer, 2012.
Notes: Belgium and Austria for 60+. France for 60+ for home care. Some of the national sources refer to age groups which may not coincide with the 65+ cut-off (see Statistical Annex). 'Home care services' include those taking a combination of cash and in-kind services but not those receiving cash benefits alone. Disaggregated data for Luxembourg and Germany extrapolated from total beneficiaries. (*) $p < 0.05$; (**) $p < 0.1$.

- Although based on a limited sample of countries there is a correlation between the availability of care services[1] and the share of those aged 65 and older receiving informal care.
- When availability of services is limited, provision of informal care seems to take the form of a full-time occupation (see also chapter 5).
- Informal care may be the default option when services are not available (Spain, Poland and Italy) or be actively supported by public policies (Austria and Germany). In the case of the Netherlands, Switzerland, Sweden and Denmark, older people on average rely much less on informal carers.
- These correlations reflect the disparate public-private mix in terms of provision of care by the state and the family in different long-term care systems (cf. Saraceno, 2010).

(1) For countries where publicly funded care benefits may take the form of cash and are used to pay informal carers (e.g Austria, Germany), or where cash benefits represent an important share of care benefits (e.g. Italy), figures refer as much as possible to users of formal care services only.

Definitions

Informal care received refers to the weighted share of 65+ receiving informal care from someone inside or outside the household (minimum 1 hour).

Intensity of informal care refers to the weighted average weekly hours of informal care provided to someone inside or outside the household (conditional on providing care).

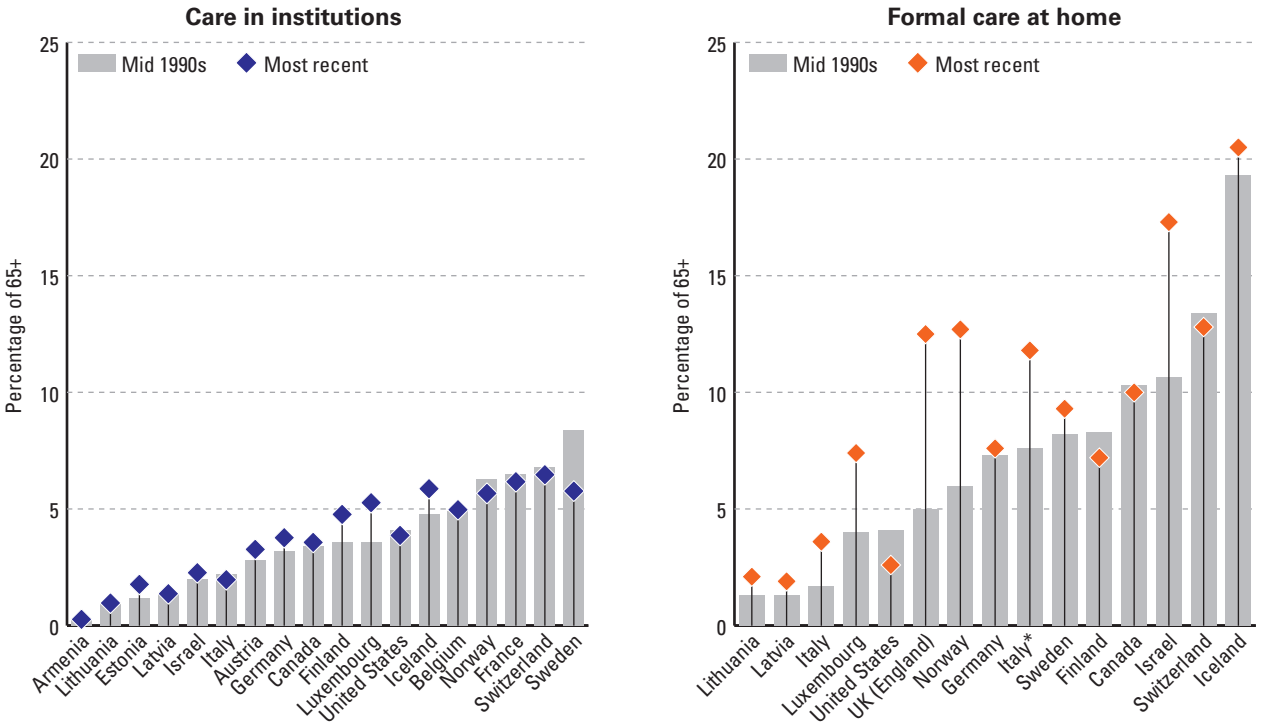
Availability of care refers to the share of 65+ receiving formal care services only, either at home or in institutions.

THE PAST DECADE HAS WITNESSED AN INCREASE IN CARE PROVIDED AT HOME

Evolution of older people receiving formal care in different care settings

This indicator portrays the evolution of the share of people aged 65 and older that receive formal care at home and in institutions, allowing for the visualisation of trends in the availability of formal care.

Figure 7.5: Evolution of people aged 65 and older receiving care in institutions and formal care in their homes



Source: OECD Health Data and national sources (see Statistical Annex).
Notes: Belgium and Austria for 60+. France for 60+ for home care. Some of the countries refer to age groups which may not coincide with the 65+ cut-off (see Statistical Annex). Italy (a) refers to *Indennità di accompagnamento*.

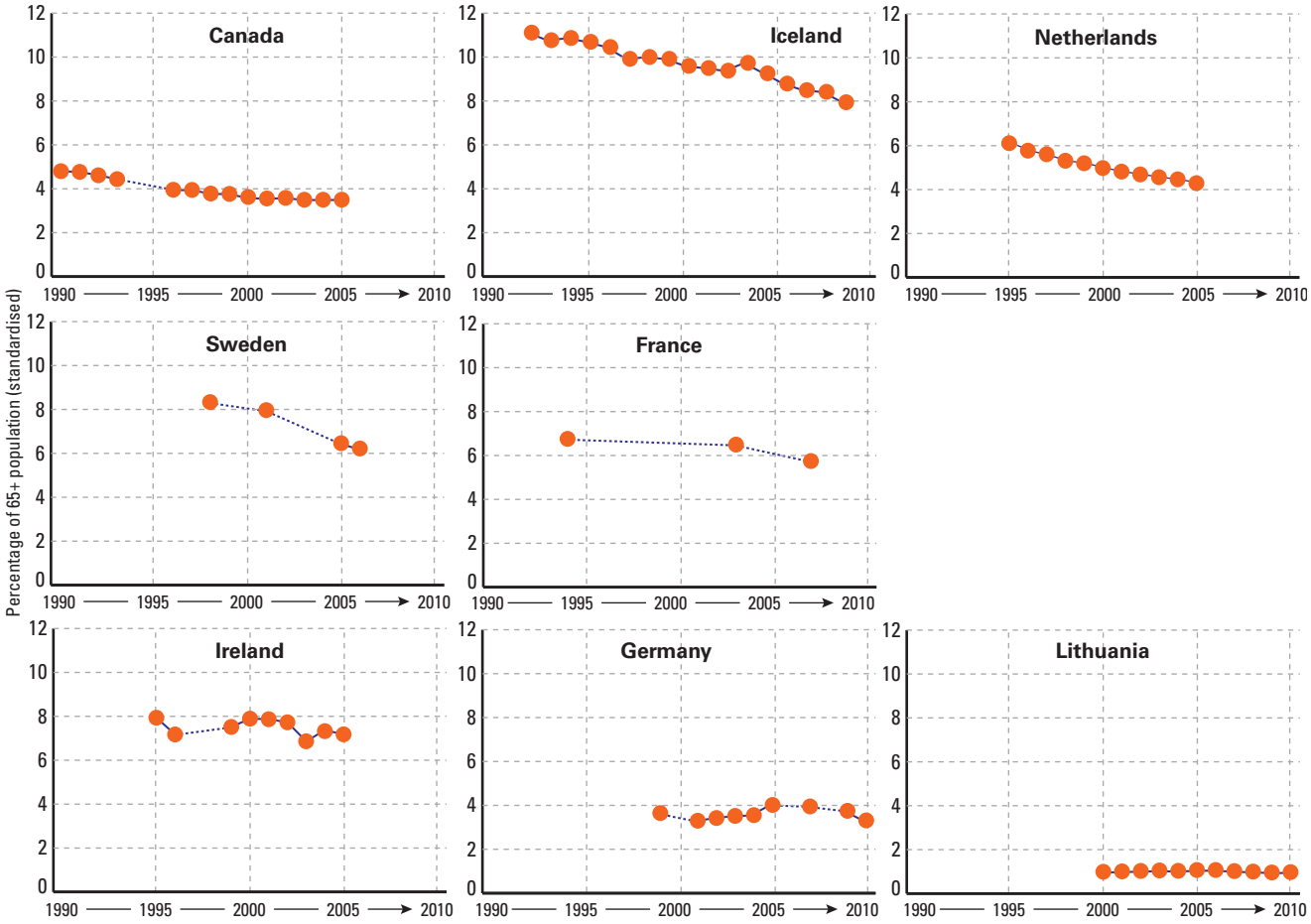
- In most countries, the percentage of older people receiving institutional care remained stable despite population ageing.
- In the past decade most gains in the availability of formal care were achieved by expanding services provided in people's own homes, which accounts for the present importance of home care in most countries (cf. Figures 7.1 and 7.3).
- Only Norway and particularly Sweden witnessed a reduction in the coverage of institutional care. Given that the old age population has diminished in absolute terms between 1990 and 2010 in Norway and only marginally increased in Sweden, this rather reflects a policy option to move away from this form of care.
- Data as far back as the middle or late 1990s is only available for a limited number of countries, but many of the countries which started with lower levels of availability of care have not yet caught up with the front-runner countries (e.g. Latvia, Lithuania and Italy, if we consider only care services in the case of the latter). One development in care provision that is not totally reflected in these figures is the expansion of care allowances and the use of migrant care workers.
- The strengthening of home care rather than of institutional care reflects the emphasis placed on achieving the goal of 'ageing at home' in most countries.

Definitions
See Figure 7.1.

Age-standardised nursing home usage rates among older people

This indicator refers to the evolution of the share of people aged 65 and older that receive care in nursing homes, accounting for the change in the age structure of the population (age-standardisation).

Figure 7.6: Age-standardised nursing home usage rates



Source: Own calculations based on Eurostat, Statistics Iceland, Statistics Canada, National Board of Health and Welfare Statistics – Social Welfare (Sweden), CBS Statline (Netherlands), Department of Health and Children, Annual Survey of Long Stay Units (Ireland), Pflegestatistik (several years) of Federal Statistics (Germany), Statistics Lithuania, Tugores (2006) and Prévot (2009).
Notes: Standard population is the 2005 population for each country.

- After controlling for demographic ageing there seems to be no clear evidence that population ageing has led to the increased use of institutional care.
- The general increase of generosity of LTC (cf. Figure 7.5) has not resulted in an expansion of LTC in institutions beyond what is needed to compensate for population ageing.
- Age-standardised nursing home usage rates have decreased for most countries for which data is available, or at least remained stable (e.g. in Ireland, Germany and Lithuania).
- The concern that as the share of those aged 80 and older increases, this would translate into increased needs and demand for (more expensive) institutional care, has not materialised so far.

Definitions

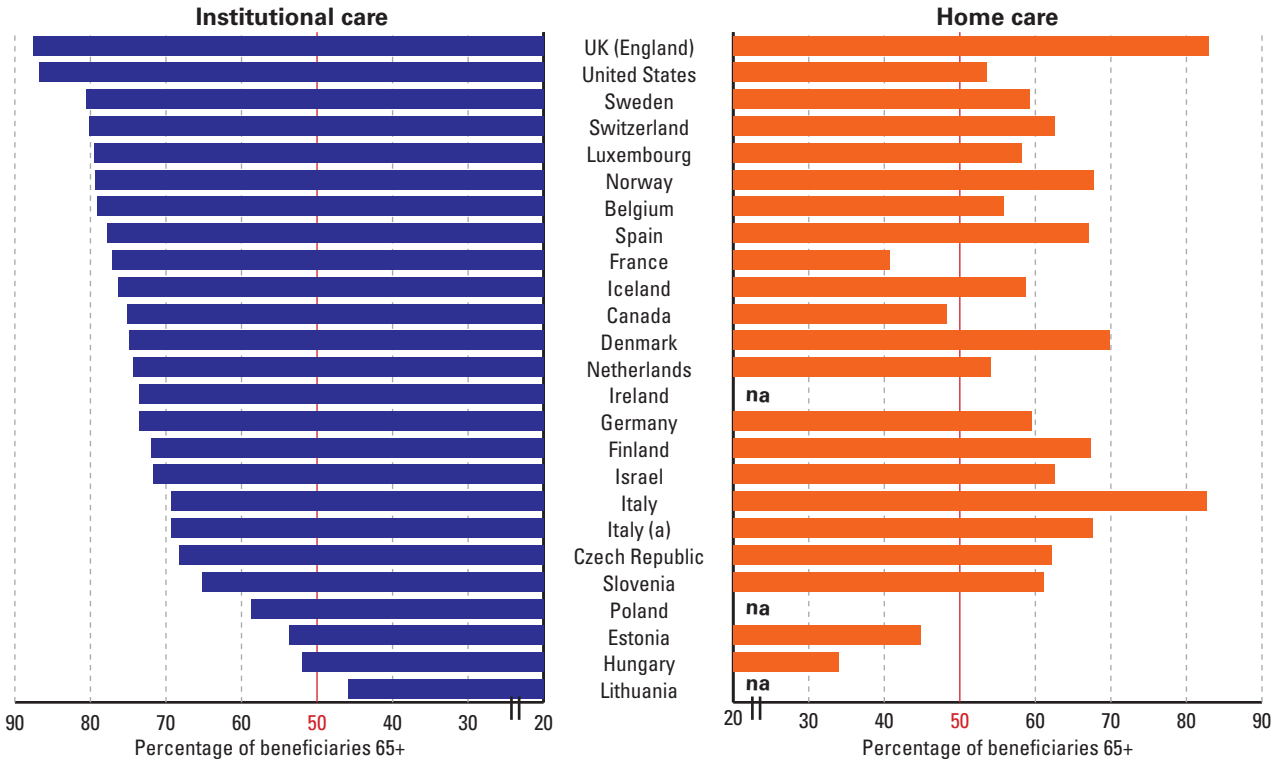
Age-standardisation allows for the effect of differences in the population age structure to be eliminated when comparing a variable across time (or countries), in this case the usage rate of nursing homes. Age-standardised usage rates compare the number of observed users in the 65+ population with the number of expected users if the age-specific usage rates were the same as a standard population. The standard population used is that of 2005 for each country.

AN OLDER AGE PROFILE AMONG USERS OF INSTITUTIONAL CARE

Share of people aged 80 and older among older users of care, in institutions and at home

This indicator provides a portrait of the age profile of users of formal care (institutional and care at home) by depicting how many of the older users of care (65 and older) are at least 80 years old.

Figure 7.7: People aged 80 and older among the older users of care – 2009 or most recent year



Source: OECD Health Data and national sources (see Statistical Annex).
Notes: Age groups for institutional care for Belgium and France refer to those aged 60-79 and in the USA to those aged 65-74. Age groups for home care for Italy (services) refer to those aged 65-74. Italy (a) refers to *Indennità di accompagnamento*.

- For most countries, more than two thirds of those residing in care homes are 80 years of age or older.
- The age profile of users of home care is noticeably younger than that of residents of institutional care. However, even among those that remain in their own homes, the majority of users is 80 years or older. Use of care services is thus strongly targeted to the oldest age groups for most countries.
- Those receiving formal care in Poland, Estonia, Hungary, Lithuania and Bulgaria are considerably younger on average than users of care in other UNECE countries, while England has the oldest age profile among both users of home care services and residents in institutional care.
- The much younger age profile of those receiving care in the countries listed above suggests that take-up of institutional care may be associated with other conditions besides dependency, such as social exclusion, poor housing conditions and material deprivation among the old-age population (cf. Chapter 3).

Definitions

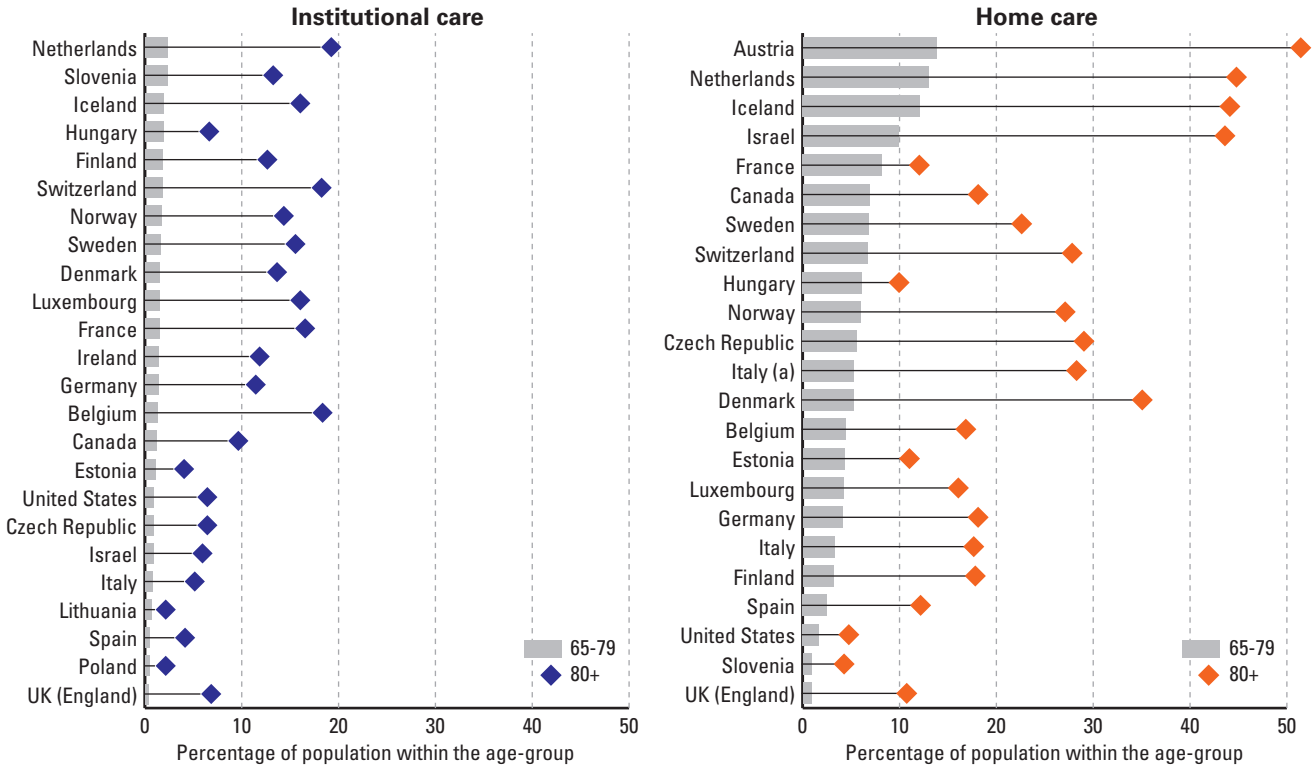
See Figure 7.1.

EVEN THE OLDEST AGE GROUPS ARE PREDOMINANTLY CARED FOR IN THEIR HOMES

People receiving formal care in their homes or in institutions as a share of different age groups

This indicator displays the share of people in different age groups that receive formal care (at home and in institutions) and allows for a comparison of in which care setting older people are more likely to be cared for as they age.

Figure 7.8: Share of different age groups receiving institutional and home care – 2009 or most recent year



Source: OECD Health Data and national sources (see Statistical Annex).

Notes: Age groups for home care for Italy (services) and UK (England) refer to those aged 65-74. Italy (a) refers to *Indennità di accompagnamento*.

Notes: Age groups for institutional care for Belgium and France refer to those aged 60-79 and in the USA and UK (England) to those aged 65-74.

- Although residents of institutional care are older on average than those receiving care in their own homes (Figure 7.7), the majority of those aged 80 and older still receive care services at home.
- Advances in home care services have made it possible for close to one out of two people aged 80 or older in Austria, the Netherlands, Iceland and Israel to have access to care while remaining at home. In some cases they benefit from care provided by informal carers paid with cash benefits.
- In stark contrast, in Hungary, France, Spain, Estonia, England, the United States and Slovenia the share of the oldest old (aged 80 and older) accessing care is well below 15%.

Definitions

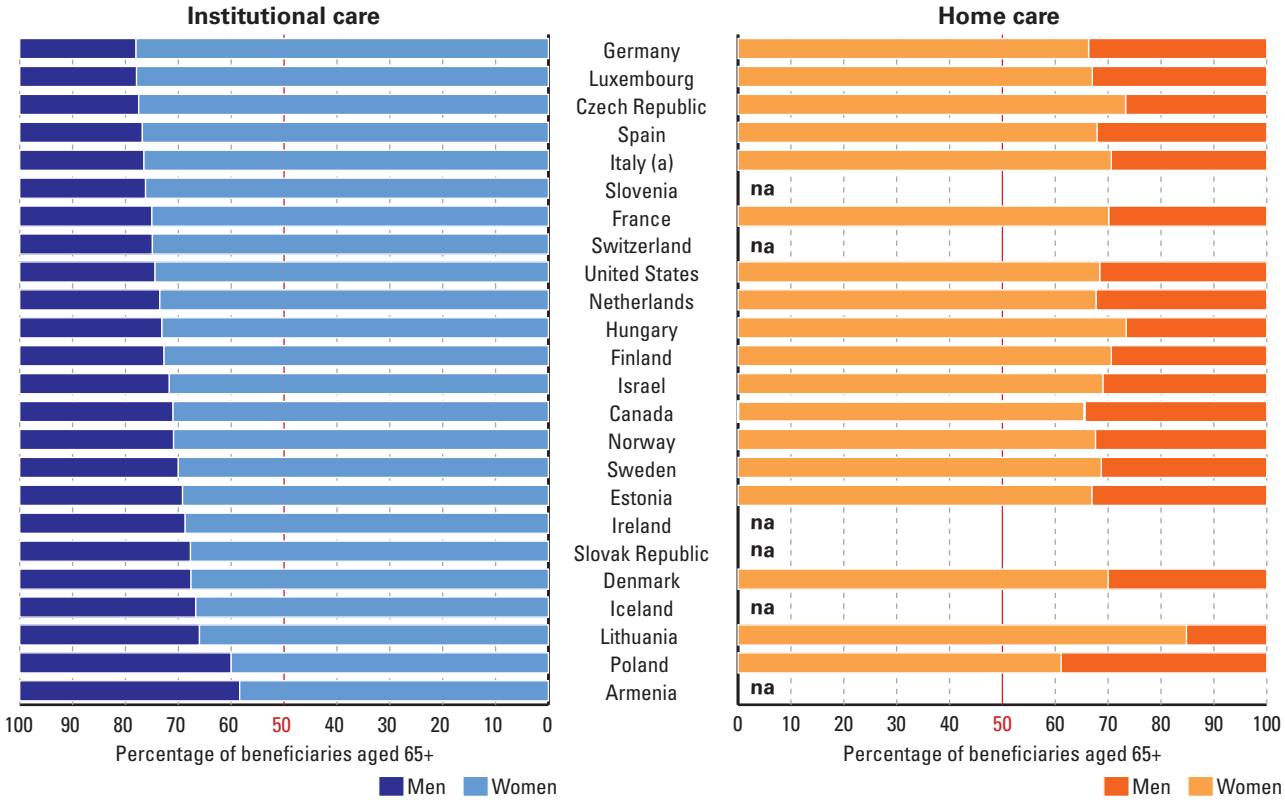
See Figure 7.1.

MEN ARE BUT A SMALL SHARE OF USERS OF FORMAL CARE

Gender distribution of older users of formal care services in different care settings

This indicator provides information on the share of users of institutional or home care aged 65 and older that are women.

Figure 7.9: Share of women among the users of care aged 65 and older – 2009 or most recent year



Source: OECD Health Data and national sources (see Statistical Annex).
Notes: Italy (a) refers to *Indennità di accompagnamento*.

- Users of care services are much more likely to be women, regardless of the care setting and country.
- In Germany, Luxembourg, the Czech Republic, Spain, Italy, Slovenia and France nearly four out of five residents in care homes are women. In Armenia – where women are the least predominant in relative terms – still nearly three out of five residents in institutional care are women.
- Predominance of women as users of care services stems in part from the large differences in gender ratios of the highest age groups, as well as health and living arrangements in older age groups more generally (see Chapters 2, 4 and 5). One of the most important factors is that those living alone are more likely to need (and often more likely to be provided with) formal care services given the absence of an (informal) carer spouse.

Definitions

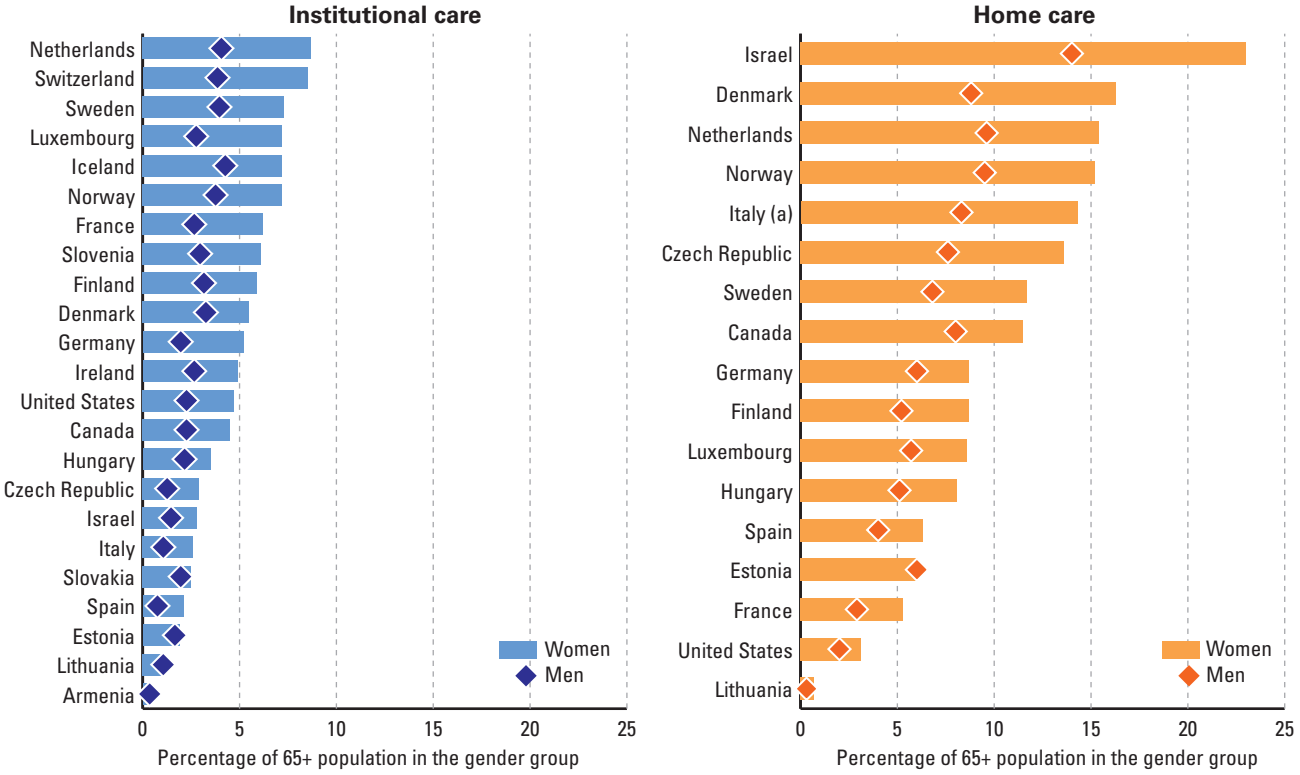
See Figure 7.1.

WOMEN NOT JUST MORE LIKELY TO CARE FOR, BUT ALSO TO RECEIVE CARE

People receiving formal care in their homes or in institutions by gender

To account for the different gender composition of the old-age population, this indicator depicts the share of the respective 65 and older gender group that is cared for in institutions or at home.

Figure 7.10: Share of people aged 65 and older cared for in institutions or at home, by gender – 2009 or most recent year



Source: OECD Health Data and national sources (see statistical annex).

Notes: Belgium and Austria for 60+. Some of the national sources refer to age groups which may not coincide with the 65+ cut-off (see statistical annex).

Notes: Belgium and Austria for 60+. Users of home care in France are 60+. Some of the national sources refer to age groups which may not coincide with the 65+ cut-off (see statistical annex). Italy (a) refers to *Indennità di accompagnamento*.

- In almost every country women have a higher probability of receiving care services, either at home or in institutions.
- In the Netherlands, Switzerland, Slovenia, Luxembourg, France, Germany, United States, Czech Republic, Italy and Spain, women are more than twice as likely to be in institutional care than men.
- It is only in Lithuania and Armenia (for institutional care) and Estonia (for home care) that men are more likely to receive care services.
- Gender differences in living arrangements and concomitantly in access to informal care can account for part of the gender differences across UNECE countries(1), but hardly for intra-country dissimilarities. Lithuania and Estonia are among the UNECE countries where the gender gap for those living alone is the highest (cf. Chapter 3) and yet a similar share of women and men use care services in these countries.

(1) The fact that eligibility conditions to access services are linked to the availability of informal care in some countries (e.g. the Netherlands) may also amplify gender differences.

Definitions

See Figure 7.1.

CARE WORKFORCE – REFLECTING VARYING DEGREES OF FORMALISATION OF CARE

Workforce employed in the care sector as percentage of old age population and as a ratio to users of care

This indicator provides information on the degree of formalisation of care – measured as the workforce of the care sector in percentage of the population aged 65 and older – and of the labour intensity of this sector – measured as the ratio of the workforce against the users of formal care services aged 65 and older. The latter indicator could also be seen as a proxy input indicator on the quality of care.

Figure 7.11a: People formally employed in the care sector as a percentage of those aged 65 and older

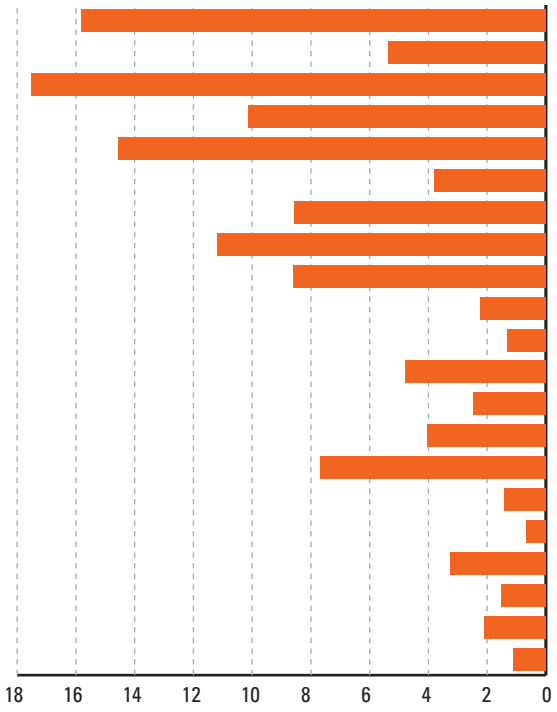
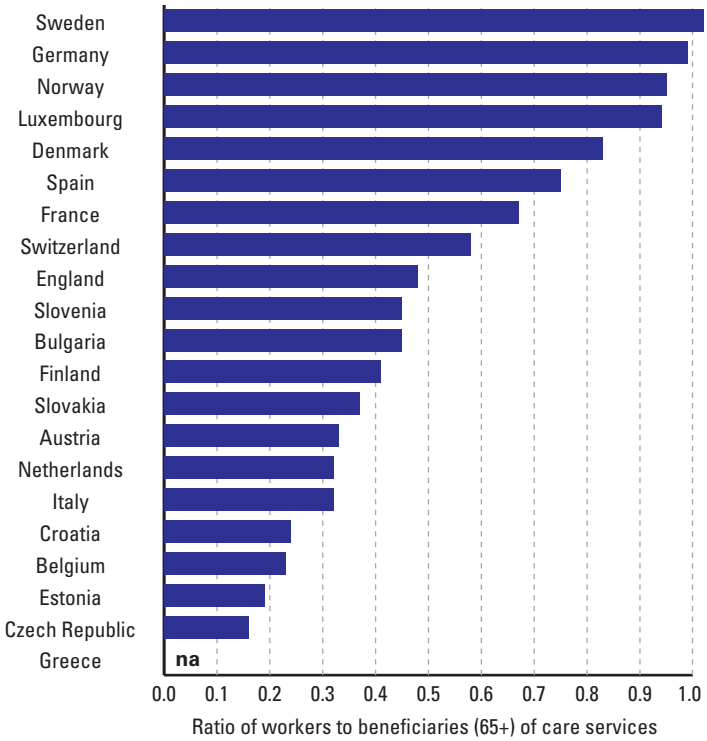


Figure 7.11b: Ratio of people formally employed in the care sector against users of formal care services



Source: Own calculations based on OECD Health Data and national sources (see Statistical Annex).
Notes: For France, data refer to those employed in the *Établissements d'Hébergement pour Personnes Âgées* (2003) and for formal LTC workers providing home care (2008) with the ratio calculated for the respective years. For Slovenia and Luxembourg data refer to social and health care personnel working in institutions only. Data for the Netherlands and Norway are for the full-time equivalent (FTE) and particularly for the former could significantly impact the comparability of figures. For Austria, Luxembourg, Italy and Germany, users include only those receiving care services (see notes of Figure 7.1). For Bulgaria figures refer to those working in home care only.

- The degree of formalisation of care arrangements is reflected in the relative importance of the long-term care workforce (a large majority of whom are women) in relation to the old-age population (Figure 7.11a).
- Norway, Denmark and Sweden stand as examples of what the literature has termed as *de-familialisation* (Leitner, 2003), i.e. making satisfaction of welfare needs independent of the family and rather a responsibility of the State, although the latter has recently shifted back to greater family responsibility.
- The ratio of the workforce in relation to the older population mimics to a great extent the availability of care services/expenditure (cf. Chapter 8). There are, however, differences caused by the prevalence of part-time work (the Netherlands) and the importance of cash benefits that can be used to pay for family members or migrant care workers (e.g. Austria or Italy).
- Comparing Figures 7.11a and 7.11b, the different degrees of formalisation of care do not seem to correspond to differences in the ratio of workers to users. For example, the ratio is quite comparable for Spain, France, the Netherlands or Denmark.

Definitions

Workers in long-term care refer to those employed by formal care providers either in the institutional or the home care sector. Whenever possible, individual personal assistants hired directly by users were not included, to avoid possible overlaps with informal carers paid through cash benefits.

Comparability of data is an issue and figures should be interpreted with caution.

THE MIXED ECONOMY OF CARE PROVISION ACROSS EUROPE

Distribution of providers of long-term care according to ownership type

Public provision and market mechanisms now coexist in the provision of long-term care and this indicator shows the relative importance of different types of providers in the national contexts.

Table 7.1: Distribution of providers of long-term care services according to ownership

Country	Public providers		Private non-profit providers		Private for-profit providers	
	Residential	Home care	Residential	Home care	Residential	Home care
Austria	55%	8%	24%	91%	21%	1%
Belgium						
Flanders	36%		52%		12%	
Wallonia	26%		21%		52%	
Brussels	24%		13%		62%	
Czech Republic (1)	59%		38%		3%	
UK (England)	7%	14%	13%	11%	80%	74%
Finland	56%	93%			44%	7%
France	23%	15%	55%	65%	22%	20%
Germany	5%	2%	55%	37%	40%	62%
Italy (1)	30%		50%		20%	
Netherlands (1)	0%		80%		20%	
Slovak Republic (1)	75%		23%		2%	
Spain (2)	23%		24%		53%	
Sweden	75%	NA	10%	NA	15%	16 %
Switzerland (1)	30%		30%		40%	

Source: Allen et al. (2011), Barnett et al. (2010) and Sowa (2010).
Notes: (1) Only aggregate data for residential and home care available. (2) No clear distinction can be made between private providers for Spain – non-profit providers include all those with a formal contract with the Autonomous Communities; private for-profit providers include those with an authorization only, i.e. all costs have to be covered by the individual resident.

- It is difficult to distinguish clear patterns between countries as the mixed economy of care seems to be greatly influenced by path dependency, i.e. by the starting point in terms of care provision (e.g. what were the incumbent providers).
- The third sector of private non-profit providers has traditionally played an important role in Austria, Germany and France, sometimes under closer coordination with the public authorities (e.g. Austria and France), and continues to be predominant in these countries, as well as in the Netherlands, Italy and the Flanders region of Belgium.
- Public providers remain predominant in the Nordic countries – despite two decades of 'privatization' of care in the Swedish case – but also in the Slovak and Czech Republics.
- As for the predominance of the private for-profit sector, England and Spain tell two different stories. Private provision in England has flourished after the introduction of quasi-markets in long-term care in the early 1990s, while in Spain private providers have filled the void of public provision.

Definitions

Public providers refer to organisations in which public authorities (e.g. Ministry, municipalities) directly manage or have power to appoint management.

Private non-profit providers include organisations whose board of directors is composed of volunteers, as well as organisations managed or owned by religious or civil society bodies (e.g. unions, political parties, cooperatives).

Private for-profit providers include organisations controlled by stockholders or that are privately owned.

Chapter 8:

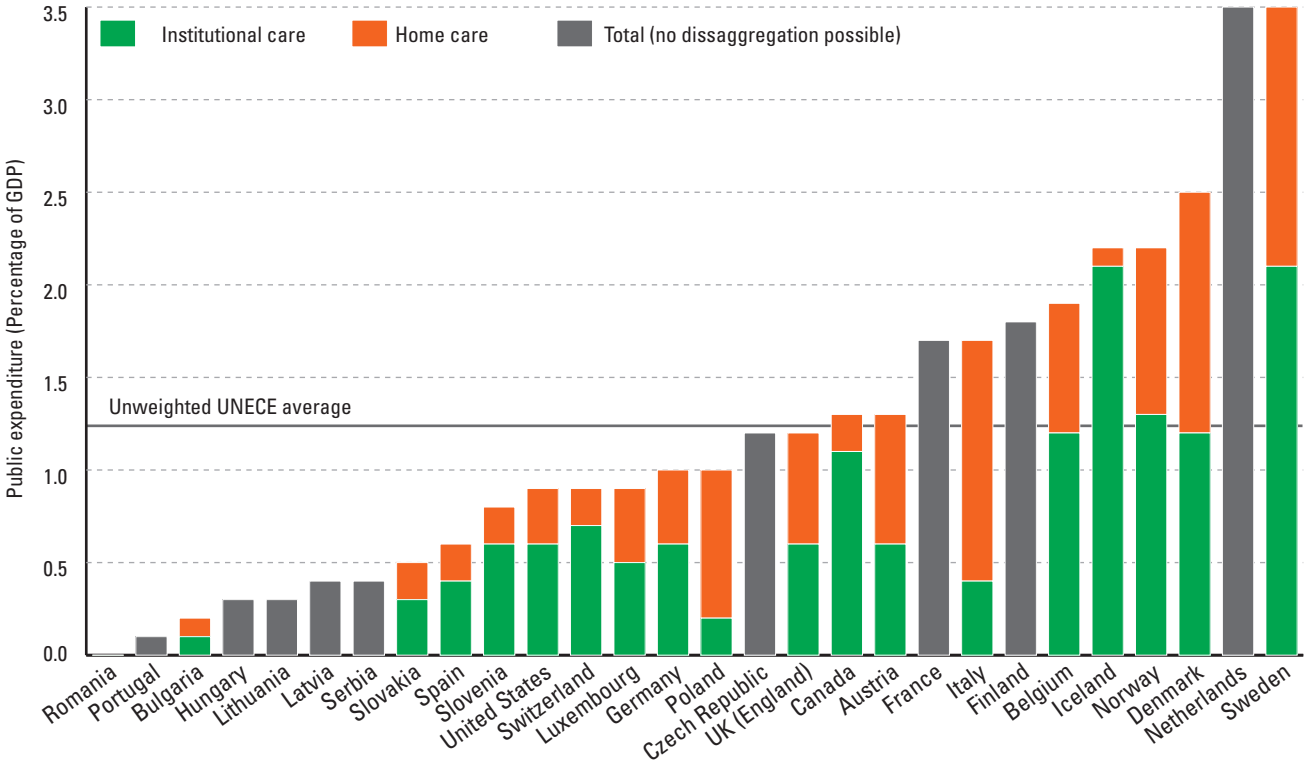
EXPENDITURE ON LONG-TERM CARE

PUBLIC EXPENDITURE ON LONG-TERM CARE – HOW MUCH AND FOR WHAT

Public expenditure on long-term care in percentage of GDP, by care setting

This indicator provides information on the public resources devoted to long-term care in a harmonised and comparable way (in percentage of GDP), allowing also to shed light on how resources are spent by care setting.

Figure 8.1: Public expenditure on long-term care, by care setting – 2009 or latest available year



Source: Own calculation based on OECD Health Data, OECD (2011) and national sources (see statistical annex).
Notes: Grey bars represent data for which no reliable information by care setting is available.

- Most UNECE countries devote a relatively small share of their GDP to publicly funded long-term care services for older people.
- While the majority of beneficiaries are cared for in their homes (Chapter 6), a large share of public expenditure is spent on institutional care in most countries.
- The Netherlands and Sweden clearly stand out with public expenditure on long-term care of approximately 3.5% of their GDP. Denmark, Norway and Iceland follow with public expenditure above 2% of their GDP.
- For the majority of countries, including some with otherwise relatively sizeable social protection systems and ageing populations (e.g. Germany), expenditure is below the unweighted average of 1.24% of GDP for the 28 countries for which data are available.
- While fiscal sustainability is a concern in the context of demographic ageing, the public resources devoted to the care of dependent people may be too low in many countries that are faced with an ageing population. Families and informal care still play an indispensable role (see Chapter 5).

Definitions

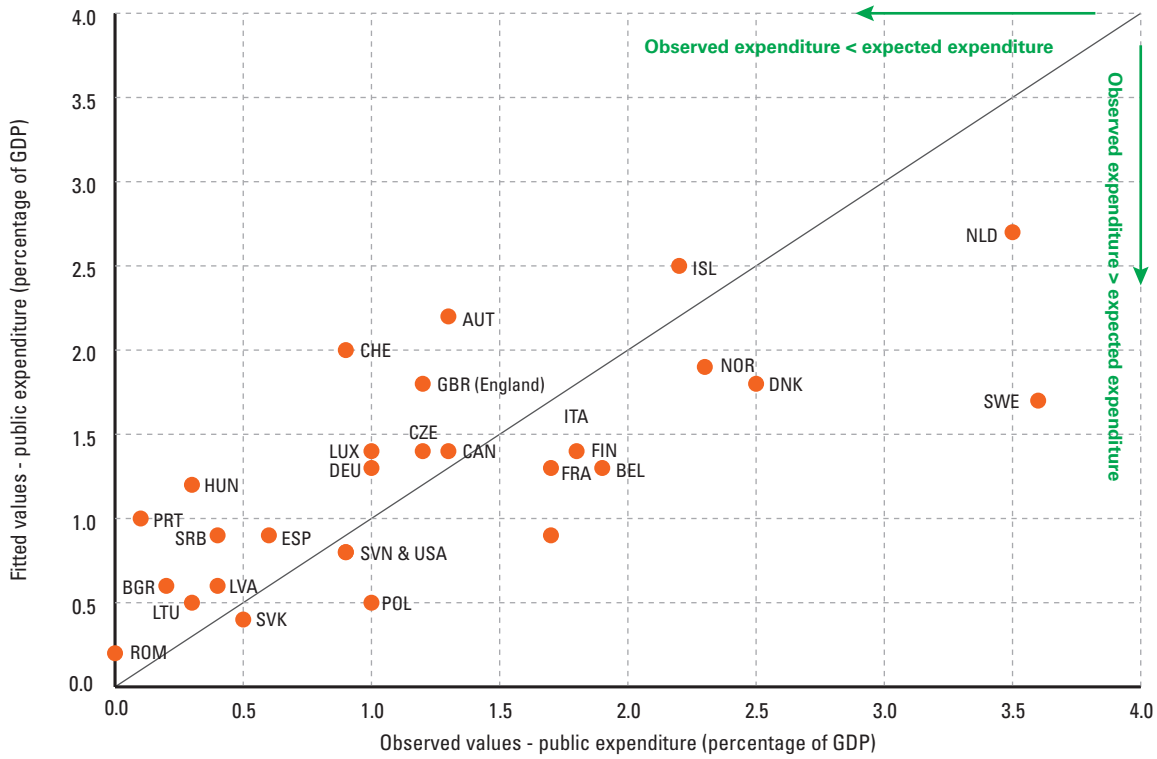
Public expenditure on long-term care refers to the provision by public (and private) institutions of benefits (in-kind or cash) to individuals due to chronic impairments and a reduced degree of independence for aged and disabled persons. Whenever an age breakdown was available, figures refer to older people (for most countries this refers to those aged 65 and older).

ARE DIFFERENCES IN DEMOGRAPHY DRIVING THE DIFFERENCES IN PUBLIC EXPENDITURE?

Observed and estimated values of long-term care that account for differences in generosity and population profiles

This indicator compares public resources devoted to long-term care as a proportion of GDP against the expected GDP-proportion if differences in population structure and system coverage (i.e. number of beneficiaries) between countries are accounted for. Considering these two latter variables as two of the main explanatory variables for public expenditure, this indicator attempts to highlight unexplained differences in expenditure ratios.

Figure 8.2: Estimated differences in public expenditure taking into account age structure and the number of beneficiaries



Source: Own calculations based on data for beneficiaries from OECD Health Data and national sources (see Statistical Annex).
Notes: Fitted values refer to regression of public expenditure controlling for share of 80+ in population and beneficiaries in percentage of 65+ (R2=0.83), no constant. See notes on Figures 6.1 and 7.1.

- Although long-term care is an age-related social expenditure, demography and the number of beneficiaries alone do not fully explain differences in public expenditure.
- The difference between estimated spending levels on the basis of age and number of beneficiaries, and observed resource use exhibits the influence of other factors such as: private expenditure, reliance on cash or in-kind services, quality, unit labour costs, etc. (OECD, 2005).
- For a number of countries situated on the lower left quadrant of the graph (e.g. Portugal, Hungary, Spain) – all of which are 'under-spending' – the observed values of public expenditure may point to a gap in services and a likely over-reliance on the family to meet care needs.
- Countries such as the Netherlands or Sweden have higher expenditure ratios than their share of old-age people and beneficiaries would otherwise suggest, hinting at higher generosity at an individual level. This includes good-quality services – particularly in Sweden where relatively generous resources are concentrated on smaller number of beneficiaries than, for example, in Austria.
- This comparison between observed and age-driven estimated expenditure points to the existence of several variables on which it is possible to act in order to impact public expenditure in face of an ageing population.

Definitions

Observed public expenditure on long-term care: this is the public expenditure on long-term care as reported by official national and international sources or that has been calculated based on those sources.

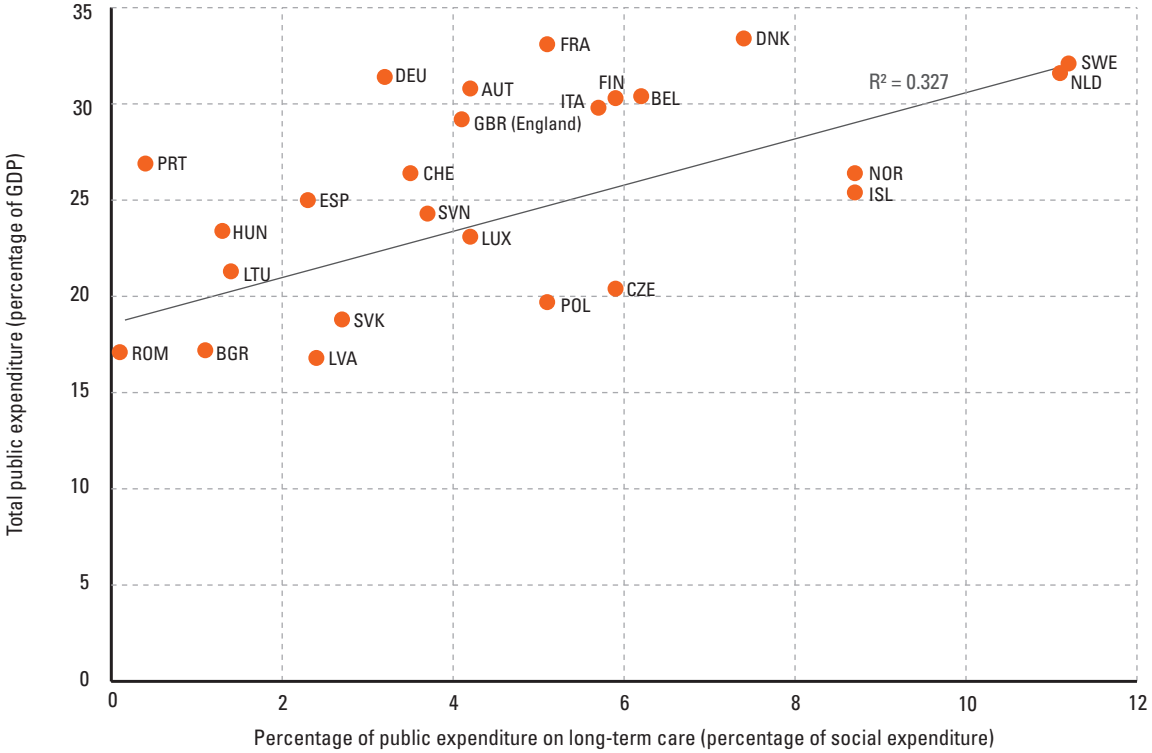
Estimated values of public expenditure on long-term care: figures estimated using an ordinary least square (OLS) regression of public expenditure in percentage of GDP on the share of people aged 65 and older receiving care benefits and the share of the total population aged 80 or older.

THE IMPORTANCE OF LONG-TERM CARE IN THE CONTEXT OF SOCIAL EXPENDITURE

Public expenditure on long-term care as a percentage of total public social expenditure

This indicator captures the importance of long-term care within overall social public expenditure as percentage of GDP.

Figure 8.3: Public expenditure on long-term care in relation to public social expenditure – 2009 or latest available year



Source: Eurostat, own calculations based on data for beneficiaries from OECD Health Data and national sources (see statistical annex).
Notes: Figures for United Kingdom refer to England only (including GDP). Data on total public social expenditure in percentage of GDP does not include public expenditure on health care.

- The importance of long-term care in the context of overall public social expenditure varies quite significantly (Figure 8.3).
- For those countries which devote fewer resources to social protection, long-term care makes up only a marginal share of those resources – e.g. in Slovakia long-term care represents only 2.7% of total public social expenditure (18.8% of GDP).
- On the contrary, long-term care amounts to close to or even surpasses 10% of public social expenditure in the higher spending countries such as Norway, Iceland, Sweden and the Netherlands.
- It therefore seems that long-term care is only a significant social programme in countries that already have relatively high social public social expenditure. Taking into consideration public expenditure projections (e.g. ECFIN, 2012), it is likely that the importance of long-term care in terms of public expenditure will increase in the future.

Definitions

See Figure 8.1.

Public social expenditure refers to the provision by public and private institutions of benefits to, and financial contributions targeted at, households and individuals in order to provide support during circumstances which adversely affect their welfare, provided that the provision of the benefits and financial contributions constitutes neither a direct payment for a particular good or service nor an individual contract or transfer (OECD).

FAMILIES ARE HEAVY CONTRIBUTORS TO PAYMENT FOR CARE

Rules governing co-payments from private households to institutional care

This indicator provides qualitative information about the rules governing co-payments by users or their relatives to institutional care.

Table 8.1: Overview of rules on user co-payments for institutional care

	Fee as % of ● Full costs ● Income	Assets ● Yes ● No	Minimum income	Max. fees ● Yes ● No	Payments by relatives ● Yes ● No
Austria	●	●	20%	–	●
Belgium	●	●	Fixed amount	–	●
Bulgaria	●	–	20%	–	–
Czech Republic	●	●	15%	–	●
Croatia	●	●	–	–	–
Cyprus	●	–	–	–	–
Denmark	●	●	–	–	–
Estonia	●	–	–	–	●
Finland	●	●	15%	–	●
France	●	●	10%	–	●
Germany	●	●	–	–	●
Hungary	●	●	20%	–	●
Iceland	●	–	–	●	●
Ireland	●	●	20%	–	●
Italy	●	–	–	–	●
Lithuania	●	●	20%	–	–
Malta	●	–	Fixed amount	–	–
Netherlands	●	●	Fixed amount	●	–
Norway	●	●	–	–	●
Poland	●	–	30%	–	●
Portugal	●	–	–	–	–
Romania	●	–	40%	–	●
Slovakia	●	●	Fixed amount	–	–
Spain	●	●	10%	–	–
Sweden	●	●	Fixed amount	●	●
United Kingdom (England)	●	●	Fixed amount	–	–

Source: MISSOC database (accessed on 18th October 2011), ANCIEN and INTERLINKS National Reports, Leichsenring et al. (2009), Barnett et al. (2011), Rodrigues & Schmidt (2010).
Notes: 'Minimum income' refers to money that is left for the user to use at his/her discretion. 'Maximum payment' refers to caps imposed on the co-payment amounts.

- For the great majority of countries for which information could be compiled, beneficiaries in institutional care contribute with a significant share of their income (e.g. pensions) to fund care or the cost of board and lodging.
- The differences between countries are also related to filial obligations to participate in the funding of care and the extent to which cost-sharing depends on an asset-test.
- With the notable exception of the Nordic countries and the Netherlands, convertible assets (such as housing) can frequently be claimed for the purpose of paying for long-term care. For example, there can be a requirement to have spent these entirely before qualifying for social assistance as 'funder of last resort'.
- Reflecting the primacy of the state over family responsibility in taking care of dependent people, in Nordic countries relatives are usually exempted to contribute to the payment of care of their older relatives.
- However, recipients are requested to contribute with their pension income, and typically beneficiaries are only guaranteed a minimum remaining amount for personal expenses (between 10-20% of income).
- A few countries established caps on the amount of co-payments required from users, which in the case of Sweden are set at relatively low values

Definitions

'Fees as % or full costs' refer to co-payments set as a share of running costs or for certain components such as board and lodging.

'Fees as % of income' refer to a proportion of income that is taken as co-payment for care.

'Assets' refer to liquid wealth required as co-payment or considered for eligibility purposes.

'Payment by relatives' refers to the obligation of relatives to pay for family members' care or to the fact that income from relatives is considered for eligibility purposes.

ASSET TEST AND FILIAL OBLIGATIONS: CITIZENS' VIEWS

Opinions of Europeans regarding asset tests and family/State responsibilities in relation to actual public expenditure on long-term care

This indicator depicts the share of European citizens who support intergenerational transfers for the payment of care

Figure 8.4a: Percentage of respondents agreeing with assets being used to pay for long-term care across different public expenditure levels

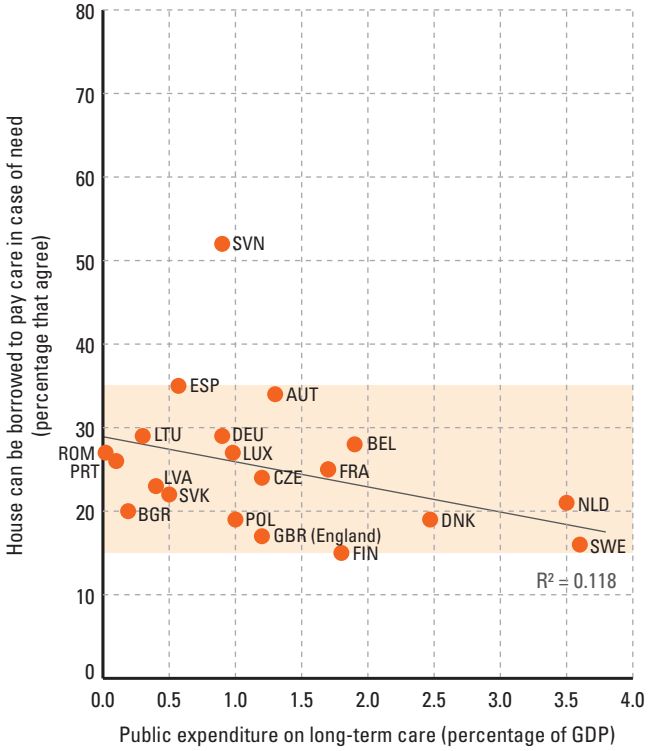
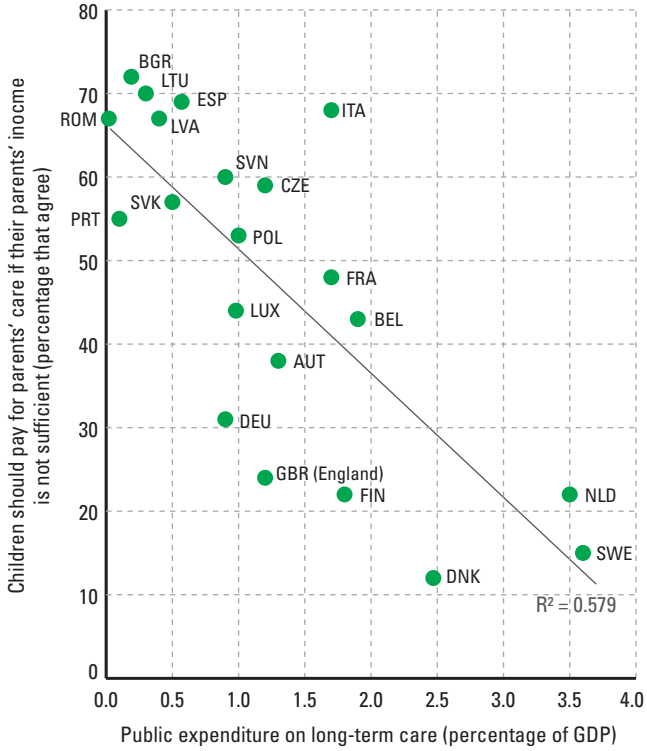


Figure 8.4b: Relation between public expenditure and the share of respondents agreeing with the statement that children should pay for their parents' care



Source: Eurobarometer (2007), own calculations based on data for beneficiaries from OECD Health Data and national sources (see statistical annex).

Notes: Eurobarometer question 8.3 – Do you agree with the statement that "if a person becomes dependent and cannot pay for care from their own income, their flat or house should be sold or borrowed against to pay for care"?

Eurobarometer question 8.4 – Do you agree with the statement that "Children should pay for the care of their parents if their parents' income is not sufficient"?

- Although convertible assets may be required to pay for long-term care in many countries (cf. Table 8.1), this practice seems to meet little support from citizens in most European countries (Figure 8.4a).
- The obligation to contribute to fund long-term care expenditures by relatives meets with the support of most citizens from a number of Southern, Central and Eastern EU countries, as well as from Mediterranean countries and is correlated with public expenditure levels.
- Irrespective of public expenditure levels, approval of using the value of one's own home to pay for care is between 15% and 35% for most countries (red shadow on graph 8.4a).
- This may correspond to different views about intergenerational solidarity but more importantly with the low level of social protection in general in these countries where living in multi-generational families is also common (see Chapter 3).
- Also, relative levels of public expenditure reflect different welfare state values and cultural views about the role of the family and the State in the funding of care or provision of care (see Chapters 5 and 7).

Definitions

See Figure 8.1.

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STATISTICAL ANNEX

Figures 2.4, 2.5 and 2.7		
Country	**Detailed Source**	**Detailed Notes**
All countries	ESS Round 5: European Social Survey Round 5 Data (2010), Data file edition 2.0. Norwegian Social Science Data Services, Norway – Data Archive and Distributor of ESS data. Source: http://ess.nsd.uib.no/ess/conditions.html	Includes nationally representative samples of altogether 50,000 individuals from 26 countries. Altogether 11,000 persons aged 65 or over are included in the sample. The field work was conducted in 2010 or 2011. The national samples include all persons aged 15 and over resident within private households, regardless of their nationality, citizenship, language or legal status in the participating countries.

Chapter 3

The data on burden of disease by age group and country group for the WHO European Region are from the WHO global burden of disease report: http://www.who.int/topics/global_burden_of_disease/en/

The WHO global burden of disease (GBD) measures burden of disease using disability-adjusted life years (DALYs). This time-based measure combines years of life lost due to premature mortality (YLL) and years of life lost due to time lived in states of less than full health (YLD). The DALY metric was developed in the original GBD 1990 study to assess the burden of disease consistently across diseases, risk factors and regions.

The most recent data are from the 2008 update report that provides estimates for the year 2004: http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html

The **years of life lost (YLL)** indicator measures the YLL due to a cause as a proportion of the total YLL lost in the population due to premature mortality. The indicator is presented in this publication as the percentage of YLL in the total of YLL of a specific age and sex group for each of three WHO country groups (see below).

The estimations of Years of life lost (YLL) take into account the age at which death occurs by calculating the hypothetical loss of years between the actual year of death and the age- and sex-specific life expectancy for Japan, which is currently the country with the longest life expectancy in the world. The estimates presented here use no additional discounting or age-weights: they are so called "no-frills" DALYs estimates.

The **years of life lived with disability (YLD)** indicator measures years lived with disability due to individual causes of diseases as a proportion of the total YLD lost in the population.

This indicator is presented in this publication as estimated percentage of YLD in the total of YLD of a specific age and sex group for three WHO country groups. YLD are estimated by weighting years lived with disease-specific disability weights. A disability weight is a weight factor that reflects the severity of the disease on a scale from 0 (perfect health) to 1 (equivalent to death). Years Lost due to Disability (YLD) are thus calculated by multiplying the incident cases by duration and disability weight for the condition.

For both the YLL and YLD estimates presented in this chapter no discounting factor or age-weights have been applied. These estimates are so called "no-frills" DALYs estimates.

Disability weights for the YLD estimates are available from: http://www.who.int/healthinfo/global_burden_disease/daly_disability_weight/en/index.html

The estimates refer to the following three country groups:

Europe A (very low child mortality; very low adult mortality): Andorra, Austria, Belgium, Croatia, Cyprus ,Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland, United Kingdom.

Europe B (low child mortality; low adult mortality): Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Georgia, Kyrgyzstan, Poland, Romania, Serbia and Montenegro, Slovakia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Uzbekistan.

Europe C (low child mortality; high adult mortality): Belarus, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Ukraine.

Figures 5.11, 5.12, 5.13, 5.14		
Country	**Detailed Source**	**Detailed Notes**
Austria	Rille-Pfeiffer, Ch. (2011). *Austria*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012. Arbeiterkammer Wien, 'Tipps zur Pflegefreistellung' [Advice on care leaves]. Available at: http://www.arbeiterkammer.at/www-413-IP-3227-AD-3227.html, accessed in January 2012.	Short-term leave refers to one average working week per year
Belgium	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Merla, L. & Deven, F. (2011). Belgium, Care Leave Network, Country Reports, Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012.	Unpaid (short-term) leave for 45 days is available only for public sector employees (Figure 5.11). Long-term leave (Figure 5.13) refers to palliative care leave. In addition there is a medical assistance leave which may last up to 12 months, can be taken in several periods, from one to three months per dependent/disabled. Both types of leave may be taken full-time or part-time and are compensated with a lump sum of 741.40 EUR (part-time proportionally reduced).
Canada	Service Canada (2011) *Compassionate Care Benefits*, March 2011. OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris.	Compassionate care leave is valid in nine jurisdictions only. It has to be used within 26 weeks for a period of six weeks. To qualify for benefits of the leave (Figure 5.13) the employee must have worked 600 hours in the last 52 weeks and weekly earnings must decrease by 40%. The length of the care leave can be shared among carers. Different provisions exist in Québec, Ontario, New Brunswick, British Columbia.
Croatia	Dobrotic, I. (2011). *Croatia*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012. Moss, P. (ed.) (2011). *International review of leave policies and related research 2011*. International network on leave policies and research. Institute of Education-University of London: London.	
Cyprus	Practical Law Company (2012). "Employment and Employee Benefits: Cyprus". PLC: London. Available at: http://crossborder.practicallaw.com/2-508-1472?source=relatedcontent#a737052, accessed in September 2012.	
Czech Republic	Kocourková, J. (2011). *Czech Republic*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012. Ministry of Labour and Social Affairs, "Reconciling professional and family roles". Available at: http://www.mpsv.cz/en/1607#rpfr, accessed in October 2012.	Data refer to 2011. There is no limit in frequency in taking the leave, with a maximum of nine days (blocked). Parents may alternate in taking the leave.
Denmark	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Rostgaard, T. (2011). *Denmark*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012.	
Estonia	Health Insurance Act 2008.	Data refer to 2009.
Finland	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Moss, P. (ed.) (2011). *International review of leave policies and related research 2011*. International network on leave policies and research, Institute of Education-University of London: London.	A minimum of 90 days has to be taken in case of long-term leave (Figure 5.13).

France	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris Service Public, "Congés dans le secteur privé". Available at: http://vosdroits.service-public.fr/N510.xhtml, accessed in September 2012.	The leave classified as short-term leave in Figure 5.11 is called *congé de solidarité familial*, and compensated only during the first 21 days (*allocation journalière d'accompagnement d'une personne en fin de vie*). It may be used as a part-time benefit too (reducing the benefit and increasing the duration proportionally). The care leave's duration can be shared among carers. In France another option for a (short-term) care leave also exists for a period of three months (renewable once), which is unpaid (*congé de soutien familial dans le secteur privé*). It must not exceed a period of 12 months in total during the whole working life (Figure 5.13).
Germany	Blum, S. & Erler, D. (2012) *Germany*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/fileadmin/Leavenetwork/Country_notes/2012/Germany.FINAL.9may.pdf, accessed in September 2012.	Data refer to 2012. The duration of the short-term leave is two average working weeks (Figure 5.11).
Greece	Moss, P. (ed.) (2011). *International review of leave policies and related research 2011*. International network on leave policies and research, Institute of Education-University of London: London. Hatzivarnava Kazassi, E. (2011). *Greece*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012.	22 days are available for care of a spouse with certain medical conditions, while only 6 to 14 days per year for care of other family members.
Hungary	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris.	
Ireland	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Eurofound (2010). *Company initiatives for workers with care responsibilities for disabled children or adults*. European Foundation for the Improvement of Living and Working Conditions: Dublin. Carer's Leave Act (2001).	Short-term leaves (Figure 5.11) are granted for three days in any 12 months or five days in any 36 months. The long-term leave (Figure 5.13) can be taken for a maximum of 104 weeks, yet with blocks of at least 13 weeks each time. Payment is received only if sufficient social insurance contributions have been paid in the time before the care leave. There is also a means-tested carers' allowance for those not eligible for the care benefits.
Israel	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris.	The care leave must be taken under the provisions of sick leave entitlements of the employee.
Italy	Moss, P. (ed.) (2011). *International review of leave policies and related research 2011*. International network on leave policies and research, Institute of Education-University of London: London. Addabbo, T. & Giovannini, D. (2011). *Italy*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012. National legislation (Law 119/2011).	
Luxembourg	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris.	Short-term leave can also be taken as reduced working hours. Payment corresponds to sick leave payments.
Netherlands	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Ministry of Social Affairs and Employment, "Q&A on long-term care leave", "Q&A on short-term care leave", "Q&A on life-course savings scheme". Available at: http://www.government.nl/documents-and-publications/leaflets, accessed in September 2012.	In addition to the ten days of short-term leave (Figures 5.11 and 5.12) paid at 70% of earnings, an emergency leave of one day can be taken, which is reimbursed at 100% of earnings. The long-term leave (Figure 5.13) can be taken as a full-time, or part-time leave during a period of 12 weeks.
Norway	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Directorate of Labor Inspection (2007). Act relating to working environment, working hours and employment protection, etc. (Working Environment Act). Arbeidslivets lover, Directorate of Labor Inspection: Trondheim.	There are two different options for care leaves: a nursing care leave of up to 20 days, and a normal care leave of up to ten days.

Poland	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Kotowska, I.E. & Michon, P. (2011). Poland, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012.	
Portugal	Wall, K. & Leitão, M. (2011). *Portugal*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012.	
Slovenia	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Stropnik, N. (2011). Slovenia, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012.	Only in exceptional cases the long-term leave can be paid for up to six months (Figure 5.13). The duration of this care leave is renewed for each case.
Spain	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris. Escobedo, A. (2011). Spain, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012.	Social security contributions are paid during long-term leave for the employee (Figures 5.21 and. 5.13). The person on leave may benefit from a care allowance (paid to the dependent older person). The short-term care leave (Figure 5.11) refers to the duration per case, and can be extended to five days for public employees if travelling is required.
Sweden	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris.	
Switzerland	OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris.	
United Kingdom	O'Brien, M. & Moss, P. (2011). *United Kingdom*, Care Leave Network, Country Reports. Available at: http://www.leavenetwork.org/lp_and_r_reports/country_reports/, accessed in January 2012. OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris.	
United States	Family and Medical Leave Act (1992). OECD (2011). *Help Wanted? Providing and paying for long-term care*. OECD: Paris.	Special regulations may apply for public sector employees. Some states also introduced paid family care leaves (e.g. California, New Jersey, State of Washington).

Figure 6.1a		
Country	**Detailed Source**	**Detailed Notes**
All countries	OECD (2011). *Help wanted? Providing and paying for long-term care*. OECD: Paris, p. 177.	Data for Germany refer to 2005 only. All reported data are based on those provided by EUROSTAT through the *European Community Labour Force Survey*.

Figure 6.1b		
All countries	Lamura, G., M.G. Melchiorre, C. Chiatti & M. di Rosa (2010). 'Migrant LTC Workers: What Role, What Challenges, What Policies?', OECD Expert Meeting on "Long-term Care Workforce and Finances", OECD, 15-16 November, Paris.	Data have been calculated in percentage of the EUROFAM-CARE national samples, which included only households providing informal care to dependent over 65 year old people.

Figure 6.2		
Austria	Lenhart, M., & Österle, A. (December 2007). 'Migration von Pflegekräften: Österreichische und europäische Trends und Perspektiven', *Österreichische Pflegezeitschrift*, pp. 8-11. Akinyosoye, C. (2008). 'Gesundheit: Kollaps ohne Migranten', *Die Presse*, 10th December 2008, p. 11.	Data for home care refer to the percentage of home care workers employed by Caritas Austria who have a migrant background. Data for institutional care refer to the share of care workers in nursing and old people's homes who have been foreign-trained.
Israel	Iecovich E. (2011) 'What makes migrant live-in home care workers in elder care be satisfied with their job?', *The Gerontologist*, 61(5), 617-629.	Data refer to the share of home care workers who are foreign-born.
Italy	Lamura, G., M.G. Melchiorre, C. Chiatti & M. di Rosa (2010). 'Migrant LTC Workers: What Role, What Challenges, What Policies?', OECD Expert Meeting on "Long-term Care Workforce and Finances, OECD", 15-16 November, Paris.	Share of officially registered domestic workers with a non-Italian nationality.
Spain	Martínez Buján R. (2010). Social Policy, International Migration and Care Work. The Spanish Case. Paper presented at the 8th ESPANET conference "Social Policy and the Global Crisis: Consequences and Responses", Budapest, 2-4 September 2010.	Share of permits for domestic work released to foreigners.
Canada, Germany, Greece and the United States	OECD (2011). *Help wanted? Providing and paying for long-term care*. OECD: Paris, p. 174.	Canada and Germany: share of institutional care workers; Greece: care workers in private households; US: share of home personal and home care aides.

Figure 6.3		
Austria, Belgium, Canada, Finland, France, Germany, Ireland, Italy, Portugal, Sweden, UK, US	Wismar M., Maier C.B., Glinos I.A., Dussault G., & Figueras J. (eds.) (2011). *Health Professional Mobility and Health Systems. Evidence from 17 European Countries*. WHO European Observatory on Health Systems and Policies.	Austria, Finland: share of foreign-born nurses; Canada, Ireland, Sweden, UK, US: share of foreign-trained nurses; Belgium, France, Germany, Italy, Portugal: share of foreign-national nurses.
Denmark, Netherlands	OECD (2011). *Help wanted? Providing and paying for long-term care*. OECD: Paris, p. 174.	Denmark: share of foreign-trained nurses. Netherlands: share of foreign-trained registered nurses.

Figures 7.1, 7.2, 7.4a and 7.4b		
Country	**Detailed Source**	**Detailed Notes**
Armenia	National Statistic Service of the Republic of Armenia (2010). *Statistical Yearbook of Armenia*. National Statistic Service of the Republic of Armenia: Yerevan.	Data refers to total beneficiaries in percentage of 65+ population. Home care (2006); institutional care (2009).
Austria	Statistik Austria, (several years) *Sozialhilfestatistik 1996-2006*. Bundesministerium für Soziales und Konsumentenschutz (several years), *Bericht des Arbeitskreises für Pflegevorsorge*. BMSK: Wien. Österle, A. & Bauer, G. (2012). 'Home care in Austria: the interplay of family orientation, cash for care and migrant care', *Health and Social Care in the Community* (doi: 10.1111/j.1365-2524.2011.01049.x)	Data refers to 60+ for both institutional (2006) and home care (2008). Recipients of residential care are those in old-people's homes and nursing homes (it may include disabled with less than 60 years). For the breakdown between cash and services at home we used estimates on total population covered by care services at home by Österle and Bauer (2012).
Belgium	OECD *Health Data*	Data refers to 60+ for both institutional (2010) and home care (2004).
Bulgaria	Chakraborty, S., Koettl, K. & Hafiz, A. (2010). *World Bank Report on Long-term Care – Case Studies – Bulgaria, Croatia, Latvia and Poland*. Europe and Central Asia Region Human Development Department/The World Bank: Washington.	Home care (2008). Data refers to total beneficiaries in institutional care (2007).
Canada	OECD *Health Data*. Canadian Community Health Survey (2003) in Carrière (2006). 'Seniors' use of home care', *Health Reports*, 17 (4).	Home care (2003); institutional care (2008).
Croatia	Chakraborty, S., Koettl, K. & Hafiz, A. (2010). *World Bank Report on Long-term Care – Case Studies – Bulgaria, Croatia, Latvia and Poland.* Europe and Central Asia Region Human Development Department/The World Bank: Washington.	Data refers to total beneficiaries in both institutional care (2007) and home care (2008).
Czech Republic	OECD *Health Data*	Home care (2009); institutional care (2009). Data is an estimate.
Denmark	OECD *Health Data*	Home care (2009); institutional care (2010).
Estonia	OECD *Health Data*	Home care (2009); institutional care (2009).
Finland	OECD *Health Data*	Home care (2009); institutional care (2009).
France	OECD *Health Data* Prévot, J. (2009). 'Les résidents des établissements d'hébergement pour personnes âgées en 2007', *Études et Résultats*, no. 699. DREES: Paris.	Institutional care (2007); data refers to 60+ for home care (2007). Percentage of population in respective age groups.
Germany	OECD *Health Data*. Statistisches Bundesamt (several years). *Pflegestatistik*. Statistisches Bundesamt: Wiesbaden. Federal Ministry of Health (2010). *Selected Facts and Figures about Long-Term Care Insurance* (07/09).	Home care (2009); institutional care (2009). Home care services result from applying the ratios of cash to services of Federal Ministry of Health (2010).
Hungary	OECD *Health Data*	Home care (2009); institutional care (2009).
Iceland	OECD *Health Data*	Home care (2009); institutional care (2009).
Ireland	OECD *Health Data*	Home care (2010); institutional care (2008).
Israel	OECD *Health Data*	Home care (2010); institutional care (2009).
Italy	OECD *Health Data* and ISTAT data accessed on 27.11.2011.	Home care (2008; 2009); institutional care (2006). For cash benefits figures are a conservative estimate of beneficiaries of *Indennitá di Accompagnamento* (2008) without beneficiaries of care services (2009) so as to avoid double counting.
Latvia	Statistics Latvia data accessed in 2010.	Data refers to total beneficiaries in both institutional care (2007) and home care (2007).
Lithuania	Statistics Lithuania, database accessed on 15.09.2011	Home care (2010); institutional care (2010).
Luxembourg	OECD *Health Data*. Ministère de la Sécurité Sociale (several years). *Rapport Général sur la Sécurité Sociale au Grand-Duché du Luxembourg*. Ministère de la Sécurité Sociale: Luxembourg.	Home care (2010); institutional care (2010). Figures for home and institutional care are an estimate. For cash benefits figures are for 2009.

Netherlands	OECD *Health Data*. Statistics Netherlands, *StatLine*, database accessed in 2008	Home care (2006); institutional care (2009). Data for home care includes only beneficiaries of the AWBZ.
Norway	OECD *Health Data*	Home care (2009); institutional care (2009).
Poland	OECD *Health Data* Wieckowska, B. (2011) Who Cares? The Institutional Framework for Long-term Care Social Care Benefits – National Report Poland. Paper prepared for the Local Government and Public Service Reform Initiative of the Open Society Institute.	Institutional care (2009). Data refers to total beneficiaries in home care (2008).
Portugal	Gabinete de Estratégia e Planeamento, Ministry of Social Solidarity and Labour	Data refers to total beneficiaries in both institutional care (2007) and home care (2007). Data does not include nursing homes under the Ministry of Health.
Romania	Popa, D. (2011). Long-term care Provision for the Elderly in Romania. Paper prepared for the Local Government and Public Service Reform Initiative of the Open Society Institute.	Institutional care (2009).
Russian Federation	Vasilchikov (2002). The System of Social Protection of Older People in the Russian Federation. International Seminar "Contribution of the NGO sector to work with the elderly population". Moscow. Andreeva, Y. (2011). Long-term Care Provision for the Elderly in Russia. Paper prepared for the Local Government and Public Service Reform Initiative of the Open Society Institute.	Institutional care (2008). Data refers to total beneficiaries in home care (2001). Data for institutional care refer only to number of beds in public institutions.
Serbia	Matkovic, G. (2011). Who Cares? The Institutional Framework for Long-term Care Social Care Benefits – National Report Serbia. Paper prepared for the Local Government and Public Service Reform Initiative of the Open Society Institute.	Home care (2010); institutional care (2010).
Slovakia	Repková, K. (2011). Who Cares? The Institutional Framework for Long-term Care Social Care Benefits – National Report Slovakia. Paper prepared for the Local Government and Public Service Reform Initiative of the Open Society Institute.	Institutional care (2009). Data refers to total beneficiaries in home care (2008).
Slovenia	OECD *Health Data*	Home care (2009); institutional care (2009).
Spain	OECD *Health Data*	Home care (2010); institutional care (2010).
Sweden	OECD *Health Data*. Data from the National Board of Health and Welfare	Home care (2008); institutional care (2008).
Switzerland	OECD *Health Data*	Home care (2009); institutional care (2009).
Ukraine	State Statistics Committee of Ukraine in WHO (2004). *Health Care Systems in Transition*. WHO (2002) *Case-study Ukraine*	Data refers to total beneficiaries in both institutional care (2000) and home care (2000). Institutional care was extrapolated from nursing home beds for the elderly and disabled per 1000 people.
United Kingdom	OECD *Health Data*. Community Care Statistics – RAP	Data refers to England only, including population data. Home care (2008); institutional care (2004). Possible double counting in home care beneficiaries.
United States	OECD *Health Data*	Home care (2007); institutional care (2004). Data for institutional care are an estimate.

Figure 7.5		
Country	**Detailed Source**	**Detailed Notes**
Armenia	National Statistic Service of the Republic of Armenia (2010), *Statistical Yearbook of Armenia*. National Statistic Service of the Republic of Armenia: Yerevan.	Data refers to total beneficiaries in percentage of 65+ population. Institutional care (1995 – 2009).
Austria	Statistik Austria (several years) *Sozialhilfestatistik 1996-2006*. Bundesministerium für Soziales und Konsumentenschutz (several years), *Bericht des Arbeitskreises für Pflegevorsorge*.	Data refers to 60+ for both institutional care (1996 – 2006). Recipients of residential care are those in old people's homes and nursing homes (it may include disabled with less than 60 years).
Belgium	OECD *Health Data*	Data refers to 60+ for institutional care (2000 – 2010).
Canada	Own calculations using data from The Home Care Sector Study Corporation (2003). *Canadian Home Care Human Resources Study*, and Statistics Canada, OECD Health Data, Canadian Community Health Survey (2003) in Carrière (2006). 'Seniors' use of home care' Health Reports, 17 (4).	Home care (1994 – 2003); institutional care (1997 – 2008). Possible inconsistency of methodology over time cannot be ruled out.
Estonia	OECD *Health Data*. Statistics Bureau of Estonia, data accessed on 22.08.2011.	Institutional care (1998 – 2009). Possible inconsistency of methodology over time cannot be ruled out.
Finland	OECD *Health Data*	Home care (2000 – 2009); institutional care (2000 – 2009).
France	Tugores, F. (2006). 'La clientele des établissements d'hébergement pour personnes âgées', *Études et Résultats*, no. 485. DREES: Paris. Prévot, J. (2009). 'Les résidents des établissements d'hébergement pour personnes âgées en 2007', *Études et Résultats*, no. 699. DREES: Paris.	Institutional care (1994 – 2007).
Germany	OECD *Health Data*	Home care (1997 – 2009); institutional care (1997 – 2009).
Iceland	NOSOSCO (1999) *Social Protection in the Nordic Countries*. NOSOSCO: Copenhagen. OECD *Health Data*	Home care (1998 – 2009); institutional care (2000 – 2009). Possible inconsistency of methodology over time cannot be ruled out for home care.
Italy	OECD *Health Data*. Ministry of Health (several years) *Annuario Statistico del Servizio Sanitario Nazionale*. ISTAT data accessed on 27.11.2011.	Home care services (1999 – 2009); home care cash (2001 – 2008); institutional care (1997 – 2006). For cash benefits, figures refer to beneficiaries of *Indennitá di Accompagnamento* without removing beneficiaries of home care services. Possible inconsistency of methodology over time cannot be ruled out for home care services.
Latvia	Statistics Latvia data accessed in 2010.	Data refers to total beneficiaries in both institutional care (1995 – 2007) and home care (1997 – 2007).
Lithuania	Statistics Lithuania, database accessed in 15.09.2011	Home care (2000 – 2010); institutional care (2000 – 2010).
Luxembourg	OECD *Health Data*	Home care (2000 – 2010); institutional care (2000 – 2010).
Norway	OECD *Health Data*. Statistics Norway	Home care (2000 – 2009); institutional care (1993 – 2009). Possible inconsistency of methodology over time cannot be ruled out for institutional care. Data refers to 67+ for institutional care (1993).
Sweden	OECD *Health Data* Data from the National Board of Health and Welfare. NOSOSCO (several years). *Social Protection in the Nordic Countries*. NOSOSCO: Copenhagen	Home care (1998 – 2008); institutional care (1995 – 2008).
Switzerland	OECD *Health Data*	Home care (1997 – 2009); institutional care (2000 – 2009).
United Kingdom	Community Care Statistics – RAP	Data refers to England only, including population data. Home care (2000 – 2008). Possible double counting in home care beneficiaries, albeit consistent over time.
United States	OECD *Health Data*. National Centre for Health Statistics *National Home and Hospice Care Data and National Nursing Home Survey*	Home care (1994 – 2007); institutional care (1995 – 2004). Data for institutional care are an estimate (2004). Possible inconsistency of methodology over time cannot be ruled out.

Figures 7.7 and 7.8		
Country	**Detailed Source**	**Detailed Notes**
Austria	OECD *Health Data*	Home care (2008). Home care includes services and cash.
Belgium	OECD *Health Data*	Home care (2004). Data refers to 60+ institutional care (2010).
Canada	OECD *Health Data*. Canadian Community Health Survey (2003) in Carrière (2006). 'Seniors' use of home care' *Health Reports*, 17 (4).	Home care (2004); institutional care (2008).
Czech Republic	OECD *Health Data*	Home care (2009); institutional care (2009). Data is an estimate.
Denmark	OECD *Health Data*	Home care (2009); institutional care (2010).
Estonia	OECD *Health Data*	Home care (2009); institutional care (2009).
Finland	OECD *Health Data*	Home care (2009); institutional care (2009).
France	OECD *Health Data*. Prévot, J. (2009). 'Les résidents des établissements d'hébergement pour personnes âgées en 2007', *Études et Résultats*, no. 699. DREES: Paris.	Home care (2009); institutional care (2007).
Germany	OECD *Health Data*	Home care (2009); institutional care (2009). Home care includes services and cash.
Hungary	OECD *Health Data*	Home care (2009); institutional care (2009).
Iceland	OECD *Health Data*	Home care (2010); institutional care (2009).
Ireland	OECD *Health Data*	Home care (2008).
Israel	OECD *Health Data*	Home care (2010); institutional care (2009).
Italy	OECD *Health Data*. Ministry of Health (several years) *Annuario Statistico del Servizio Sanitario Nazionale*. ISTAT data accessed on 27.11.2011	Home care (2005; 2008); institutional care (2006) For cash benefits, figures for *Indennitá di Accompagnamento* (2005) may include beneficiaries of care services (*Assistenza Domiciliare Integrate*).
Lithuania	Statistics Lithuania, database accessed on 15.09.2011	Institutional care (2010).
Luxembourg	OECD *Health Data*	Home care (2010); institutional care (2010).
Netherlands	OECD *Health Data*. Statistics Netherlands, *StatLine*, database accessed in 2008	Home care (2006); institutional care (2009). Data for home care includes only beneficiaries of the AWBZ.
Norway	OECD *Health Data*	Home care (2009); institutional care (2009).
Poland	OECD *Health Data*	Institutional care (2009).
Slovenia	OECD *Health Data*	Home care (2009); institutional care (2009).
Spain	OECD *Health Data*	Home care (2010); institutional care (2010).
Sweden	OECD *Health Data*	Home care (2008); institutional care (2008). Data for home care is not comparable with that of Figure 7.1 (see table in this annex).
Switzerland	OECD *Health Data*	Home care (2009); institutional care (2009).
United Kingdom	Community Care Statistics – RAP and Supported Residents (Adults).	Data refers to England only, including population data. Home care (2008); institutional care (2008). Home care included only beneficiaries of home-care and direct payments receiving community-based services (not comparable with Figure 7.1 – see table in this annex). Institutional care refers to council supported residents of registered care homes (independent sector and local authorities) (not comparable with Figure 7.1 – see table in this annex).
United States	OECD *Health Data*. National Centre for Health Statistics (2005) *National Nursing Home Survey*.	Home care (2007); institutional care (2004). Data for institutional care includes short-term stays (< 3 months).

Figures 7.9 and 7.10		
Country	**Detailed Source**	**Detailed Notes**
Armenia	National Statistic Service of the Republic of Armenia (2010), *Statistical Yearbook of Armenia*. National Statistic Service of the Republic of Armenia: Yerevan.	Data refers to total beneficiaries in percentage of 65+ population. Institutional care (2007).
Canada	OECD *Health Data*. Canadian Community Health Survey (2003) in Carrière (2006). 'Seniors' use of home care', *Health Reports*, 17 (4).	Home care (2003); institutional care (2008).
Czech Republic	OECD *Health Data*	Home care (2009); institutional care (2009). Data is an estimate.
Denmark	OECD *Health Data*	Home care (2009); institutional care (2010).
Estonia	OECD *Health Data*	Home care (2009); institutional care (2009).
Finland	OECD *Health Data*	Home care (2009); institutional care (2009).
France	OECD *Health Data*. Prévot, J. (2009). 'Les résidents des établissements d'hébergement pour personnes âgées en 2007', *Études et Résultats*, no. 699. DREES: Paris.	Home care (2009); institutional care (2007).
Germany	OECD *Health Data*	Home care (2009); institutional care (2009).
Hungary	OECD *Health Data*	Home care (2009); institutional care (2009).
Iceland	OECD *Health Data*	Institutional care (2009).
Ireland	OECD *Health Data*	Institutional care (2008).
Israel	OECD *Health Data*	Home care (2010); institutional care (2009).
Italy	ISTAT (2009) *I trattamenti pensionistici*. ISTAT data accessed on 27.11.2011	Home care (2008); institutional care (2006). Home care refers to beneficiaries of *Indennitá di Accompagnamento* without removing beneficiaries of home care services.
Lithuania	Statistics Lithuania, database accessed in 15.09.2011	Home care (2007); institutional care (2010).
Luxembourg	OECD *Health Data*	Home care (2010); institutional care (2010).
Norway	OECD *Health Data*	Home care (2009); institutional care (2009).
Netherlands	OECD *Health Data*	Home care (2009); institutional care (2009). Data for home care is not comparable with that of Figure 7.1 (see table in this annex)
Poland	OECD *Health Data*	Home care (2006); institutional care (2009).
Slovakia	Statistical Office of the Slovak Republic (2007). *Women and Men of the Slovak Republic in the EU*. Statistical Office of the Slovak Republic: Bratislava.	Institutional care (2005). Data refers to total beneficiaries.
Slovenia	OECD *Health Data*	Institutional care (2009).
Spain	OECD *Health Data*	Home care (2010); institutional care (2010).
Sweden	OECD *Health Data*	Home care (2007); institutional care (2008). Data for home care is not comparable with that of Figure 7.1 (see table in this annex).
Switzerland	OECD *Health Data*	Institutional care (2009).
United States	OECD *Health Data*	Home care (2007); institutional care (2003).

Figures 7.11a and 7.11b		
Country	**Detailed Source**	**Detailed Notes**
Austria	Own calculations based on BMSK (2008). *Österreichischer Pflegevorsorgebericht 2007*. BMSK: Wien.	Data for 2007.
Bulgaria	Chakraborty, S., Koettl, K. & Hafiz, A. (2010). *World Bank Report on Long-term Care – Case Studies – Bulgaria, Croatia, Latvia and Poland*. Europe and Central Asia Region Human Development Department/The World Bank: Washington.	Data for 2008. Figures refer to home care only.
Belgium	OECD *Health Data*	Data for 2009.
Croatia	Chakraborty, S., Koettl, K. & Hafiz, A. (2010). *World Bank Report on Long–term Care – Case Studies – Bulgaria, Croatia, Latvia and Poland*. Europe and Central Asia Region Human Development Department/The World Bank: Washington.	Number of employees for institutional and non-institutional programmes for the elderly. Data for 2007.
Czech Republic	OECD *Health Data*	Data for 2009.
Denmark	Statistics Denmark	Total number employed in municipal elderly care (including those not directly involved in caring). Data for 2009.
Estonia	OECD *Health Data*	Data for 2009.
Finland	SOTKAnet database accessed on 07.10.2011	Institutional care and home-help services for older people. Data for 2004.
France	Marquier, R. (2010). 'Les activités des aides à domicile en 2008', *Études et Résultats*, no. 741. DREES: Paris. Tugores, F. (2006). 'La clientele des établissements d'hébergement pour personnes âgées', *Études et Résultats*, no. 485. DREES: Paris.	
Germany	Statistisches Bundesamt (2011). *Pflegestatistik 2009*. Statistisches Bundesamt: Wiesbaden.	Data for 2009.
Greece	Simonazzi (2009). 'Care regimes and national employment models', *Cambridge Journal of Economics*, 33 (2): 211-232, Table 5.	Total employment in the social care sector. Data for 2001.
Italy	Simonazzi (2009). 'Care regimes and national employment models', *Cambridge Journal of Economics*, 33(2): 211-232, Table 5.	Total employment in the social care sector. Data for 2003.
Luxembourg	Ministére de la Securité Sociale	Figures expressed in full-time equivalent. Data for 2008.
Netherlands	OECD *Health Data*	Data for 2009.
Norway	Statistics Norway	Figures expressed in full-time equivalent. Data for 2009.
Slovakia	OECD *Health Data*	Data for 2009.
Slovenia	Statistics Slovenia (2009) *Statistical Yearbook of Slovenia 2009*	Social and health care personal working in institutions. Data for 2009.
Spain	OECD *Health Data*	Data for 2009.
Sweden	SALAR (2007). *Developments in Elderly Policy in Sweden*. SALAR: Stockholm..	Employed in medical and social services for old-age people in the local authorities. Data for 2007.
Switzerland	Office Fédéral de la Statistique (2010). *Statistique de l'aide et des soins à domicilie 2009*. OFS: Neuchâtel. Office Fédéral de la Statistique, Statistique des institutions médico-sociales, data accessed on 07.10.2011.	Includes personal providing care to those aged less than 65. Data for 2009.

Figures 8.1, 8.2, 8.3, 8.4a and 8.4b		
Country	**Detailed Source**	**Detailed Notes**
Austria	Own calculations based on data from the BMSK (2008). *Österreichischer Pflegevorsorgebericht 2007*. BMSK: Wien. Statistik Austria.	Data includes expenditure at the federal and regional level. Home care refers to the LTC allowance net of payments for home and institutional care plus home care services (that includes payments from cash allowance); institutional care refers to institutional in-kind plus payments from cash allowance. May include public expenditure with those younger than 60 years old. Data refer to 2008.
Belgium	OECD *Health Data*	Data refer to 2009.
Bulgaria	ECFIN (2009). *The 2009 Ageing Report: Economic and Budgetary projections for the 27 EU Member States (2009-2060).* European Economy, 2, European Commission: Brussels.	Data refer to 2007. Disaggregations of home and institutional care are an estimate.
Canada	OECD *Health Data*	Data refer to 2009.
Czech Republic	OECD (2011) *Help Wanted? Providing and Paying for Long-term Care*. OECD: Paris.	Data refer to 2008 and are an estimate.
Denmark	OECD *Health Data*	Data refer to 2009.
Finland	OECD *Health Data*	Data refer to 2009. Total results from sum of SHA categories "In-patient long-term nursing care", "Long-term nursing care: home care" and "Social services of LTC (LTC other than HC.3)". The latter category could not be allocated to home or institutional care.
France	OECD *Health Data*	Data refer to 2009. Total results from sum of SHA categories "In-patient long-term nursing care", "Long-term nursing care: home care" and "Social services of LTC (LTC other than HC.3)". The latter category could not be allocated to home or institutional care.
Germany	OECD *Health Data*	Data refer to 2009.
Hungary	OECD *Health Data*	Data refer to 2009.
Iceland	Eurostat ESSPROS	Data refer to 2005.
Italy	Ministero dell'Economia e delle Finanze (2009) *Le tendenze di medio-lungo periodo del sistema pensionistico e sanitário*.	Data refer to 2008. It includes those younger than 65.
Latvia	Data provided directly by the Social Service Board, Ministry of Welfare of Latvia	Data refer to 2008.
Lithuania	Eurostat ESSPROS	Data refer to 2005.
Luxembourg	OECD *Health Data*	Data refer to 2008.
Netherlands	OECD (2011) *Help Wanted? Providing and Paying for Long-term Care*. OECD: Paris.	Data refer to 2008.
Norway	Eurostat ESSPROS	Data refer to 2005.
Poland	Wieckowska, B. (2010). Long-term financing – the case of Poland. Presented at "Long-term care in Europe – discussing trends and relevant views", Budapest, February. Available at: http://www.euro.centre.org/data/1267718533_34607.pdf, accessed on 19.10.2012.	Data refer to 2008.
Portugal	OECD *Health Data*	Data refer to 2007.
Romania	Popa, D. (2011). Long-term care Provision for the Elderly in Romania. Paper prepared for the Local Government and Public Service Reform Initiative of the Open Society Institute.	Data refer to 2008.
Serbia	Matkovic, G. (2011). Who Cares? The Institutional Framework for Long-term Care Social Care Benefits – National Report Serbia. Paper prepared for the Local Government and Public Service Reform Initiative of the Open Society Institute.	Data refer to 2010. Public expenditure with health care is not included.
Slovakia	Bednárik, R., Brichtová, L. & Repková, K. (2010). INTERLINKS *WP6 Governance and finance. Slovak national report*. IVPR: Bratislava.	Data refers to 2008.

Slovenia	OECD *Health Data*	Data refer to 2009.
Spain	OECD *Health Data*	Data refer to 2009.
Sweden	OECD (2011) *Help Wanted? Providing and Paying for Long-term Care*. OECD: Paris. SALAR (2009). *Developments in Elderly Care in Sweden 2009*. SALAR: Stockholm.	Data refers to 2008. Disaggregations of home and institutional care are an estimate.
Switzerland	OECD *Health Data*	Data refer to 2009.
United Kingdom	Wanless, D. (2006) *Securing good care for older people: Taking a long-term view*. King Fund: London.	Data refer to 2005. Data refer to England only, including GDP, and for old-age.
United States	Own calculations based on information from Centres for Medicare & Medicare Services and Office of the Actuary	Data refer to 2006. Home and institutional care breakdowns refer to nursing health and nursing home care respectively. Includes Medicare, Medicaid and other benefits on the Federal, State and local level.

LIST OF COUNTRY ACRONYMS

List of country acronyms

ISO code	Country
ALB	Albania
ARM	Armenia
AUT	Austria
AZE	Azerbaijan
BEL	Belgium
BGR	Bulgaria
BIH	Bosnia and Herzegovina
BLR	Belarus
CAN	Canada
CHE	Switzerland
CYP	Cyprus
CZE	Czech Republic
DEU	Germany
DNK	Denmark
ESP	Spain
EST	Estonia
FIN	Finland
FRA	France
GBR	United Kingdom
GEO	Georgia
GRC	Greece
HRV	Croatia
HUN	Hungary
IRL	Ireland
ISL	Iceland
ISR	Israel

ISO code	Country
ITA	Italy
KAZ	Kazakhstan
KGZ	Kyrgyzstan
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MDA	Republic of Moldova
MKD	TFYR Macedonia
MLT	Malta
MNE	Montenegro
NLD	Netherlands
NOR	Norway
POL	Poland
PRT	Portugal
ROM	Romania
RUS	Russian Federation
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
TJK	Tajikistan
TKM	Turkmenistan
TUR	Turkey
UKR	Ukraine
USA	United States of America
UZB	Uzbekistan