

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

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*IMA Microsimulation World Congress  
Stakeholder Meeting JPI WellCARE Project  
10 January 2024*

# Objectives

- Setting the stage for **dynamic microsimulation projections**:
  - Providing analytical framework to understand **features and vulnerabilities** of different care systems
  - Examining factors influencing current care demand and its fulfillment and **salient issues to be addressed with the model-based projections**.
- Particular attention to how different care systems and policies influence **size and composition of the caregiving groups** in society:
  - **Formal-informal care mix, gender differences** and role of **migration**
  - Implications for **employment** and the LTC **labour market**

# The “Care Regimes” Literature

- **Comparative LTC literature**, different strands going back to 1990s:
  1. Early literature with **broad approach**, encompassing different forms of care/social **SERVICES** (Anttonen and Sipilä, 1996; Kautto, 2002; Leitner, 2003; Bettio and Plantenga, 2004).
  2. Studies with specific **focus on LTC regimes** (mainly for age groups 65+) (Kraus et al., 2010; Damiani et al., 2011; Halásková et al., 2017; Ariaans et al., 2021; Pavolini 2021)
  3. Comparative research on **specific features of LTC systems**, f.i. role of cash-for-care schemes or the link between care work and migration (van Hooren, 2012; Ranci et al., 2019)
- Large number of different approaches and diverse set of countries/time periods -> **no simple, clear systematization possible**

# The “Care Regimes” Literature

- Choice of **criteria and indicators** to describe systems necessarily reflects a particular perspective and line of research
- Main dimensions used in the literature:
  - **Financing** (taxes vs insurance, public vs private...)
  - **Regulations** (coverage and entitlement)
  - **Supply of care** (particularly formal/informal mix)
- **Comparatively little attention** on output indicators for **situation of caregivers** and systemic implications for their employment perspectives and **LTC labour market**

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

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

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

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

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

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

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

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



# Demographic risks in a nutshell

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

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

Source: OECD Database, Population Projections

# Health risks

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

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

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

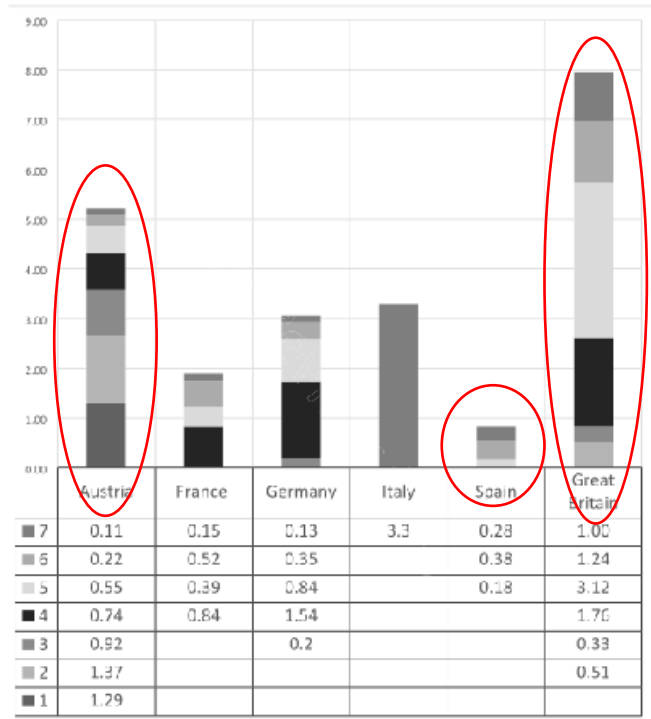
# Macroeconomic relevance and financing LTC

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

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

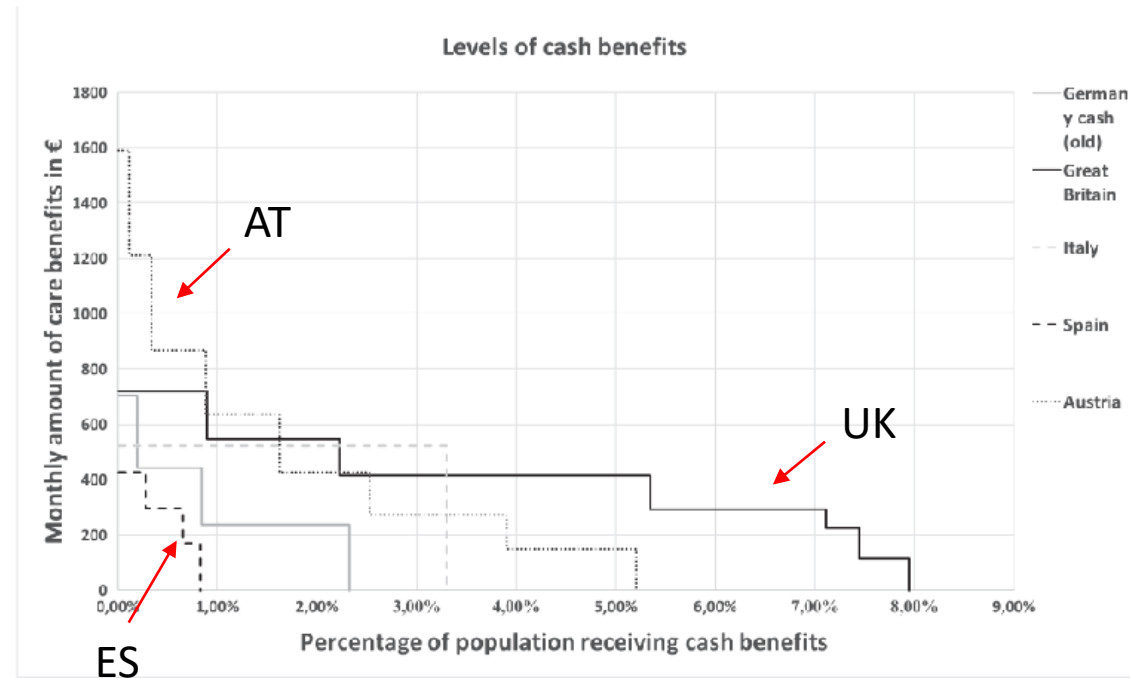
- Higher public LTC spending in UK and Austria than in Spain
- All countries finance the public LTC spending through taxes (no public insurance system)

# Cash-for-care systems



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

Ranci et al. 2019



**FIGURE 3** Coverage rates and amount of benefits of cash-based programmes by disability classes

Source: Own elaboration on national data.  
 Note: Amounts adjusted by PPPs (1 = EU28), 2015 values except for Spain (2018). Year: 2015, except for France (2016) and Spain (2018). Number of beneficiaries divided by total population (also for France, where the APA is restricted to population aged 60 or more)

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

# LTC basic regulation and benefits

	Austria	England	Spain
Main forms of support	<ul style="list-style-type: none"> <li>LTC allowance: 7 levels (needs-tested) (federal state)</li> <li>Support for LTC services (means- and needs-tested) (regions)</li> <li>Financial support for live-in carers (federal state)</li> </ul>	<ul style="list-style-type: none"> <li>NHS funds LTC for „complex health needs“ (not social care)</li> <li>Attendance allowance or Personal Independence Payments (needs tested)</li> <li>Carers allowance (needs tested)</li> <li>Support for LTC services by local authorities (means- and needs-tested)</li> </ul>	<ul style="list-style-type: none"> <li>Assessment: 3 levels, individual care plan</li> <li>If LTC services cannot be provided -&gt; cash benefits</li> <li>40-50% receive cash benefit</li> </ul>
LTC providers	Not-for-profit, for-profit and public providers	Mostly privately owned providers	Residential care predominantly for-profit private providers, home care: public and private providers
Noteworthy	No wealth-test for institutional care (only income)	Support for LTC services subject to a very low wealth threshold (planned to be changed in 10/2025)	Budget cuts due to austerity policy led to a long waiting list for LTC services

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

# Distribution of public expenditure for LTC services

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

➤ More resources on institutional care, especially in Austria

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

# Commodification - Types of care (65+)

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

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

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

# Unmet LTC needs

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

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

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



# Gendered LTC

	Austria	UK	Spain
<b>Informal caregivers: Share women</b>	(73%)	58%	58%
<b>Formal caregivers: Share women (2021)</b>	87%	83%	81%

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

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

# Support for informal caregivers

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

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

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

# LTC Labour market

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

Sources: OECD Beyond Applaus? (2023)

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

# Conclusions /I

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

# Conclusions /II

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