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Special issue: The human right to long-term care for the elderly: Extending the role of social security programmes

issa

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Special issue: The human right to long-term care for the elderly: Extending the role of social security programmes

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Foreword

The content of this special double issue, *The human right to long-term care for the elderly: Extending the role of social security programmes*, talks to current debates on social security coverage in a context of population ageing. It addresses the challenge of how to sustainably provide affordable and adequate access to quality long-term medical and social care for the world's growing elderly population.

While population ageing is more advanced in certain countries, the transition will affect all countries, and the future pace of this demographic transition is projected to be more rapid in those countries whose populations are currently relatively younger. In most cases, these are lower- and middle-income countries without comprehensive systems of social protection. Regardless, for all societies to adequately meet the medical and social care needs of a growing elderly population, the articles in this special double issue set out the demographic, financial, institutional, regulatory, administrative and labour market challenges to be surmounted in the coming years and decades. For each country, the key questions to be addressed are the roles that social security systems can and should play in helping to meet the long-term medical and social care needs of elders.

The International Social Security Association (ISSA) global online "Country profiles" database of national social security provisions offers concise empirical reporting of over 180 countries and territories. Its contents reveal that few are those countries that provide social insurance coverage to elders to address the medical and social care risks associated with the contingency of long-term care. With this observation to the fore, this special double issue seeks to make an important contribution to knowledge regarding the broader questions of social security coverage, social and economic inclusion and programme resilience in the context of population ageing.

The content of this special double issue thereby complements the broad range of ISSA knowledge produced during the triennium 2020–2022 in pursuing our triennial priority of meeting the social security needs of ageing populations. This includes the 2021 ISSA report, *Long-term care: Global efforts and international attention from the health perspective*, a series of webinars bringing together experiences of international organizations and ISSA member organizations, and analytical articles published on the ISSA website.

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This knowledge and its dissemination will be instrumental to support the operational objectives of ISSA member organizations. It will not only accompany and stimulate the debates at the ISSA 2022 World Social Security Forum in Morocco, but also constitute the basis for further analysis and knowledge production during the triennium 2023–2025, possibly including ISSA Guidelines on the implementation of long-term care.

Marcelo Abi-Ramia Caetano
Secretary General
International Social Security Association

Introduction: Making the case to formally revise the international social security standards to include long-term care for the elderly

Roddy McKinnon

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Abstract First published in April 1948 as the *Bulletin of the International Social Security Association*, this year marks the 75th anniversary of what, since January 1967, we have all come to know as the *International Social Security Review*. To mark this important anniversary, this special double issue, "The human right to long-term care for the elderly: Extending the role of social security programmes", talks to current debates on social security coverage extension in a context of population ageing. There is a case to be made for revising the international social security standards to formally recognize long-term care for the elderly, possibly as a distinct branch of social security. At the heart of this discussion, the questions to be addressed by all countries are the roles that social security systems can and should play in helping to meet the long-term medical and social care needs of elders.

Keywords long term care, ageing population, coverage, social security scheme, ILO Convention, international

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Introduction

Framed by the global trend in population ageing and the ambition of the international community to progressively extend and improve social security coverage, this special double issue of the *International Social Security Review* selectively addresses the important topic of "The human right to long-term care for the elderly: Extending the role of social security programmes". The aim is to address the challenge of how to sustainably extend social security coverage to provide affordable and adequate access to quality medical and social care for the world's growing elderly population.

Making the case for long-term medical and social care for the elderly

The motivation for the development of this special double issue is anchored firmly on the assumption that social security systems are a legitimate mechanism for addressing the long-term medical and social care needs of a growing elderly population. This assumption is not as banal as it may appear. "Long-term care" does not feature in the international minimum social security standards, as set out 70 years ago in the International Labour Organization (ILO) Convention on Social Security (Minimum Standards), 1952 (No. 102). Over the recent decades, only a limited number of countries have added "long-term care" as a new branch to their national social security systems.

It is therefore as a deliberate act of faith and ambition that this introduction calls for consideration to be given to formally commence the process to revise and extend the international social security standards, to include long-term medical and social care for the elderly, possibly as a recognized tenth branch of social security.[1] In the first instance, such a process would take many years to complete, possibly up to a decade, and thereafter perhaps a further decade to revise and align the wider corpus of the international social security standards. This call is directed specifically at the ILO Governing Body and the ILO's tripartite Standard Review Mechanism, with the objective that this may be achieved through the formal revision of an existing standard or the adoption of a

1. The ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), establishes minimum standards for nine branches of social security: i) medical care; ii) sickness benefit; iii) unemployment benefit; iv) old-age benefit; v) employment injury benefit; vi) family benefit; vii) maternity benefit; viii) invalidity benefit; and ix) survivors' benefit.

new standard by the International Labour Conference.[2] Success in this regard will be a matter of political will, and is dependent on the commitment and vision of ILO constituents and staff, as well as of others, who may be willing to champion this agenda.

There are numerous precedents of the revision of ILO standards, including the international social security standards. Of note, over the last decades, numerous examples of the revision of the latter have sought to "deepen the 'vertical level' of individual protection for specific contingencies to those who could be covered by traditional social security schemes. Typically, they did not seek "to extend coverage 'horizontally' to people that were left so far without protection" (Cichon, 2013, p. 25). In the light of this historical reality, the importance that is attributed to the years of hard work that led to the success achieved a decade ago, in making the case for horizontal coverage extension by securing the adoption of the Recommendation on Social Protection Floors, 2012 (No. 202), can be more readily and fully understood.

However, as voluntary legal instruments, the ILO social security standards can be considered as "relatively weak instruments of global social governance" (Cichon, 2013, p. 25). Nevertheless, their strength lies with the recognition that "the body of up-to-date social security standards remains the only set of globally accepted social security benefit standards and the only global comprehensive legal reference framework for governments, social partners and other interest groups. Without these standards national benefit provisions could not be globally benchmarked, and the adequacy of national provisions could not be judged by national advocacy groups" (Cichon, 2013, p. 26). It needs no reminding that the absence of such a global "benchmark" is precisely the situation that confronts the current provision of long-term medical and social care for the elderly.

The human rights argument

To make the case for such a benchmark, let us first consider the human rights argument – the philosophical and legal point of departure – in favour of formally extending the international social security standards to include long-term medical and social care, possibly as a recognized branch of social security.

The United Nations Universal Declaration of Human Rights of 1948, Article 22, is unequivocal as regards the inalienable human right to social security: "Everyone,

2. The web portal of the International Labour Organization provides a full explanation and examples of the formal process with regard to seeking the adoption of the "Revision" of an existing standard by the International Labour Conference, highlighting differences as these apply to Conventions and Recommendations.

as a member of society, has the right to social security". In turn, the International Covenant on Economic, Social and Cultural Rights of 1966 affirms in Article 9: "The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance". The United Nations Sustainable Development Goal target 1.3 commits to progressively realize the human right to social security: "implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable". The practical pursuit of the human right to social security for all is guided by the international social security standards, most prominent amongst which are the relevant Conventions and Recommendations of the International Labour Organization (ILO).[3]

Of course, the realization of the human right to social security "for all" remains work in progress. As the ILO report, in 2020 and excluding health care and sickness benefits, "only 46.9 per cent of the global population were effectively covered by at least one social protection benefit" (ILO, 2022, p. 19).

This begs a first obvious question. Given the global reality of low levels of coverage, why should a case be made for priority to be given to long-term medical and social care?

The honest response to this is that the long-term care coverage challenge is indeed only one priority amongst others. When compared with other areas identified also as requiring action on social security coverage extension, the distinguishing factor, as we have outlined, is that there is no international social security standard to help guide the development and expansion of coverage for long-term care. In this regard, as a proposed aspirant branch of social security, the current ambition to develop long-term care programmes and extend their coverage is uniquely disadvantaged. Only once the question concerning a social security standard has been addressed may it be possible for countries with ageing populations to more readily resolve the other important technical, financial, regulatory, administrative and workforce challenges that sit in the pathway to driving forward coordinated access to adequate and quality long-term medical and social care systems.

No less important, and beyond a host of desired social outcomes bound tightly to the necessary realization of human rights and social justice,[4] the case for extending coverage for long-term care is supported by economic arguments. The

3. For a fuller discussion of these issues, see Hujo, Behrendt and McKinnon (2017).

4. For instance, issues of improved levels of individual social protection and well-being, strengthened social cohesion and social inclusion, reduced perceptions of stigma and shame, and the regulation and enforcement of rights to ensure elders are treated with dignity and respect as well as to prevent the neglect and abuse of vulnerable people who require or receive care. Also important is the social protection and well-being of the care workforce – informal and formal carers alike.

expansion of formal responses to meet the needs for long-term medical and social care can be expected to result in improved levels of productive employment, with higher levels of formalized employment and decent work – and thus a relative reduced dependence on high levels of informal, untrained and unregulated care provision – and growth in the professional care workforce. It should support the improved social and economic inclusion of women, as well as migrant care workers – in all countries, the gendered nature of care provision is acknowledged. As such, adopting a gender-transformative approach is deemed essential. Generally, the expansion of regulated formal care provision should support higher levels of contributory social security coverage, higher levels of social security contributions and improved levels of social protection for the care workforce in all its diverse forms.

Long-term medical and social care for the elderly

A second question is why to prioritize long-term medical and social care for the elderly?

The United Nations has reported that "life expectancy at birth for the world, which increased from 64.2 years in 1990 to 72.6 years in 2019, is expected to increase further to 77.1 years in 2050". Moreover, "by 2050, one in six people in the world will be over age 65 (16 per cent), up from one in 11 in 2019 (9 per cent). In turn, "the potential support ratio, which compares numbers of working-age people aged 25-64 to those over age 65, is falling around the world" (UNDESA, 2019, pp. 1–2).

With reference to these demographic trends, and as the contributions to this special issue draw attention to, there is a growing urgency to coordinate policy responses capable of addressing the care needs presented by the unprecedented scale and pace of global population ageing, including the increasing numbers of those aged 85+. This political priority comes from a recognition of the increasing medical and social vulnerability of greater number of elders, as it does from an acknowledgement of the evolving nature of the family, household structures and traditional forms of care in the community. To an important degree, the political impetus for action is encapsulated by the United Nations Decade of Healthy Ageing (2021–2030), which seeks the realization of "concerted, catalytic and collaborative action to improve the lives of older people, their families, and their communities".[5]

It also comes from fluid societal expectations of what should constitute adequate and quality care. One aspect of this is the contested debate in some Member countries of the Organization for Economic Cooperation and Development concerning the perceived risk of a future care "mismatch" resulting from a

5. See the Decade of Healthy Ageing platform.

misplaced expectation that care strategies centred upon "ageing in place"[6] can satisfactorily, in every instance, substitute for the need for residential long-term care for a growing elderly population with cognitive as well as somatic disabilities (Alders and Schut, 2019).

The reality of this debate is more nuanced. Indeed, and regardless of a growing voiced preference by elders for, and wider recognition of the perceived benefits for personal well-being resulting from, ageing in place, anecdotal evidence shows that even those elderly people who can live independently are likely to be confronted, from time to time, with a need for periods of residential care, with a view to returning home thereafter when appropriate to do so. Thus, in all instances, the continuum of care should not be considered in simplistic terms as a linear and unidirectional process, from a state of relative independence at home to dependent residential care. Furthermore, it should be possible for elderly persons who receive care at home from informal carers, typically family members, to enter formal residential care for short periods, to permit respite for the primary carer. As such, to ensure adequate and quality care for the elderly, the care continuum, which necessitates a variety of coordinated institutional actors, should consider the physical and mental well-being of all carers too, including – perhaps, especially – informal primary carers. As part of coordinated care systems, and to support primary informal carers specifically, social protection systems should also consider aiming to cover not only the cost of periodic formal residential care to permit periods of respite for the primary carer, but also provide credited contribution periods and, where possible, cash benefits for the primary carer, including during respite periods.

What do we know and how can this knowledge be shared?

Placing aside momentarily the longer-term objective to make the case for revising and extending the international social security standards to include long-term medical and social care for the elderly, the immediate objectives of this special double issue are twofold.

First, it seeks to map out what we already know about i) the challenges presented by population ageing for the long-term medical and social care needs of a growing elderly population and ii) the scale, scope, coordination and regulatory oversight of the mechanisms of current care responses (the family/community, the private sector, non-profit organizations and the State) to meet these needs in a manner that permits a continuum of care.

6. Wiles et al. (2012) discuss in detail the meaning of ageing in place to older people, suggesting that this may include, in addition to the home, places to which older people are emotionally attached or familiar with or have a social connection.

Second, it seeks to identify in which ways, and inform about how, social security programmes can better contribute to the sustainable development of coordinated national systems of long-term medical and social care for the elderly. As such, the content of this issue seeks to contribute to the process of policy learning and knowledge sharing in this field, not least for the member organizations of the International Social Security Association (ISSA) as well as the ISSA's partner organizations, policy-makers, practitioners and academia.

We know that population ageing (defined by measures of declining rates of fertility and increasing longevity)[7] is more advanced in certain countries. We also know that the demographic transition will affect all countries, and the future pace of this transition is projected to be more rapid in those countries whose populations are currently relatively younger. In most cases, these are lower- and middle-income countries without comprehensive systems of social protection and coverage.

As discussed, the human right to social security is anchored in international social security standards and international legal instruments. As previously stated, the human right to income security for elders is equally well defined, not least so by ILO Recommendation No. 202 (para. 5(d)). However, the right to long-term care for the elderly is not defined as part of the international social security standards per se.

Of course, the human right to essential health care is very well defined (UN, 2000). Moreover, in Part II of the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), which addresses Medical Care, reference is given to the expectation that although medical benefits are normally awarded for a predetermined duration they may be "extended for prescribed diseases recognized as entailing prolonged care" (article 12). The important semantic question is whether the notion of prolonged care set out in 1952 is synonymous with the notion of long-term medical as well as social care as understood in 2022. This may be worthy of reflection by the ILO and its constituents.

Factually, and a starting point for knowledge sharing concerning the focus of this special issue, as reported in the ISSA's global "Country profiles" database of national social security provisions and legislation, only a small number of countries include the right to long-term care as part of the right to social security.

At the regional level, the European Union (EU) is driving this issue forward. One of the 20 principles that comprise the European Commission's European Pillar of Social Rights defines long-term care as a goal for EU Member States to achieve by 2030, on the grounds that everyone "has the right to affordable

7. A further factor to consider is the net migration rate, the difference between the number of emigrants and immigrants.

long-term care services of good quality, in particular home-care and community-based services" (European Commission, 2021).

At the international level, the adoption of ILO Recommendation on Social Protection Floors, 2012 (No. 202), represents an important, albeit implicit, shift in perspective. As an international declaration of intent for coverage extension, unanimously adopted by 185 member States of the ILO (Hagemejer and McKinnon, 2013, p. 11), the Recommendation sets out in very broad terms the road map necessary to enable the future development and sustainable extension of social protection, to "progressively ensure higher levels of social security to as many people as possible" (para. 1(b)). The ambition of the Recommendation to extend coverage is boundless and thus should encompass long-term care programmes anchored in national social security legislation. However, also in paragraph 1(b), the Recommendation equally asserts that "strategies for the extension of social security" be "guided by ILO social security standards". As mentioned, the current ILO standards make no direct reference to long-term (social and medical) care. On the one hand, the succinct wording of Recommendation No. 202, in necessarily seeking to be inclusive of all contingencies, offers a positive vector of change. On the other hand, for as long as the formal epithet of "social security" (or in contemporary parlance, social protection) is not conferred to long-term care, by not being formally recognized as such in the standards, by there not being a global "benchmark" against which to measure the adequacy of national programmes, there is a risk of its continuing relative neglect when there is a growing urgency for it to be, de facto, part and parcel of the global ambition for countries to realize "social security for all".

Despite these concerns, the policy context remains dynamic. In 2021, the International Labour Conference adopted a *Resolution concerning the second recurrent discussion on social protection (social security)*, wherein paragraph 13(g) included a commitment:

> Members, with the support of the Organization, and in accordance with national circumstances, should:
> (g) invest in the care economy to facilitate access to affordable and quality childcare *and long-term care services* as an integral part of social protection systems, in a manner that is supportive of the workforce participation of workers with care-giving responsibilities and an equal sharing of care work between women and men (ILO, 2021, emphasis added).

Accordingly, and seeking to drive this policy debate further forward, a key objective of the content of this special double issue is to use comparative evidence to develop and share an improved understanding of how countries may

design and implement rights-based long-term care (LTC) programmes rooted, where feasible, in national social security legislation.

The content: What does it teach us?

The articles that comprise this special double issue address international experience and offer country examples concerning the challenge of delivering long-term medical and social care for the elderly. They focus on how this challenge is currently being addressed, and differently so, and where hurdles to be surmounted remain. Gratitude is expressed to all the authors for their important contributions. Based on these contributions, and to inform future developments in this policy field, several key lessons are identified.

The lead article by Lou Tessier, Nathalie De Wulf and Yuta Momose maps out the common ground and shared vision of the Social Protection Department of the International Labour Office and the International Social Security Association. In discussing the roles that social security systems can and should play alongside other key actors in meeting the long-term medical and social care needs of elders, a wealth of considerations are spotlighted. Of importance, this framing paper makes clear the complexity of the LTC policy challenge.

The starting point of this first paper is to reaffirm the importance of the human right to social security and the international social security standards, especially those of the International Labour Organization. The article emphasizes that while there is no one-size-fits-all solution and while other important gaps in coverage remain, such as for pensions and health care, the standards can guide the development of country-owned LTC solutions rooted in a rights-based approach. Specific features of such solutions should be universality of coverage, solidarity in financing, broad risk pooling, gender equality in care provision and non-discrimination. To be pursued also is strong coordination between health, social and employment policies (not least to accord social protection to informal carers and encourage higher levels of employment and decent work in this sector), as is a strengthening of the legal basis surrounding how services are often provided and regulated. Acknowledging the roles of multiple actors, the aim is to enable a continuum of care, which can contribute to the realization of people's rights to LTC, and which does so without creating hardship (as regards the financing mechanism, limited or no co-payments are key) while also supporting individual well-being and combatting ageism. The ILO-ISSA authors make three important assertions concerning the roles of social protection policies as these relate to the agenda for healthy ageing and the growing need for LTC. First, that social protection policies can help address the social determinants of health throughout the life cycle that influence the loss of functional abilities among older persons. Second, social protection policies can facilitate access to long-term

care without hardship for those older persons who need it. Third, social protection policies should be inclusive of caregivers in all their diversity by promoting equal opportunities for women and men and supporting workers with family responsibilities.

The second article, by Rainer Kotschy and David E. Bloom, presents a valuable and necessary comparative perspective on a select number of formal long-term care systems. The paper first estimates the prospective care demand for 30 developed countries based on projected ageing and disabilities among the elderly then outlines challenges for care systems. The findings indicate that the scale of the LTC challenge posed by ageing populations and projected levels of disability among elders varies, even across neighbouring European countries – across the surveyed countries, care demand will grow most in Southern and Eastern Europe. To identify possible solutions, the article compares the social insurance long-term care systems of Germany, Israel, Japan, the Republic of Korea and the Netherlands; as sources for policy learning, these countries encompass many of the formal social insurance approaches to long-term medical and social care. This selective short list of countries acts to underline that few countries provide social insurance coverage to elders to address the medical and social care risks associated with the contingency of long-term care. To improve the resilience of social insurance approaches, and consistent with the aims of the UN Decade of Healthy Ageing, the authors conclude by emphasizing the associated need for the roles of prevention and rehabilitation in care provision, to promote individual well-being and absorb pressure from long-term care systems by promoting good health, especially among the elderly.

The third article, by Elena Glinskaya (World Bank), Zhanlian Feng and Guadalupe Suarez, provides a detailed overview of the "state of play" of long-term care provision in low- and middle-income countries (LMICs). Projections indicate that by 2050, more than three-quarters of the global population aged 65+ will live in LMICs. With the population growing older and with life expectancy increasing, the burden of non-communicable diseases and age-related loss of autonomy will also rise. With the demographic context defined, the authors remind that comprehensive LTC policies and systems are non-existent in virtually all LMICs. In turn, traditional family-based elder care is no longer sufficient to meet the escalating demand for LTC services. To develop comprehensive LTC policy solutions, the paper suggests that a first question for policy-makers is whether to set up a standalone LTC system or cover LTC within the existing public health care systems. Beyond this, four key sets of policy options are presented. First, given the large gaps between rising LTC needs and the lack of formal LTC provision across LMICs, the requirement to increase government policy interventions to address these gaps is imperative. Second, in the continuing absence of public provision, it is necessary to engage the private

sector in developing – for instance, through tightly regulated public-private partnerships – LTC services, markets and delivery systems in LMICs. Without question, this must go hand in hand with strengthened government stewardship, to offer clear guidance on rules of engagement as well as quality assurance and the regulatory capacity to enforce them. Third, as a proposed financing model, policy-makers in LMICs should, ideally, follow a broad-based social insurance model. To complement this, tax-financed provision is acknowledged as important for older people in need, while the role of private commercial LTC insurance (for the wealthy) is expected, as in other countries, to be minimal. Fourth, the authors argue the need for policy-makers in LMICs to draw on the experiences of high-income countries, to consider multipronged strategies to build and strengthen the LTC workforce as well as to support a continuing role for family caregivers. For the latter, supporting informal caregivers should be seen as a priority, not least to address inequality and the disproportionate burden on women.

As underlined by these arguments regarding the need for different financing approaches and multipronged strategies to strengthen the care workforce, there are limits to what traditional standalone social security systems can and should do alone. Without question, in countries where social security and health care coverage is not comprehensive, in the immediate term a more pragmatic approach is necessary. The lesson here is that the development of national systems of long-term medical and social care, by definition, necessitates the coordinated and regulated actions of multiple actors.

This is a point taken up in the fourth article, by Peter Lloyd-Sherlock, Karla Giacomin, Poliana Fialho de Carvalho and Quesia Nayrane Ferreira de Sousa. Their contribution addresses, first, the policy agenda for enhanced integration between health and social care for older people in high-income countries and, second, demonstrates its wider relevance to low- and middle-income countries. The article then explores the context for this agenda in Brazil by presenting a case study project of partnering for LTC between local social assistance and health agencies in the Brazilian city of Belo Horizonte; the city runs an innovative scheme to support care-dependent older people in disadvantaged communities. As is argued, existing models of care for older people are deemed unsustainable and will fail to meet the needs of many older people and their family carers. In the absence of integrated approaches, cash transfers and long-term care homes do not offer practical solutions. Rather, collaboration between primary health care providers and social assistance agencies operating at the community level is required. However, such collaboration equally demands structural integration of health and social care responsibility at the national level – something that is often lacking.

The fifth article, by Ana Llena Nozal, Eileen Rocard and Paola Sillitti of the Organisation for Economic Co-operation and Development (OECD), considers the workforce challenges as they relate to the long-term care sector. Key amongst these are an insufficient workforce, poor working conditions, skills mismatch and training gaps. The gender dimension of the care workforce is a further issue: the majority of LTC workers are females. Addressing the challenges as they pertain to OECD Member countries, a key observation is that poor working condition act to limit the recruitment of enough workers. In turn, a skills mismatch and poor integration with the rest of health care lie at the root of preventable and costly hospital admissions. In the absence of action, such challenges are likely to become ever more acute given the speed of population ageing. As the authors conclude, policies to improve recruitment, which also address retention through training, improvements in coordination and productivity, leveraging the effect of digital technologies, are needed. Also, an important continuing role will be played by informal caregivers, essentially by family members. Accordingly, also required are policies to support these carers and ensure the coordination of their care with that of formal carers.

The sixth article by Zofia Szweda-Lewandowska considers the respective roles of institutional approaches versus strategies of ageing in place in elderly long-term care. An important observation is that deinstitutionalization – the transition from institutional to community-based care – requires an increase in human resources in the care and health sectors. Specifically, the article addresses long-term care systems for the elderly and the conditions affecting the possibility for Poland, Czechia, Hungary and Slovakia to transition from a post-socialist model (familialism by default/unsupported familialization) to a European care model based on deinstitutionalization. As Member States of the European Union (EU), the article shows differences in the provision of long-term care for the elderly, as well as the "care gaps" that result in large part from an insufficient supply of public services, that are observed in these four Central European countries, characteristics that should be considered when planning and designing public policies and guidelines for social policy at the EU level. The paper underlines how national antecedents as well as current conditions matter.

The seventh and final article, by Arunika Agarwal and David E. Bloom, examines the case of India, which is characterized by very low levels of social security coverage (not least for old-age pensions) and health insurance, and thus a heavy reliance on out-of-pocket health expenditure. To meet the growing need for long-term care for the elderly, India must trace its own path. In India, the family is the dominant source of care. Yet, projections suggest that such informal family-based arrangements will be insufficient to accommodate India's growing need for long-term care. A robust expansion of the current care system is required, especially its non-familial components. In the quest to identify possible scalable

home-grown solutions, the authors single out the role played by community health workers in rural India. Using this good practice example, they suggest – in a manner that chimes with the case study of Belo Horizonte in Brazil – that, in seeking immediate solutions to meet the rapidly growing care needs of the vulnerable elderly population in a context where comprehensive nationwide social security is absent, the involvement of formal community-level responses is not only feasible but will be crucial.

To conclude, the substantive contributions to this special double issue offer important guidance in relation to contextual factors operating at the national level, including population dynamics, the level of economic development, the effects on policy-making and policy implementation of institutional path dependency as well as the influence of long-standing and deeply rooted cultural and faith-based perspectives concerning the duty of care for family members. Indeed, in some countries, the duty of care for elderly family members is enshrined as a legal obligation for adult children. For the design of long-term care programmes, other identified key factors concern choices regarding the relative respective roles of public versus private provision and their regulation, of programme coordination at the national, sub-national and community levels, of the use of strategies of ageing in place and residential care, of the appropriate use of digital technologies and communication tools in programme administration and the tailored person-centric delivery of services and care, and the continuing caregiving role of the family and the local community, often with a heavily gendered distribution of roles. The sustainable and equitable financing as well as the appropriate regulation of quality care and the labour market challenges of ensuring a professional care workforce, decent work and social protection in the sector are further important issues presented for deliberation.

While most of these issues may be common to many countries, the evidence presented in this set of articles suggests that the proposed solutions to challenges at the national level do vary. As is the case for other social policy domains, where policy challenges are nested in each country's specific national cultural context, a key take-home point is that the development of systems of long-term medical and social care offering a continuum of care will require tailored responses.

To return to a point made earlier, the ILO Recommendation on Social Protection Floors, 2012 (No. 202), was unanimously adopted by 185 ILO member States. The Recommendation asserts the ambition to "progressively ensure higher levels of social security to as many people as possible" (para. 1(b)). In the spirit of the ambition of Recommendation No. 202, and as part of the answer to fulfilling this, it is time for consideration to be given to revising and extending the international social security standards, to expressly include long-term medical and social care for the elderly.

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Long-term care in the context of population ageing: What role for social protection policies?

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Abstract With the acceleration of population ageing, healthy ageing is becoming an imperative for all. Social protection systems have an important role to play in this endeavour. Through a life cycle approach, social protection systems can support i) the prevention of disability in old age (i.e. by addressing the social determinants of health and rehabilitation), ii) effective access to long-term care without hardship for those who need it, and iii) decent work in the care economy. To do so will require adopting a gender-transformative approach. Indeed, women are disproportionately represented among both older persons and long-term care providers in their diversity. Further, to adequately contribute to healthy ageing and effective access to long-term care without hardship as a rights-based entitlement, social protection systems will need to build strong coordination between health care, social care and other social policies. This article highlights the key entry points for social protection systems to contribute to the United Nations Decade of Healthy Ageing, building on the rights-based approach of human rights and international social security standards.

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Keywords long term care, social protection, ageing population, coverage, gender, international

Introduction

The world's population is ageing with an increasing number of countries undergoing a demographic transition. Fertility rates are decreasing while mortality rates are declining or stagnating in many countries (Wang et al., 2020). In 2019, half of the world's countries and territories had a below-replacement rate of fertility, meaning that the policy challenges associated with ageing populations are becoming extremely acute. This phenomenon is progressing more rapidly in middle- and low-income countries (MLICs) than it is in high-income countries (HICs). At present, two out of three older persons live in MLICs, and it is projected that this proportion will increase to four out of five older persons by 2050 (UNDESA, 2019). These changes in MLICs are occurring in a context of economic and institutional development that tends to be less favourable than in HICs. Against this background, the COVID-19 public health crisis has starkly revealed the degree to which countries are ill-prepared to secure healthy ageing and adequately respond to the needs of older persons experiencing loss in their functional abilities.

Focusing on long-term care (LTC) in the context of ageing,[1] this article argues that the objectives of social protection policies should be, in that respect, to contribute to prevent the need for LTC across the life cycle while all older persons in need of LTC can access it without hardship and the ones who provide it (caregivers) can enjoy continuous social protection coverage. The article first sets the context by providing the definition for and estimating the scale of long-term care needs. It further explores the role of social protection policies in supporting healthy ageing with a threefold objective. First, social protection policies can help address the social determinants of health throughout the life cycle that influence the loss of functional abilities among older persons. Second, social protection policies can facilitate access to long-term care without hardship

1. There is no universal age threshold to define when a person is considered "old". In many countries, pension system reforms centred around the retirement age have also shown that such thresholds can be relative and do not always match individual perceptions and the capacities of people. This article will display available statistics that use age 60, age 65 or the official national retirement age, as available, and will attempt to highlight the practical challenges of threshold definition in the context of social protection policies.

for those older persons who need it. Third, social protection policies need to be inclusive of caregivers in all their diversity by promoting equal opportunities for women and men and supporting workers with family responsibilities.

The context

In December 2020, the United Nations General Assembly adopted the UN Resolution on the Decade on Healthy Ageing.[2] Therein, recognition is given to the role of social protection in ensuring the full realization of all human rights and fundamental freedoms for older persons. In June 2021, the International Labour Conference (ILC) called Member States and the International Labour Organization (ILO) to consider LTC as an integral part of social protection systems, and to invest in the care economy and supporting workers with care responsibilities (ILO, 2021a). In response to this call, this article aims to reflect on the role that international social security standards and national social protection policies and systems can play when it comes to long-term care in the context of population ageing.

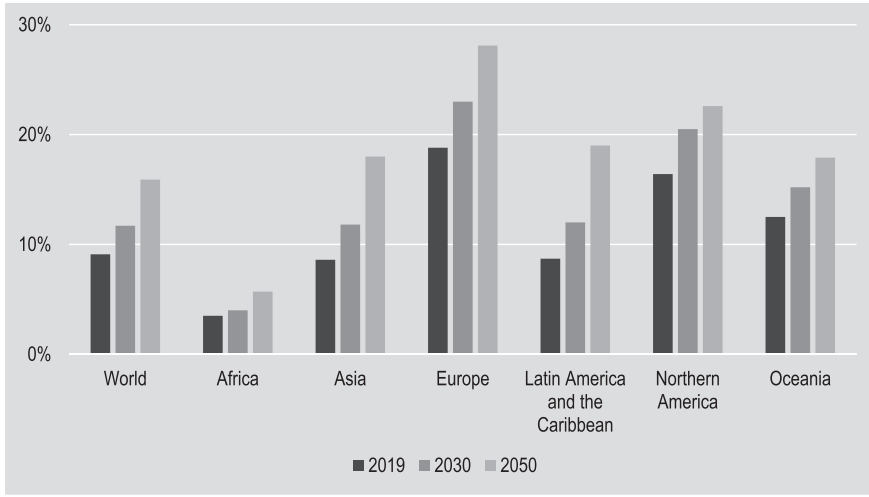
While there is a growing body of literature discussing LTC, definitions of its scope can vary. Some authors include health care and social care services needed across all age groups who require care or support to conduct activities of daily living (Addati, Cattaneo and Pozzan, 2022). While activities of daily living are considered a core element, some authors and agencies put the emphasis on the ability to live independently or to enjoy fundamental human rights and freedoms (Love and Lynch, 2018). The World Health Organization (WHO) defines long-term care systems' objectives as to "enable older people, who experience significant declines in capacity, to receive the care and support that allow them to live a life consistent with their basic rights, fundamental freedoms and human dignity" (WHO, 2020). While countries are increasingly adopting long-term care policies,[3] their scope and the depth of their linkages with social protection policies varies greatly (Scheil-Adlung, 2015; WHO, 2020).

The need for LTC for older persons is determined by both demography and health status. While there is ample data on the demographic aspect, which

2. United Nations General Assembly Resolution A/RES/75/131. United Nations Decade of Healthy Ageing (2021–2030). The text of the Resolution is available here. This notion was embedded already in the 2002 Madrid International Plan of Action on Ageing (MIPAA), adopted during the Second World Assembly on Ageing and further in the United Nations General Assembly's declaration of 2021–2030 as the Decade of Healthy Ageing.

3. Research conducted by the ILO in 2013 on countries that account for 80 per cent of the population older than age 65 showed that 32 countries had a policy, while in 2018 the WHO counted 80 countries with such policies and 96 in 2020, all pointing to an upward trend.

Figure 1. *Percentage of the total population aged 65 or older in 2019 and projections for 2030, and 2050*



Source: UNDESA (2019).

consistently point to ageing (see Figure 1), the situation is very different when it comes to evidence on the health status, functional abilities and intrinsic capacities of older persons worldwide. The data is both scarce and difficult to compare.[4] Yet, based on countries for which data is available, the WHO estimates that 142 million persons aged 60+ worldwide currently lack the functional ability to meet daily needs such as to get dressed, take medication and manage their finances independently, a figure that represents 14 per cent of older persons (WHO, 2020, p. vii).

There is a clear pattern of increased loss of intrinsic capacities with age, especially after age 80, and it is more significant for women than for men, a gap which widens with age (WHO, 2020, p. 35). This highlights the noteworthy gender dimension of long-term care (see Box 1). This trend also masks considerable variations, some of which are largely determined by socioeconomic and other inequalities. There is evidence that older persons at the lowest end of the wealth distribution and with low educational attainment tend to have higher LTC needs. For example, older persons who had not completed high school in the United States of America were found to be three times more likely to have severe LTC needs than those with a university degree (Johnson, 2019).

4. Three-quarters of countries have limited or no comparable data on healthy ageing or on older age groups (WHO, 2020, p. 71).

Box 1. Gender and LTC

Women make up the majority of older patients, as well as care providers (both paid and unpaid), making the gender dimension a priority issue for building LTC systems that are rights-based, inclusive and financially and socially sustainable (ILO, 2018). Women are more likely to need LTC, as they tend to live longer than men – often in poor health – and face higher rates of disability or chronic health problems. The proportion of women increases with age and globally older women constitute approximately almost two-thirds of those aged 80 or more (UN Women, 2022). Being more likely to have a lower average income, older women tend to be more marginalized and disadvantaged than older men, with higher rates of poverty among older women. At the same time, women also provide the vast majority of unpaid long-term care. Globally 76.2 per cent of unpaid care workers are female (ILO, 2018). Similarly, the paid care workforce is predominantly made up of women. Decent work deficits, including the absence of social protection coverage, are common in the sector. This calls for a gender-transformative approach to social protection policies when it comes to LTC.

This situation has two important implications. First, at the individual level, it means the need for LTC, both in term of timing and magnitude, cannot be anticipated with any certainty. The uncertainty of the risk and its inequitable distribution make a strong case for treating LTC as a whole-of-society matter, which thus calls for solidarity and collective action. Second, levers are available that can help prevent some of the need for LTC from arising. There is evidence that diversity in functional abilities and intrinsic capacities in old age are often, at least partially, determined by the compounded impact of the disadvantages and deprivations people experience throughout their lives. This has fed calls for a life-cycle approach to healthy ageing that addresses the social determinants of health (Commission on Social Determinants of Health and WHO, 2008). Universal social protection, characterized by a rights-based approach aiming for universal population coverage, comprising comprehensive and adequate protection, offers a solid basis.

Social protection and healthy ageing

The leading causes of disability[5] in populations older than age 50 include cancer, chronic kidney conditions, hearing impairment, dementia and falls (Vos et al., 2020). Non-communicable diseases (NCDs)[6] are on the rise globally, their prevalence increases with age, and they have important consequences for the loss of functional abilities and intrinsic capacities in old age. They impact the balance between disability[7] and death in the global burden of diseases.[8] Generally speaking, premature death has become less common while people suffer more from long-term conditions. Prevalence of multi-morbidities in older adults is often higher than for other population groups, which affects their functional abilities and requires chronic disease management for many. Further, the burden of NCDs on older adults makes them particularly vulnerable to some of the impacts of climate change, such as temperature rise and the increased frequency and intensity of adverse weather events (McDermott-Levy et al., 2019).

A large share of NCDs can be prevented or their effects limited through early detection, appropriate management and rehabilitation. Supporting people throughout their lives to prevent illness and disability in old age therefore is contingent on addressing the barriers they may encounter in adopting desired behaviours, to maintain their health and to access the professional support they need to monitor it (Heikkinen, 2003). It is in this respect that social protection policies can and should make an important contribution in line with international social security standards (see Box 2).

5. Within the framework of the global burden of disease, years of healthy life lost due to disability is a time-based measure that represents years of life lost due to time lived in states of less than full health.

6. According to the WHO, noncommunicable diseases (NCDs), also known as chronic diseases, tend to be of long duration and are the result of a combination of genetic, physiological, environmental and behavioural factors. The main types of NCD are cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes. NCDs account for 70 per cent of global deaths and NCDs disproportionately affect people in low- and middle-income countries (Allen et al., 2017).

7. Understood in the context of the global burden of diseases as time lived in states of less than full health.

8. Disability is coming to represent a greater share of the global disease burden and makes up a larger share of health expenditure than was previously so.

Box 2. Universal social protection throughout the life cycle

ILO Recommendation No. 202 calls for the urgent establishment of national social protection floors accessible to all and guaranteeing that people have effective access to health care without hardship and income security through a life cycle approach. Universal social protection (USP) refers to comprehensive, adequate and sustainable protection along three core dimensions:

- Universal coverage in terms of persons protected – all persons should have effective access to social protection throughout the life cycle if and when needed.
- Comprehensive protection with regard to the social risks and contingencies that are covered – including nine contingencies that all human beings may face over their life course: the need for medical care, and the need for benefits in the event of sickness, unemployment, old age, employment injury, family responsibilities, maternity, invalidity and survivorship.
- Adequate protection – benefits provided need to be set at a level that effectively prevents poverty, vulnerability and social exclusion, maintains a decent standard of living and allows people to lead healthy and dignified lives.

Source: ILO (2021a).

Access to health care without hardship and the prevention of functional loss

In line with the objective of universal health coverage (UHC), social protection systems ought to guarantee access to health care without hardship that meets the criteria of availability, accessibility, acceptability and quality (Bayarsaikhan, Tessier and Ron, 2022). By lowering financial barriers to access a comprehensive range of quality health interventions, social health protection contributes to improving continuous access to health care throughout the life cycle. International social security standards have for decades called for universality of coverage,[9] but important gaps remain. While two-thirds of the global population is protected by a social health protection scheme, this proportion is only 34 per cent and 16 per cent in middle-income and low-income countries, respectively (ILO, 2021b). This absence of social protection combined with insufficient public

9. ILO Recommendations and Conventions on social health protection, in particular, the Medical Care Recommendation, 1944 (No. 69), the Social Security (Minimum Standards) Convention, 1952 (No. 102), the Medical Care and Sickness Benefits Convention, 1969 (No. 130), and the Medical Care and Sickness Benefits Recommendation, 1969 (No. 134).

health expenditure more generally translates into catastrophic out-of-pocket (OOP) spending on health made by households, which is on the rise globally (Angrisani, Regalado and Hashiguchi, 2022; WHO and World Bank, 2021).

Securing effective access to health care without hardship across a wide range of services including health promotion, prevention, early detection and rehabilitation throughout the life cycle can make a crucial contribution to preventing severe health outcomes, fostering healthy ageing and addressing the determinants of poor health in old age. Access to a wide range of inter-disciplinary services as well as assistive products is needed. It is recommended that social health protection schemes include such services and products to increase access and utilization and tackle impoverishment, in line with the ILO Convention on Social Security (Minimum Standards), (1952) No. 202, and the ILO Convention on Medical Care and Sickness Benefits, (1969) No. 130. Indeed, there is evidence that people living with a disability, who are more likely to require rehabilitation services, are also significantly more likely to experience catastrophic health expenditure (Mitra et al., 2017). Covering the costs of rehabilitation services and products should be seen as an investment. However, all too often, little attention is given to these preventive strategies, which ultimately influence the need for LTC and the related costs (Stucki, Bickenbach and Frontera, 2019).

Similarly, while ILO standards stipulate that the range of services covered should be comprehensive, in practice, specific services are often excluded from benefits packages, such as dental and optometry care (ILO, 2020a). For instance, a recent review of social health protection in Asia and the Pacific found that such services were excluded from health benefits in Cambodia, the People's Republic of China, Lao PDR and Viet Nam (ILO, 2021c). Such interventions can be essential to enable individuals to perform daily activities and demand for these tends to increase with age. They can also be central to remaining healthy; for instance, poor dental and oral health results in malnutrition among older persons (Ástvaldsdóttir et al., 2018).

Even when social health protection entitlements are comprehensive, further barriers to effective access and utilization remain in practice. In particular, recent analysis shows that access and utilization of health interventions increased between 2000 and 2019, but NCD-related interventions showed lower gains than other sub-indexes (WHO and World Bank, 2021).

Income security throughout the life cycle as a policy lever to address the social determinants of health

Effective access to income security benefits, in addition to health care benefits, can support healthy ageing and shape its determinants along the life cycle through three main entry points.

Social protection cash benefits can secure an adequate standard of living, including in old age. Having income security impacts on households' financial ability to adopt a healthy diet, maintain appropriate housing, obtain education and partake in the social and physical activities that are crucial to staying healthy. For instance, there is evidence that adequately designed old-age pensions can have an impact on nutrition (Duflo, 2003; Ko, 2019; Zheng, Fang and Brown, 2020). Further, access to social protection is identified as being closely related to good self-reported health in Europe, underlining the strongly intertwined relationship (WHO, 2019). Regrettably, income security is not yet a universal reality. Less than half of the world's population is effectively covered by at least one social protection cash benefit across the life cycle (ILO, 2021b). Only 38.6 per cent and 23.2 per cent of older persons in middle-income and low-income countries, respectively, enjoy effective old-age pension coverage. This is further compounded by important differentials in pension adequacy, with pension benefit levels reflecting the gender pay gap in many regions as well as the unequal labour market participation of women (European Commission, 2021; ILO, 2021d). This means that while women live longer than men, they are also less likely to have income security in old age, which in turn affects their ability to stay healthy longer.

Access to social protection further impacts people's ability to face shocks and contingencies during their adult life. Having the security to be able to meet basic needs in a crisis situation influences mental health and immediate physical needs (Cappelletti et al., 2015). For instance, there is evidence that social protection systems contributed a great deal to cushion the socioeconomic impacts of the economic crisis induced by the COVID-19 pandemic (ILO, 2020b). More generally, being able to have the time to properly recover from episodes of maternity, illness or injury, without losing one's income, can help ensure that people do not experience preventable adverse health impacts in the long run.

Lastly, when social protection policies are well coordinated with employment policies, it can smooth transitions between different phases of life and make an important contribution to healthy ageing. Indeed, it is crucial that people who can no longer perform a professional activity are able to stop working and benefit from a pension, while people who can and wish to continue working, possibly under more flexible modalities, are able to do so. For older persons who can and wish to retain a level of professional activity, there is evidence that this has positive effects on their health (WHO, 2020). International social security standards made provisions as early as the 1960s to ensure that social protection systems could adapt accordingly.[10] Some countries have reformed their pension systems, simultaneously ensuring that people who start working at a

10. See ILO Convention on Invalidity, Old-Age and Survivors' Benefits, 1967 (No. 128), article 15.

younger age or those who perform hazardous or physically demanding work can retire earlier, while those who are still able to work and wish to do so can stay in full or partial activity longer (ILO, 2013). For instance, Greece lowered the pension reduction that was applied to pensioners who maintain a professional activity (European Commission, 2021).

Social protection policies therefore have an important role to play in countries' attempts to foster healthy ageing. In this respect, countries should view social protection benefits as an investment that is much needed to counter current trends of disease and disability in old age.

Key considerations in securing access to long-term care without hardship

While efforts need to be deployed to prevent as much as possible the need for LTC in old age, with the absolute number of older people and longevity increasing, the need for LTC is growing. This is a multi-faceted issue, which goes well beyond the sole scope of social protection policies. While modalities for the delivery of the needed services and their financing may vary greatly, social protection policies need to offer tailored solutions while keeping the aspirations of older persons in need of LTC and their caregivers at the centre of coordinated policy responses. Most countries still lack comprehensive long-term care guarantees to protect those in need (Addati, Cattaneo and Pozzan, 2022). International social security standards offer principles, along the dimensions of population coverage, benefit adequacy, administration and financing, which can support the design and implementation of social protection LTC schemes with a view to support life in dignity.

Coverage of the population

Given that the risk of having to require LTC is uncertain, and the determining factors are complex and difficult to anticipate, such a risk is best financed and managed collectively. Old age, disease and disability are not evenly distributed across geographical locations and income levels in many countries, which calls for adopting an approach based on broad risk-sharing.

LTC policies constitute an enabling right for older persons who experience functional impairments that permit, in turn, the enjoyment of other human rights. Accessing LTC services is necessary to enable older persons' continuous meaningful participation in public and family life and to maximize the contribution they can make to society. There is limited data on legal coverage for LTC entitlements and the available evidence highlights important coverage gaps,

suggesting that as few as 5.6 per cent of the global population aged 65+ live in countries that provide universal legal entitlements to free or affordable LTC (Scheil-Adlung, 2015).

Broad risk pooling and universality of coverage are most appropriate to cover the risk of needing LTC. Currently, 55 out of 60 countries that have recognized the public provision of LTC services in national legislation use targeted or means-tested provisions (Addati, Cattaneo and Pozzan, 2022). The rationale behind this policy choice is often to contain public expenditure (ILO, 2017). The scalability of this approach and its desirability are limited. First, while it ensures a level of solidarity between the poor and higher income groups, it fails to share the risk of needing LTC services amongst all members of society, and therefore tends to favour the development of a two-tiered system.[11] Creating de facto different risk pools runs the danger of creating or perpetuating large inequities in access to and the quality of services. Typically, in a context of health and care worker shortages, the wealthiest pools can attract most of the available supply, while those with less wealth are locked out of market-based services and, indeed, may not be deemed sufficiently poor to qualify for means-tested targeted provisions. Second, there are well-documented exclusion errors in the implementation of means-tests, and particularly proxy means-tests, that are used in countries where access to reliable information on household income is limited (Devereux et al., 2015; Kidd, Gelders and Bailey-Athias, 2017).

Reaching universal coverage requires a broader effort to close social protection coverage gaps. In the current situation, building LTC schemes using existing health and pension schemes runs the risk of replicating coverage gaps. For instance, when the city of Shanghai decided to provide some LTC benefits it did so by expanding the benefit packages of the (at the time) three different social health insurance schemes. However, this meant that the LTC scheme also suffered from the coverage gaps and inequities inherited from a fragmented social health insurance landscape (Yang et al., 2016). Therefore, there is an urgent need to address the coverage gaps of pension and health benefits alongside the design of solutions to cover LTC costs.

Adequacy

While international social security standards clearly provide a normative basis for social protection systems to support access to LTC without hardship, they do not

11. In such a system, public provision is for the poorest, who tend to be poorly represented and have less voice in policy processes, and is therefore more subject to budget cuts and deterioration of service quality over time. The rest of the population may buy LTC services from markets that tend to remain poorly regulated in many countries and which largely result in segmentation and cream skimming.

yet provide a benchmark when it comes to adequacy of LTC services as they do for other contingencies. Entitlements are materialized through: i) a clear definition of the contingency covered, ii) a package of benefits responsive to the contingency, namely the range of LTC services that are made accessible, iii) the level of financial protection provided to cover the costs of the benefit package, and iv) a dedicated network of service providers from which services can be availed of and which meet certain quality criteria.

Contingency and eligibility. The contingency that LTC benefits should aim at covering can be understood as a decline in individual capacity, which requires care and support to live a life consistent with human rights standards and people's sense of dignity. In practice, countries have defined different rules governing eligibility to LTC benefits, which provide concrete interpretations of such a contingency. The ability to carry out activities of daily living (ADLs)[12] is generally used for assessing the need for LTC (ISSA, 2022). For example, in Singapore, the assessment of loss of function is carried out by an assessor accredited by the Ministry of Health, and LTC benefits awarded under the ElderShield and the CareShield Life schemes are granted to older persons and persons with severe disabilities who require the physical assistance of another person to perform at least three ADLs (ILO, 2021c).[13] While the inability to perform one or several ADL alone is widely used across existing LTC provisions, care needs may go beyond those. For instance, taking into account the impacts of mental illness, including dementia, as well as the constraints in the environment, is crucial. To support life in dignity, a broad consideration of functional loss is needed, as well as the crucial consideration of people's aspiration to independent living.

A shared understanding of disease, interventions and functioning can support such assessments. However, a recent review of LTC in Latin America suggests that only one country in the region had a unified nationwide methodology to assess LTC needs (Aranco et al., 2022). When it comes to countries with limited resources, it is important to consider solutions that will be implementable within the context of existing health and social care structures. In the Dominican Republic, the national census was used to create a social registry, which includes the identification of persons with disabilities as regards six domains

12. Most often eating, bathing, dressing, toileting, moving about and continence.

13. Washing, feeding, dressing, toileting, mobility and transferring (i.e. the ability to move from bed to an upright chair or wheelchair). Introduced in 2002, ElderShield is no longer open to new applicants. Since 1 October 2020, enrollment in the CareShield Life programme is automatic for Singaporeans born in 1980 or after, or when reaching age 30, whichever is later.

(Lizardo, 2022).[14] Also, eligibility requires periodic re-assessment to reflect the changing needs and circumstances of beneficiaries as well as to determine any adjustments in the level of care needed.

Package of benefits. Deciding on the package of benefits that has to be provided to adequately secure access to LTC without hardship is arguably one of the central elements of the design of such a social protection guarantee. Responsiveness to actual needs permits to ensure access to a range of services, encompassing health care services and social care services provided in the home, in the community or in institutions, as well as to house adaptations and assistive medical devices and, possibly, cash benefits to complement these. While no global benchmark exists, preliminary work at the global level indicates the mixed nature of the benefits to be provided (Perracini et al., 2022).

In practice, benefit packages are very different across countries and in some countries different types of benefits are provided via different schemes. When designing LTC benefits, countries often need to take into consideration which health services may already be included under existing health and social care programmes. It may not always be necessary to create a new dedicated programme, but it is crucial to map the existing gaps and find adequate solutions to bridge them. For instance, comparing Japan and the Republic of Korea, diverse approaches were taken. In Japan, health and social care can be accessed through facility-based services, home-based services, community-based services, and preventive long-term care services, depending on the level of care needed (Yamada and Arai, 2020). Conversely, the Republic of Korean LTC insurance includes home care services, nursing, assistance with household services, institutional care and, in exceptional cases, cash benefits,[15] including for family caregivers (Lee, 2015).

Financial protection. No or limited co-payments are key features to avoid hardship, in line with international social security standards (ILO, 2020a). There is evidence that OOP payments for LTC services are high globally, as these are the main funding mechanism for such services in many countries. Less than a fifth of countries were found to have embedded free LTC in national legislation (Addati, Cattaneo and Pozzan, 2022). In addition, most LTC programmes include some level of co-payment. The absence of adequate financial protection

14. Namely, communication, mobility, ability to bath, recall/concentration, hearing and vision.

15. LTC insurance in the Republic of Korea also provides financial support to purchase necessary equipment that provides assistance in daily and physical activities for those who have difficulties carrying out their daily routines due to physical or cognitive decline (NHIS, 2020). Cash benefits are also provided on a case-by-case basis to older persons living in remote areas with no access to in-kind benefits (Choi, 2015).

can lead to impoverishment and the erosion of old-age pensions, which may be insufficient to cover OOP on LTC. For example, a study in Malaysia, which compared the monthly cost of private nursing homes (public nursing homes are only available upon means-test and other narrow eligibility criteria[16]) with the mean income of older adults, found the cost of private nursing homes to be two to three times higher than mean income, a situation compounded by a retirement system based on individual accounts with no guaranteed income level (Yunus, Johar and Katiman, 2022).

Network of service providers and contracting modalities. A network of service providers, from whom beneficiaries will be able to avail themselves of the benefit, must be identified. This can take various forms depending on the scheme. Some countries provide only cash benefits that beneficiaries are free to use within a more or less regulated care market, while other countries provide predominantly public LTC services to those eligible for coverage. Weak legal frameworks and great diversity in care models and providers are factors that add complexity to the identification and, in some instances, contracting of LTC services.

A weak legal basis affects the ways in which services are provided and regulated.[17] In 89 of 179 countries[18] with statutory national LTC services for older persons established in law, 69 mention in-home personal care services while 87 mention residential services (Addati, Cattaneo and Pozzan, 2022). In turn, a lack of regulation is a barrier to contracting providers and, more broadly, to the provision of care that meets the criteria of availability, acceptability, accessibility and quality. The establishment of harmonized quality standards for LTC service providers would be an important step forward. However, such harmonization is seldom present at the national level and monitoring is weak, particularly for home care services. A recent regional study in Latin America found overall low levels of registration and licensing requirements, compliance as well as controls of care providers and care workers, even though most countries have established minimum quality criteria (Cafagna et al., 2019).

Models of care encompass very diverse realities, even within countries that have statutory provisions. Ideally, there should be a continuum of care along family, home-based social and health care, and residential care provided in different types of institutions for older persons who cannot or no longer wish to stay at

16. In Malaysia only 0.4 per cent of the population lived below the national poverty line in 2020 according to the Department of Statistics of Malaysia. See report on: Household income estimates and incidence of poverty.
17. Regulation encompasses authorization, licensing, control and oversight of service providers.
18. Representing half of older persons globally.

home. Collaboration between health care, social care and social protection systems is needed to ensure quality, especially in care models that are pluralistic in nature. In practice, this continuum is not always realized, and coordination is weak (WHO, 2021). LTC services can be delivered in the home (through family support, community-based mechanisms, professional health or personal caregivers) or in different types of institutions (pertaining to health care or social care sectors). Contracting modalities have to be adapted to each type of provider and intervention, and the diversity of these adds complexity to the process. Considering the largely informal nature of care work in many settings, many countries have made efforts to support the structuration of care providers into registered non-profit organizations anchored in the community, such as associations, mutual benefit societies or cooperatives (ILO, 2022a). Some countries have explored simplified procedures for the formalization of care work with a view to make contracting possible. For example, the French Central Agency of Social Security Bodies (*Agence centrale des organismes de sécurité sociale* – ACOSS) set up services to simplify the formalization of home-based services (ISSA, 2021a).

Administration

Administrative arrangements should encourage excellence in social security administration, the provision of adequate incentives for providers and effective coordination between health care and social care. The diversity of provider payment methods currently reflects the diversity of care models, providers and legal entitlements to receive LTC without hardship. Often, a range of payment methods may co-exist in a country, depending on the type of services (home-based, institutional care), the type of provider (public, private, voluntary sector) and the scheme securing the entitlements (LTC social insurance, national health care system, social assistance scheme, etc). For example, in the People's Republic of China, several LTC programmes have been implemented in different localities using different provider payment mechanisms. In Shanghai, institutional LTC was covered by the social health insurance schemes using fee for service, while in Qingdao the LTC nursing insurance was able to negotiate a per diem price schedule with institutional providers and daily rates with home-based care providers (Yang et al., 2016).

While there is little published information available in terms of systematic compilations and comparisons for MLICs, many of the caveats concerning strategic purchasing for health care apply to LTC, and particularly so concerning institutional care. The health branch of social security systems is the only branch that deals with purchasing services on behalf of the protected

population. In this respect, some functions could usefully be mutualized. At the same time, the pressure to contain costs in HICs has motivated a number of reforms seeking to shift the burden of LTC onto the social care system through home-based care, which is viewed as a cheaper option for older persons at the lower end of the dependency spectrum. There are proven benefits to this strategy aligned with "ageing in place" (Wiles et al., 2012). While this holds true, the cost containment motivation behind such measures tends to affect the method and level of provider payments, which in turn impacts on the working conditions and remuneration of care workers (ILO, 2022b).

With the increasing incidence of people in need of LTC, the necessity to receive different kinds of health and social services also increases. Social security institutions can provide an essential interface in this context, to guarantee equal access to benefits as well as to provide attractive working conditions for professionals providing home-based care that is financed using a solidarity-based financing mechanism. As management and coordination tasks are accomplished by different organizations, professions as well as family carers, a more horizontal coordination and integration of social and health care is crucial. This can be difficult to achieve because of different funding streams and eligibility criteria (ISSA, 2021a). Ensuring coordination contributes to enhancing the quality of care, improves the "patient" experience and offers greater opportunities for preventive care measures. The move to professionalize services that are aimed specifically at older people should be accompanied by technical solutions provided to support the work of all who are involved in a person's care. The Social Insurance Fund of Costa Rica, for example, has developed a mobile application giving home-care providers access to a patient's medical history and profile to enable coordinated care (ISSA, 2021b). To reduce discontinuities in the health-care pathway and avoidable hospitalizations, countries have developed responses to ensure coordinated, continuous and appropriate care, which allow the person in need of care to remain at home for as long as possible. In France, a series of "pilots for autonomy-preserving senior health pathways" (PAERPA)[19] are in place, where a primary health-care team is set up to implement a personalized health-care plan from a combined social welfare and health care perspective. Greater coordination between different branches of social security is also essential (i.e. across disability, unemployment, health and retirement systems) with a view to respond to the needs of older persons in a holistic manner.

19. See the PAERPA website (in French).

Financing

Financing arrangements are not neutral. The international social security principles of broad risk-pooling and solidarity in financing are no less relevant when it comes to financing LTC. Public financing is needed for several reasons. First, the absence of public financing for LTC – or its insufficient level – is detrimental to the adequacy of pension benefits, which will be rendered too low to cover both living expenses and LTC costs, as it is for the financial sustainability of health benefits, since some LTC costs are shifted towards the health system. For instance, in the United Kingdom, the National Health Service did not initially finance most LTC services, which were underfunded and poorly coordinated. In 2016, it was estimated that the use of over 60,000 hospital bed days per month resulted from delayed discharges from hospital attributable to failures in social care (Smith, 2018).

Further, leaving LTC to be financed by OOP and dependent on unpaid family caregivers is regressive, inequitable for those who do not have family members who can provide this care as well as representing an important opportunity cost for unpaid caregivers. Some costs are typically overlooked, such as the opportunity cost for society of family members who would like to participate in the labour market but cannot do so because of their care responsibilities, or the costs incurred because of mental health issues that may confront unpaid caregivers who receive little training, respite and psycho-social support (Utz, 2022). In this respect, solidarity-based financing mechanisms are most appropriate to foster stronger social inclusion and contribute to renewing the social contract that binds people in society (Razavi et al., 2020).

As part of efforts to extend social protection coverage for LTC, countries have adopted different strategies and institutional arrangements. Schematically, countries have i) created dedicated LTC schemes, such as Japan and the Republic of Korea; ii) provided "top-up" pension benefits or expanded the scope of disability benefits; or iii) embedded LTC provision within social health protection benefit packages, such as in Northern Ireland[20] (Roland, Forder and Jones, 2022). In practice, many countries have a mix of the above arrangements. For example, the Netherlands have a LTC insurance scheme that initially was used to finance nursing care. In 2015, nursing care in the context of LTC returned to being financed by social health insurance, with a view to reduce costs through improved coordination between different health services (Alders and Schut, 2019). Similarly, Uruguay created a scheme for home-based care that covers LTC needs across all age groups, while residential care is covered by a programme operated through the national

20. The Department of Health is responsible for financing LTC through five health and social care trusts.

social security organization, the Social Insurance Bank (*Banco de Previsión Social* – BPS) (Matus-López and Terra, 2021).

While strategies differ, there will be additional financing needs as LTC benefits are put in place, regardless of the institutional arrangements to deliver them (ILO, 2022a). Mobilizing fiscal space for social protection can be achieved in a number of ways (Ortiz et al., 2019). For instance, Singapore raised additional revenues for LTC through additional personal social security contributions that were mandatory starting from age 40. France created a new earmarked tax (Doty, Nadash and Racco, 2015). In Finland, municipalities are responsible for up to two-thirds of public LTC funding and for the collection of non-earmarked taxes (Anttonen and Karsio, 2016). In Qingdao, the People's Republic of China, the LTC nursing insurance is financed by a mix of transfers from social health insurance schemes and revenues from lottery funds (Yang et al., 2016; Hu et al., 2021). To avoid the pitfall of creating inequities across municipalities (regions), many countries maintain financial stability at the local level by pooling and transferring revenues collected nationally (Ariaans, Linden and Wendt, 2021; Colombo et al., 2011).

Social protection for decent work in the care economy

Securing quality LTC services also involves social protection policies that effectively cover all caregivers, whether paid or unpaid, and which support a gender transformative approach. In this way, social protection systems can contribute to care policies that respect the human and labour rights of paid and unpaid caregivers and support workers with family responsibilities, in line with the ILO Convention on Discrimination (Employment and Occupation), 1958 (No. 111) and the ILO Convention on Workers with Family Responsibilities, 1981 (No. 156).

Securing social protection coverage for unpaid family caregivers

At present, 70 countries set a legal obligation for family members to provide LTC to their older relatives when needed, limiting collective responsibility for LTC and risk sharing within society (Addati, Cattaneo and Pozzan, 2022). It is worth noting that some countries adopt a mixed approach between family and collective responsibilities, an approach that acknowledges changes in family structures and the geographical distribution of their population. While there is no one-size-fits-all solution, the bulk of LTC remains provided by family relatives. Unpaid LTC work represents a sizeable amount of time that cannot be dedicated to paid employment. LTC provided by unpaid family members, usually women, adds to a situation in households where women already undertake most of the unpaid

work in the home. In turn, this impacts the ability of caregivers to stay employed or to re-integrate in the labour market, with fragmented formal work histories negatively affecting access to coverage under social protection systems and the adequacy of entitlements (ILO, 2021b).

Social protection systems should support families to provide some aspects of needed care within a broader continuum of care complemented by professional services (WHO, 2021). When individuals (spouses, siblings, offspring) provide some long-term care for family members, it is important that they are not penalized as regards their own rights to social protection. Care credits in pension systems, for example, ensure continuity of social protection entitlements, permitting caregivers the flexibility to provide care directly while remaining in the labour force. For instance, in the United Kingdom, National Insurance credits are granted to those who perform unpaid care work for at least 20 hours a week, thus avoiding gaps in the carer's National Insurance contribution record.[21] Similarly, the German LTC insurance scheme pays the social security contributions of unpaid family caregivers. In Mauritius, a monthly allowance is provided to family caregivers by the government (WHO, 2017).

Social protection systems therefore need to adopt gender-transformative policies that allow family members to play a role in the continuum of LTC without jeopardizing their entitlements to social protection and employment opportunities. While this holds true, social protection policies also need to support the development of LTC guarantees substantiated by professional LTC services. This has become more pressing given women's increasing labour force participation rates, and the growing demand for professional LTC services. While the LTC sector can be an important engine of employment creation, it is critical that there are decent employment opportunities for paid care workers.

Social protection as a central element to foster decent work for health and care workers

There is an urgent need to secure decent work, including social protection coverage, for paid health and care workers. This urgency relates to the relatively poor working conditions and social protection coverage gaps these workers currently experience, which in turn has an impact on the attractiveness of the sector as well as global migratory dynamics and the overall shortage in health and care worker supply. The conditions of employment, in turn, directly influence the quality of the care that is provided by paid care workers to older persons in need of LTC.

Globally, the care economy is characterized by important decent work deficits, which vary greatly depending on country context, workplace type and cadre of

21. See Government of the United Kingdom: Carer's Allowance.

workers (ILO, 2022b). At the most vulnerable end of the spectrum are personal care workers. They are particularly important in LTC provision, both in institutional settings and in home-based and community care. In HICs, they represent more than half of total LTC employment and the majority of these are home-based (ILO, 2018). Salaries are relatively low and working-time patterns with night shifts and broken shifts are more prevalent in home-based care than in other sectors. Similarly, care workers are more likely to experience being "on call" without any remuneration for their time (*Deutsche Welle*, 2021).

The isolated setting in people's homes can make the care workers' environment unsafe, and conflicts of interests between LTC recipients, family members and personal care workers can arise and impact on their health and safety (ILO, 2018). Similarly, the very nature of the work, if appropriate training and respite is not provided, can impact on their health, given the physical nature of the work to support persons with very limited motor capacities as well as mental exhaustion when supporting persons with dementia or depression. Due to their insecure work contracts and isolation, care workers are also at a higher risk of experiencing violence and harassment at work. This is compounded by the fact that the lack of full-time and long-term employment contracts often means that care workers must work in multiple facilities or homes to ensure a living wage. This reality of multiple workplaces acted to render these workers specifically vulnerable during the COVID-19 pandemic, when they were at a higher risk of both contracting and transmitting the virus (ILO, 2020c).

The care workforce is as diverse as the providers across the continuum of care. Therefore, the care workforce is heterogeneous in terms of skills level, occupations and employment status. Some LTC workers are licenced health professionals operating in the health sector, others are licenced professionals operating in the social care sector, and many licenced and unlicenced care workers operate in the home through domestic work. This means that they may fall under different sectoral labour regulations. In many countries, care work is to a large extent provided through domestic work, which is often excluded from labour law and social protection coverage. The ILO estimates that 61.4 million (or 81.2 per cent) of all domestic workers are in informal employment – a figure that is more than double the share of informal employment for other employees (39.7 per cent) (ILO, 2022c; 2021e). This situation thus impacts social protection coverage. Globally, only half of all domestic workers are legally covered by at least one branch of social security, while only 6 per cent of all domestic workers are legally covered for all benefits.

Recent estimates show the significant discrepancy between legal coverage and the implementation of these laws in practice, which essentially translates into important gaps in effective coverage. Worldwide, more than 80 per cent of domestic workers are not effectively covered by employment-based social

protection (ILO, 2021e). Similarly, the COVID-19 pandemic revealed that many frontline workers in the health sector, and in particular those in temporary, part-time and self-employment, and at the lowest echelons of the skills and wage spectrum, were not benefitting from occupational safety and health measures and were inadequately covered, or not covered at all, by social protection (ILO, 2020d).

Working conditions and wages are also determined by the marketization and outsourcing of long-term care services, processes that are largely driven by the objective of lowering provision costs. Cut-backs in public spending translate into lower prices being paid to LTC providers, with further repercussions on working conditions and wages (ILO, 2018). This situation is aggravated by the fact that, in many countries, social protection policies and systems to guarantee access to childcare, health care and LTC without hardship are still underdeveloped (Scheil-Adlung, 2015). With no sustainable mechanism to finance such guarantees and overall low investments in LTC provision, informal care is widespread.

Poor working conditions and a lack of adequate social protection make the health and social care sectors unattractive to potential workers. The related shortage of health and care workers further impacts on the quality of care provided. Estimates from before the outbreak of the COVID-19 pandemic suggested that an additional 17.4 million health workers were needed to meet the Sustainable Development Goals (SDGs) health index according to the 2013 threshold (ILO, 2018). The existing shortfall in the health workforce could be further exacerbated by the effects of the ongoing pandemic, with increased numbers of health workers who have left the profession, and a growing number of workers reporting the intention to leave after the pandemic, due to exhaustion, dissatisfaction with working conditions and insufficient staffing (International Council of Nurses, 2021; WHO, 2022). At the country level, MLICs experience greater shortages than in HICs. The situation of greater shortages in countries with less resources is partly reinforced by the globalized nature of the health and social care workforce. Migrant workers in the care economy in many countries, whether providing care in institutions or in the home, face hurdles to have their skills recognized as well as barriers in accessing social protection and decent working conditions. Therefore, greater commitment is needed to level the playing field when it comes to the working conditions and social protection coverage of health and care workers. An insufficient number of ratifications of international Conventions in this respect highlights the urgent need for action (ILO, 2022b).

Conclusion

Ageing populations call for profound changes to enable access to LTC without hardship. Many countries face a growing demand for LTC linked to fundamental

demographic and epidemiologic changes combined with shifts in traditional care structures, which urge social protection institutions to develop tailored responses rapidly. Strategies include better coordination among institutions and service providers, and strengthened roles for prevention and health promotion, rehabilitation, ageing-in-place strategies, as well as the use of innovative technologies.

Depending on the context, countries vary greatly in the way LTC is organized, delivered and financed. LTC involves diverse types of benefits (medical, health, care support). In addition, income, in particular old-age pensions, plays a key role, although it is not part of LTC benefit packages. Further, the governance of the LTC system includes multiple sectors, making coordination of the essence. Comprising a diversity of service providers and delivery mechanisms, ensuring the adequacy of LTC also remains challenging. Social and health care models need to be redesigned to allow a greater focus to be placed on prevention, to address staff shortages and to improve access to person-centred quality care. Unlike other social protection areas, paying attention to caregivers is both central to the implementation of LTC and currently a critical gap as regards overlapping gender inequalities.

International social security standards provide guiding principles that, when followed, can maximize the contribution of social protection systems to support the prevention of, and respond to, growing LTC needs. While there is no one-size-fits-all solution, these guiding principles provide a useful compass to tailor country-owned solutions adopting a rights-based approach. Universality of coverage, solidarity in financing, broad risk pooling, gender equality and non-discrimination, as well as strong coordination between health, social and employment policies can contribute to the realization of people's rights to LTC without hardship, in a way that contributes to their well-being while combatting ageism. This contributes not only to achieving the SDGs, but also to the UN Decade on Healthy Ageing. In this respect, the life-cycle approach contained in the Universal Social Protection concept is most adapted to address some of the social determinants of disease and disability in old age, while making sure that both older persons in need of LTC and their caregivers are supported by adequate, inclusive and gender-transformative social protection policies and benefits.

A number of knowledge gaps have been identified in the article. While most of the available evidence and data collection on LTC and on the health impacts of social protection policies concerns HICs, more evidence from MLICs is required. Specific areas of interest are successful examples of practice regarding the coordination of social protection, health and social care that contribute towards the delivery and financing of a guaranteed package of services and products that range across several sectors and effectively includes rehabilitation.

Similarly, contracting modalities and provider payment methods for LTC providers, especially in MLICs, require both documentation and analysis, including regarding their possible impact on the working conditions of care workers. Further, there is an important gap when it comes to the monitoring of social protection LTC programmes outside of the Member countries of the Organisation for Economic Co-operation and Development, to measure and assess the progression of legal and effective coverage over time. Bridging such knowledge gaps will help to foster evidence-based national policies geared towards the design of a guaranteed package of LTC services and products.

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A comparative perspective on long-term care systems

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Abstract This article investigates the challenges of ageing for long-term care. The analysis proceeds in three steps. In the first step, we estimate the prospective care demand for 30 developed countries based on projected ageing and disabilities among the elderly. In the second step, we outline challenges for care systems with respect to shortages of care workers, increasing skill requirements for care workers, barriers to universal and equitable access to care, and cost containment subject to adequate care quality. In the third step, we identify solutions for these challenges by comparing the care systems of Germany, Israel, Japan, the Republic of Korea and the Netherlands.

Keywords long term care, social insurance, ageing population, quality of care, independent living, international

Introduction

Long-term care insurance markets are prone to market failure. Reasons for this failure are imperfect competition, insurers' uncertainty about consumers' risks of requiring care, limited incentives for consumers to avoid risks after purchasing full insurance, long intervals between the time when consumers purchase insurance and when they need it, and high insurance risks of the chronically ill (confer Barr, 1992). This failure leads to actuarially unfair

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insurance premiums and limited coverage (Brown and Finkelstein, 2009; Bell and Lemmon, forthcoming). Existing social health care systems cannot correct this failure because they are not designed for recipients' long-term care (LTC) needs. Therefore, several developed countries have additionally implemented social long-term care insurance to provide their citizens with universal insurance coverage for long-term care. A notable exception is the United States of America, where neither social health care nor social long-term care insurance exists.

Given the process of population ageing, a key challenge for public long-term care systems will be to provide an adequate level of care for a growing elderly population with a declining number of contributors. Although societies may have quite different perceptions of adequate care for cultural, institutional and economic reasons, the implications of population ageing for long-term care systems will be similar. In particular, these systems will need to accommodate an increasing number of frail elderly over the next 20 to 30 years. This surge in demand will require extensive policy reform to secure the sustainability of long-term care insurance and universal access to care.

To guide these reforms, this article investigates the challenges that population ageing poses to long-term care. We aim to address the following questions: How large will the ageing-induced increase in the demand for long-term care be between 2020 and 2040? Which challenges do long-term care systems face when meeting this growing care demand? What are potential solutions to address these challenges?[1]

We proceed in three steps to answer these questions. First, we estimate the prospective increase in care demand over the period 2020–2040. Specifically, we combine the projected demographic structure with data on limitations in activities of daily living in a sample of the elderly from 30 countries to compute the growth in the population share that will rely on long-term care because of old age. We view this share as an approximation of care demand. Our analysis concentrates on European Union (EU) Member States,[2] Israel, Switzerland, the United Kingdom, and the United States for which we have comparable data on limitations in activities of daily living. Our results predict an average increase in care demand of 47 per cent with the largest increases in Southern and Eastern Europe. Our results further highlight that good population health – in terms of a low disability share among the elderly – can moderate growth in care demand.

1. In our discussion, we focus on solutions to meet growing care demand. We acknowledge that growing care demand may also require a trade-off between expenditures on long-term care and other social security programmes because of finite budgets and the saturated contributory capacity of the workforce. However, a discussion of this trade-off is beyond the scope of this article.
2. All EU Member States are included, except for Ireland, which has its own dataset (The Irish Longitudinal Study on Ageing – TILDA).

Second, we discuss potential challenges to long-term care systems that are caused or reinforced by growing care demand. Specifically, we discuss shortages in the long-term care workforce, increasing skill requirements for care workers, barriers to universal and equitable access to care, and cost containment subject to adequate care quality. Our discussion highlights that growth of the care workforce has kept pace with population ageing only in few countries in recent years. Moreover, we point out the importance of eligibility criteria for equitable access to care, care quality, and costs.

Third, we compare the long-term care systems of Germany, Israel, Japan, the Republic of Korea and the Netherlands to formulate potential solutions for meeting growing care demand based on their experiences. We focus on these countries because their long-term care systems typify many of the formal approaches to care in developed countries. This comparison suggests that extending the care workforce requires that work in care professions becomes more attractive and that care workers be recruited from a larger candidate pool. Moreover, we compare different approaches to cost control focusing on their implications for care quality. Finally, we conclude this article by emphasizing prevention and rehabilitation as promising avenues to promote individual well-being and absorb pressure from long-term care systems.

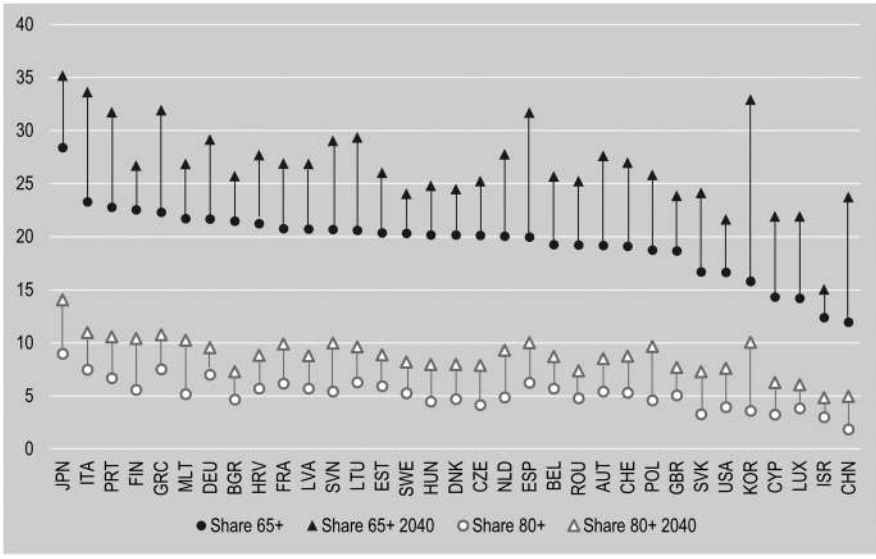
Demand for long-term care insurance in ageing societies

To understand the extent to which population ageing raises care demand, we estimate the prospective demand potential based on projected demographic change and individuals' limitations in pursuing an independent life.

We start by comparing the population share of the elderly in 2020 with the projected population share in 2040. Data are from the United Nations (UNDESA, 2019). Figure 1 documents a considerable rise in the elderly population for selected countries, as measured by the share of persons aged 65 or older and aged 80 or older. On average, the share of persons aged 65 or older will increase by more than a third from 19.6 per cent in 2020 to 26.7 per cent in 2040. This increase is even more pronounced for the share of persons aged 80 or older: the share will increase by 69 per cent from 5.2 per cent in 2020 to 8.8 per cent in 2040.

Furthermore, the figure shows considerable heterogeneity in ageing across countries. For example, Italy, Greece and Spain are ageing particularly fast among the countries with a comparably old population in 2020, whereas Finland, Sweden and Denmark are ageing rather slowly. Moreover, some countries in 2020 still have a comparably young population, such as the People's Republic of China, Israel, and the Republic of Korea. However, while Israel's population is

Figure 1. *Population ageing in selected countries*



Note: The figure shows the share of persons older than age 65 (age 80) in the total population.
Source: UNDESA (2019).

ageing slowly, the populations of the People's Republic of China and the Republic of Korea are ageing faster than any other population. Much of this variation in the elderly share can be attributed to country differences in declining fertility rates, dynamics in life expectancy, and past variations of birth and death rates that produced particularly large cohorts, such as the baby boom generation (Bloom and McKinnon, 2010).

Together, the projections of the elderly share indicate that long-term care systems in all these countries will face a considerable growth in potential care recipients and that this growth will be particularly pronounced for fast-ageing countries.

Fortunately, however, not every elderly person will need long-term care. To learn more about what fraction of the elderly will rely on long-term care, we use individual-level data from a family of surveys on health, ageing, and retirement that are representative at the country level and comparable across countries. Specifically, we use data from the Survey of Health, Ageing and Retirement in Europe (SHARE) for the EU-27 (except Ireland), Israel and Switzerland, the Health and Retirement Study (HRS) for the United States, and the English Longitudinal Study of Ageing (ELSA) for England. We draw data from the most recent survey

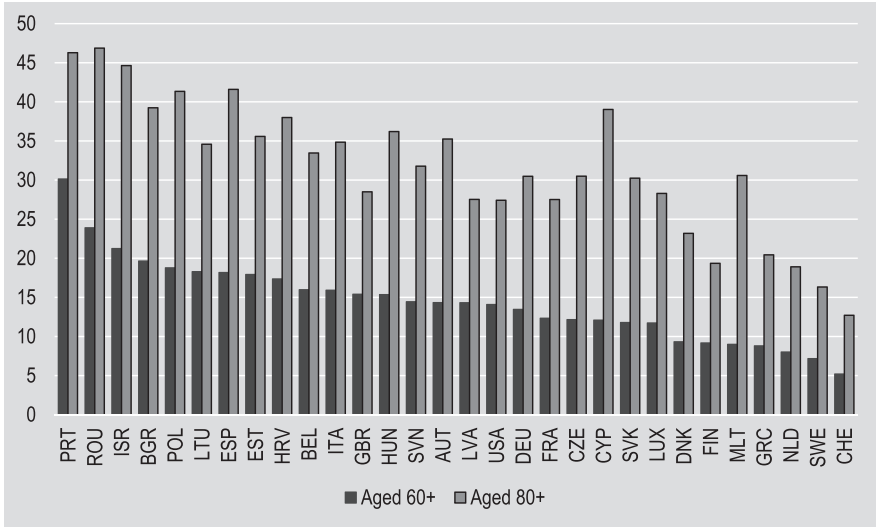
waves, which were collected around the same time but before the COVID-19 pandemic. Therefore, we use data from SHARE wave 7 (Börsch-Supan, 2020), HRS wave 13 (Health and Retirement Study, 2021a, 2021b), and ELSA wave 8 (Banks et al., 2021), which were collected over the period 2016–2017. Given that the Netherlands did not participate in SHARE wave 7, we add data from wave 8 (Börsch-Supan, 2021).

We measure the share of frail elderly as the population aged 65 or older and aged 80 or older with at least two limitations in activities of daily living (ADL) or instrumental activities of daily living (IADL) combined. We construct this measure from five limitations in both ADL and IADL, which are available consistently across surveys. For limitations in ADL, we use information on whether individuals have difficulties with i) dressing (including shoes and socks), ii) walking across a room, iii) bathing or showering, iv) eating or cutting up food, or v) getting in and out of bed. For limitations in IADL, we use information on whether individuals have difficulties with i) preparing a hot meal, ii) shopping for groceries, iii) making telephone calls, iv) taking medication, or v) managing money. In total, elderly individuals can have between 0 (no disability) and 10 limitations in ADL and IADL (severe disability).

Limitations in ADL and IADL are well suited to approximate the fraction of the elderly that requires care for several reasons. First, they are predictive of whether individuals rely on formal or informal care at home or have stayed in a nursing home. Second, they correlate with aggregated measures of care needs, such as the average amount of care hours and domestic help individuals receive per week. Third, they are predictive of whether individuals suffer from dementia, which is expected to become one of the major drivers of old-age disability in the foreseeable future (Counts et al., 2021). Fourth, they form an integral component of eligibility assessment tests that many countries use to determine for which benefit levels or care arrangements potential care recipients qualify.

Figure 2 shows the share of individuals aged 65 or older and aged 80 or older with at least two limitations in ADL or IADL. We concentrate on two or more limitations to exclude mild forms of disability, which often do not require long-term care. On average, 14.5 per cent of individuals aged 65 or older have two or more limitations in ADL or IADL. This number increases to 31.7 per cent for individuals aged 80 or older. However, countries vary considerably. Only 5 per cent of those aged 65 or older in Switzerland have two or more limitations compared with 30 per cent in Portugal. With a few exceptions, the elderly share with two or more limitations is higher in Eastern and Southern Europe than in Northern and Western Europe. Germany, the United Kingdom, and the United States fall in the middle of this distribution. This heterogeneity also obtains for the elderly population aged 80 or older, though the relative differences shrink somewhat in size.

Figure 2. *Share of elderly with disabilities in selected countries*



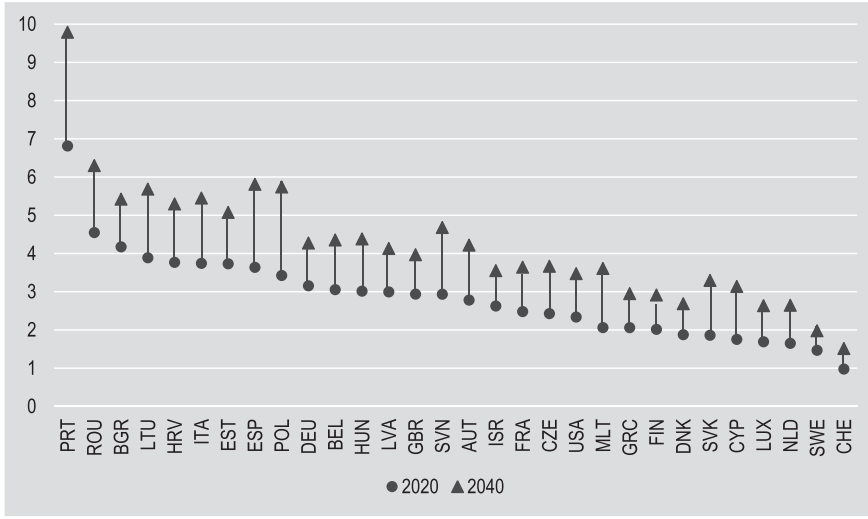
Notes: The figure shows the share of individuals older than age 65 (age 80) with at least two limitations in ADL or IADL. The values for the United Kingdom refer to England only.
Sources: Banks et al. (2021), Börsch-Supan (2020, 2021), and Health and Retirement Study (2021a, 2021b).

Together with the demographic projections, these numbers indicate that the number of potential care recipients will rise as population ageing raises the elderly share in the population and shifts more mass into the group aged 80 or older in which disabilities are widespread. In addition, the figure suggests that population ageing will hit Southern and Eastern European countries, where a high share of elderly individuals have disabilities, particularly hard.

To get a sense of the quantitative dimension of the ageing-induced increase in care demand, we estimate the share of the population that will likely rely on long-term care. Specifically, we combine the projected change in the relative size of the age groups aged 65–79 and aged 80 or older between 2020 and 2040 with our age-specific data on limitations in ADL and IADL from 2016–2017 and then compute the share of the total population that is aged 65 or older and has at least two limitations in ADL or IADL. By construction, this measure only captures disability of individuals aged 65 or older, so that it only reflects the care demand that is due to old age. We view the growth in this measure as a coarse approximation of the expected increase in care demand related to population ageing.

Figure 3 presents the results of this projection exercise. On average, population ageing raises the share of the population that will likely rely on long-term care from 2.9 per cent to 4.2 per cent, which corresponds to an increase in care demand of

Figure 3. *Projected demand for long-term care in selected countries*



Note: The figure shows the share of the population that is composed of individuals older than age 65 with at least two limitations in ADL or IADL.

around 47 per cent. Again, countries vary considerably. With few exceptions, care demand is higher in Southern and Eastern Europe than in Western and Northern Europe. In absolute terms, projected care demand increases most in Poland, Portugal and Spain and least in Switzerland and the Scandinavian countries. In relative terms, projected care demand increases most in Cyprus, Malta and Slovakia (around three-quarters) and least in Bulgaria, Sweden, and the United Kingdom (around a third). Germany faces a similar increase in care demand as the United Kingdom, whereas the France and United States and fall in the middle of this distribution.

This evidence highlights the interplay of population ageing and population health for the prospective need for long-term care. The projected growth in care demand is most pronounced in countries that are ageing fast and concomitantly have a high prevalence of disabilities among their elderly. The coincidence of these two forces will pose challenges for long-term care systems in Southern and Eastern Europe in particular. Moreover, the evidence indicates that good population health can absorb significant pressure on long-term care systems. For example, Switzerland and the Netherlands face only moderate growth in projected care demand, even though their populations are ageing comparably fast. The reason for this moderate growth is the low prevalence of disabilities compared with other countries in our sample. Measures that prevent disability and support

the elderly in leading independent lives may therefore help countries reduce the pressure on long-term care systems and increase individual well-being. We return to this point at the end of this article.

Altogether, our evidence shows that population ageing significantly raises the demand for long-term care in developed countries. This rise will increase and intensify challenges for long-term care systems to provide an adequate level of care for the elderly population. We discuss these challenges next.

Challenges for long-term care systems to meet growing demand

Population ageing requires long-term care systems to significantly extend their service capacity to keep up with growing demand for social as well as medical care. In this section, we discuss four challenges that long-term care systems face when trying to meet additional demand: i) overcoming supply shortages of care workers, ii) meeting skill requirements of care workers, iii) providing access to adequate care, and iv) keeping the cost of care systems under control while guaranteeing a minimum quality of care services. We formulate potential solutions to these challenges later in this article.

Supply shortages of long-term care workers

Long-term care services are labour intensive. Meeting the prospective care demand therefore requires a considerable extension of the care workforce, including qualified nurses and personal care workers who can assist with activities of daily living or provide personal support. According to the Organisation of Economic Co-operation and Development (OECD, 2020, pp. 34–35), the absolute number of nurses and personal care workers increased in half of OECD Member countries between 2011 and 2016, and it has increased for at least one of the two groups in three-quarters of OECD Member countries. In relation to the elderly population, however, the care workforce has grown only in a few states (for example, Germany, Israel, and Japan) and has stagnated in most other OECD Member countries (OECD, 2019, Figure 11.25).

Of course, holding the ratio of care workforce to elderly population constant in the context of population ageing is a success if the care sector can reasonably meet the care needs of citizens. However, if the number of total available carers is low, a stagnating ratio implies that the brunt of care must be borne by informal care, which can effectively substitute for formal care only if care needs are low and do not require professional skills (Bonsang, 2009). This concern applies in particular to countries in Southern and Eastern Europe, where the care

workforce is significantly below the OECD average (OECD, 2019, Figure 11.25). In these countries, informal care is indeed more widespread than in Northern and Western European countries (Barczyk and Kredler, 2019), whereas satisfaction with long-term care systems is lower (Carrera et al., 2013, Figure 2.13). Making matters worse, informal care provision can come with significant economic costs for caregivers who tend to reduce labour supply to provide care (see Bauer and Sousa-Poza, 2015, for a literature survey). These costs are predominantly borne by women who constitute the majority of caregivers (OECD, 2019, Figure 11.21), and counteract gains from policies promoting employment – especially of women – to support the fiscal sustainability of social security programmes.

Skill requirements of care workers

Care tasks span a broad range of activities including assistance with activities of daily living, administration of medication, health status monitoring, psychological support, and case management. These tasks require sufficient skills of both personal care workers and nurses, which presents challenges in practice.

Training requirements for personal care workers are low in many countries, although personal care workers are involved in monitoring care recipients' health status, the implementation of care plans, and communication with relatives (OECD, 2020). In contrast, training requirements for nurses are high. In half of the OECD Member countries, nurses must have a bachelor's degree or equivalent vocational training (OECD, 2020). Nevertheless, nurses rarely receive specialized training in geriatrics, which is required for dealing with ageing-induced diseases, such as dementia (OECD, 2020). Moreover, foreign nurses often work as personal care workers because their degrees are not fully acknowledged.

These shortcomings in meeting skill requirements impair care quality. This situation is additionally aggravated by low pay, limited career prospects, and low perceived respect and appreciation for care work, which can produce high turnover at care facilities and thus further deteriorate care quality and productivity (Squillace et al., 2008). Moreover, care workers' low pay, education, and social status may contribute to elder abuse among other things (Abolfathi Momtaz, Hamid and Ibrahim, 2013). Finally, the mismatch between skills and tasks of foreign nurses raises ethical concerns about recruitment of migrant care workers from less-developed countries that encounter similar challenges from population ageing but that cannot retain their skilled workers.

Access to adequate care

Access to care can be viewed as the availability of care services, their accessibility by potential recipients, and their utilization (Brugiavini et al., 2017; for a discussion of different conceptualizations of access, see Levesque, Harris and Russel, 2013). Long-term care systems regulate this access along three axes. First, they implement the legal and institutional framework that determines private and public care provision. Second, they define under which conditions an individual qualifies for any support from long-term care insurance. Third, they impose criteria that assign benefit levels or claims to benefit or care services for eligible recipients. In public long-term care systems, these regulations are often codified as legal entitlements to guarantee universal and equitable access to care (for example, in Germany, Japan and the Netherlands).

The design of these regulations poses challenges to long-term care systems that are amplified by demographic change. On the one hand, eligibility criteria determine the weighting of physical, cognitive, and psychological impairments for access to care. To provide adequate care, this weighting must account for disabilities that will become more widespread as populations age. For example, until a reform in 2017, many dementia patients in Germany received few benefits because the eligibility criteria emphasized physical functioning more than cognitive and psychological functioning (Theobald and Hampel, 2013; BMG, 2021). On the other hand, adequate care requires the assignment of benefit levels to be flexible enough to account for differential care needs. For example, until a reform in 2018, Israel's long-term care insurance assigned similar benefit levels to recipients with different care needs, such that the benefits were not always adequate to meet the care needs of more disabled recipients (Asiskovitch, 2013; Cohen, 2020).

Costs of long-term care systems and quality of care services

Providing universal access to care services of sufficient quality is expensive. With growing demand, long-term care systems will face considerable financial strain. To provide an acceptable supply of care services nonetheless, policy-makers need to promote efficiency of long-term care systems without jeopardizing care quality. In pursuing this goal, policy-makers will encounter several challenges.

First, the design of eligibility criteria determines much of the quality and costs of long-term care systems. Ceteris paribus, a more generous design of these criteria provides benefits to a larger number of recipients and grants higher benefits per recipient (that is, more and better services) than a thriftier design. Hence, the eligibility criteria imply a trade-off between the costs and quality of care systems. Growing care demand and changing care needs may challenge existing benefit

structures and result in excessive costs or inadequate service quality. Second, care must follow stable long-run trends in demography, which require reliable funding. Funding can take place at the federal (national), regional, or municipal level, depending both on the tasks each level performs and path dependency in institutions. While strong involvement of municipalities seems ideal to provide services close to the people in need, municipal funding can vary considerably if tax revenues and demographic structure correlate with economic performance. This variation may impede equitable access to care if long-term care insurance does not sufficiently pool risks to stabilize funding streams. Third, insufficient funding of long-term care may shift costs into the health care sector and create new financial strain.

To deal with these problems, many long-term care systems try to improve cost efficiency by promoting competition between private and public care providers. Competition is an effective way to improve efficiency if providers compete over prices for a given level of service quality. However, this rationale fails if providers compete over quality rather than prices. In this case, care costs do not fall, but care quality deteriorates. We turn to potential solutions for the above-mentioned challenges next.

Experiences and potential solutions from selected countries

Growing care demand poses considerable challenges for long-term care systems. In this section, we compare the care systems of Germany, the Netherlands, Israel, Japan, and the Republic of Korea to highlight potential avenues for addressing these challenges. We focus on these countries because their care systems encompass many of the formal approaches to long-term care around the world. Table 1 provides a brief overview of each of these systems with respect to i) welfare system and funding, ii) access, iii) benefits, iv) service provision, and v) system structure.

In each of these countries, compulsory long-term care insurance accounts for the lion's share of care. The systems are mainly financed by payroll contributions (Germany and Israel) or by a mix of payroll contributions and taxes (Japan, the Republic of Korea and the Netherlands). Co-payments help care systems control costs by lowering incentives for service use (Soga et al., 2020) and redistribute economic burdens among income groups through means-testing (Wouterse, Hussem and Wong, 2022).[3] Access is regulated by assessment tests, which in

3. More generally, work on the implications of insurance co-payments for service use in the health context dates back as far as to the Rand Health Insurance Experiment in the 1970s, which documented that demand for medical services falls as co-payments rise (see, for example, Manning et al., 1987). Many of the conceptual arguments raised in this literature also extend to long-term care insurance.

Table 1. *Long term care insurance (LTCI) in selected countries*

Country	Welfare system and funding	Access	Benefits	Service provision	System structure
Germany	Compulsory public LTCI with option of private LTCI for high-income earners and civil servants. Public LTCI is financed by payroll contributions and co-payments.	Access is open to anybody who meets the eligibility criteria. Individuals receive benefits if they qualify for 1 out of 5 care grades. Care grades are based on impairments in mobility, cognitive ability, behaviour, ADL, and IADL.	Benefits are in-kind or in cash. Benefits depend on care grades. Co-payments and additional costs are borne by recipients, or by social assistance if they are too high. Cash benefits can be used to pay informal carers.	Recipients choose between institutional and home care. Care advisors help with applications, service choice, benefits, and care plans. Informal carers can receive professional training, entitlements for paid leave from work, and respite support.	Multi-payer system in which care funds are organized under the umbrella of sick funds. Providers negotiate contracts with care funds and local authorities. Services must meet uniform quality standards, which are monitored regularly. Community-based LTC centres help with care management.
Netherlands	Compulsory public LTCI, which is financed by payroll contributions and co-payments. Social care is tax funded at the municipal level.	Access is open to anybody who meets the eligibility criteria. Individuals receive benefits according to assessed care needs, which are based on impairments in mobility, cognitive ability, behaviour, ADL, and IADL.	Benefits are in-kind or in cash. Benefits depend on care needs. Income-dependent co-payments are borne by recipients. Cash benefits can be used to pay informal carers.	Recipients receive non-residential care or residential care if non-residential care is infeasible. Home nursing care is provided through health insurance. Recipients choose care providers. Non-residential care is organized by insurers or municipalities. Social care is provided by municipalities. Informal carers can receive respite support.	Multi-payer system with home care, institutional care, and social care. Providers negotiate contracts with regional care offices and municipalities, which purchase care from public funds. Services must meet uniform quality standards, which are monitored regularly.
Israel	Compulsory public LTCI, which is financed by payroll contributions.	Access is subject to eligibility criteria and means test. Individuals receive benefits if they qualify for 1 out of 6 benefit levels based on whether individuals live alone and on their impairments in mobility, ADL, cognitive ability, and behaviour.	Benefits are in-kind or in cash. Care hours depend on benefit levels. Benefits can be used to pay informal carers only under certain conditions as LTC aims at complementing family care.	Recipients receive only home care under LTCI. Institutional care is financed by sick funds, social welfare programmes, and co-payments. Services and providers are determined by LTC committees. However, recipients can ask for specific providers.	Single-payer system administered by the National Insurance Institute, which issues tenders for care contracts over which LTC providers compete in a quasi-market setting. These tenders specify employment conditions, required qualifications, and wages.

(Continued)

Table 1. *Long term care insurance (LTCI) in selected countries – Continued*

Country	Welfare system and funding	Access	Benefits	Service provision	System structure
Japan	Compulsory public LTCI, which is financed by payroll contributions; subsidies from national, prefectural, and municipal taxes; and co-payments. Contributions are means-tested over age 65.	Access is open to anybody who meets the eligibility criteria. Individuals receive benefits if they qualify for 1 out of 2 support levels or 1 out of 5 care levels. Support and care levels are based on impairments in physical and cognitive ability, ADL, and IADL.	Benefits are in-kind only. Benefits depend on support or care level. Individuals without a support or care level may use preventive care at the community level.	Recipients choose between institutional and home care. They also choose care managers and providers. Institutional care is provided in nursing homes, geriatric health services facilities, and medical LTC sanatoriums. Care managers help with care plans and service arrangement. Informal carers can receive respite support.	Single-payer system with LTC, social care, and health care. Municipalities formulate service plans for which they receive funding. Municipalities license providers. Services must meet uniform quality standards, which are monitored regularly. Policy reforms aim to integrate all aspects of care in a community-based health care system.
Rep. of Korea	Compulsory public LTCI, which is financed by payroll contributions, tax subsidies, and co-payments.	Access is open to anybody who meets the eligibility criteria. Individuals receive benefits if they qualify for 1 out of 6 care levels, which are based on impairments in ADL and IADL, cognitive ability, behaviour, and mobility.	Benefits are in-kind except when in-kind provision is infeasible. Benefits depend on care levels. Means-tested co-payments and additional costs are borne by recipients.	Recipients choose between home care or institutional care. Institutional care is provided in LTC facilities or in LTC hospitals. Care management is planned but not yet introduced.	Single-payer system administered by the National Health Insurance Service. Local governments regulate and license providers. Services must meet uniform quality standards, which are monitored regularly. Health care and LTC are separated, complicating coordination. Policy reforms aim to integrate all aspects of care in community-based care system.

Sources: Mot et al. (2010), Tamiya et al. (2011, 2020), Asiskovitch (2013), Da Roit (2013), Won (2013), Choi (2015), van Ginneken and Kroneman (2015), Maarse and Jeurissen (2016), European Commission (2017, 2019), Joshua (2017), Alders and Schut (2019), Hasson and Dagan Buzaglo (2019), Cohen (2020), Ga (2020), Yamada and Arai (2020), BMG (2021), and Kim and Kwon (2021).

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some form consider living circumstances and impairments in mobility, cognitive ability, behaviour, ADL, and IADL. In Israel, benefits are additionally means-tested, so people receive benefits only if their household income does not exceed certain income thresholds linked to the average wage (Asiskovitch, 2013). All systems provide in-kind benefits, with the possibility of cash benefits in Germany, Israel and the Netherlands. Services are provided at the local level with varying degrees of consumer choice, whereas funding mainly takes place at higher organizational levels. Germany and the Netherlands have a multi-payer system with numerous regional care funds or care offices, whereas Israel, Japan, and the Republic of Korea have a single-payer system with care insurance organized at the national level. We next examine how these countries address challenges from growing care demand.

How can the care workforce be extended and shortages be avoided?

One solution is to make work in care professions more attractive. Germany has launched several measures to enhance working conditions in the care sector. These measures include care-specific minimum wages and regulations that foster collective bargaining; improved compatibility of family and work; a uniform nursing education combining general, geriatric, and paediatric nursing; and remunerated, free-of-charge nursing education (BMG, 2021). Additional measures reduce the economic costs of informal care. In particular, care recipients can compensate informal caregivers with cash benefits, and long-term care insurance contributes to social security for performed care hours if caregivers work 30 hours per week or less (BMG, 2021, pp. 53–54).

Another solution is to recruit care workers from a larger candidate pool. For example, Japan offers unemployed people training programmes and job opportunities in long-term care, which raised the number of care workers by 320,000 between 2011 and 2015 (OECD, 2020, p. 50). An alternative strategy is to recruit foreign care workers. In Israel, for example, more than half of long-term care workers are foreigners (Asiskovitch, 2013, p. 15). To facilitate recruitment of foreign care workers, the German Federal Employment Agency coordinates with its partner institutions to attract trainees and care workers from Bosnia and Hercegovina, Brazil, El Salvador, Mexico, the Philippines, Tunisia, and Viet Nam (BMG, 2021, p. 49). This coordination aims to improve acknowledgment of foreign degrees, accelerate visa processing, and raise ethical standards for recruitment from outside the European Union (BMG, 2021, pp. 49–50). Finally, Germany, Israel and the Netherlands create financial incentives for informal care by allowing recipients to pay caregivers with cash benefits.

How can skill requirements for long-term care workers be met?

One solution is to license care professions. Such practice is common for nurses, whereas only few countries require personal care workers to hold a license or certificate to work in the care sector (OECD, 2020, p. 14). In the Republic of Korea, for example, personal care workers receive a certificate from the local government documenting that they have the basic competencies to work in elderly care or health care (OECD, 2020, Table 3.4). An alternative to licensing is to regulate the tasks personal care workers are allowed to perform. In Israel, personal care workers predominantly assist with activities of daily living and provide psychological support through communication, whereas in the Republic of Korea they also help with medication and act as case managers (OECD, 2020, Table 3.1).

Apart from regulating entry into care professions, facilitating access to long-term care training improves care workers' skills. Therefore, Germany, Israel, and Japan sponsor training in long-term care; the Republic of Korea provides internship and mentoring programmes; and the Netherlands offers career guidance to help care workers choose the best training options (OECD, 2020, p. 85). In addition, better curricula may improve career prospects of care workers and equip them with the skills needed for elderly care. For this reason, nursing education has combined general, geriatric, and paediatric nursing in Germany since 2020 (BMG, 2021, p. 46).

How can long-term care systems provide access to adequate care?

A common solution is to grant people legal entitlement to long-term care if they meet certain eligibility criteria. Such commitments from governments are implemented to guarantee universal and equitable access to care at the appropriate time. In the Netherlands, for example, cost containment strategies in the 1980s and 1990s resulted in rationing of care services and long waiting lists. A court decision successfully challenged this practice in 1999, which asserted that citizens have a right to timely care, thus leading to the eventual suspension of the prevailing cost containment strategies (Schut and van den Berg, 2010; Da Roit, 2013).

Once individuals are entitled to care, eligibility criteria determine the support from long-term care insurance. Typically, these criteria either define several disability levels, which entitle recipients to benefits, or they directly define benefits for or legal claims to care services depending on the type of disabilities. In Japan, for example, people receive long-term care benefits according to one of five care levels or preventive long-term care benefits according to one of two

support levels (Yamada and Arai, 2020). In contrast, people in the Netherlands receive benefits according to support needs in functional domains that inter alia cover personal care, nursing care, household management, psychological health, treatment and rehabilitation, and housing (Joshua, 2017). Given that eligibility criteria determine the benefit structure of long-term care insurance, assessments should be standardized to provide equitable access to care but leave sufficient flexibility for individuals' care needs.

Co-payments constitute yet another dimension to regulate access to long-term care. Their purpose is twofold: on the one hand, they subsidize long-term care insurance, on the other hand, they reallocate costs to care recipients and thus influence service demand. A concern is that high co-payments can financially ruin the least affluent or deter them from using care services at all (Scheil-Adlung and Bonan, 2013). Two solutions help avoid such catastrophic scenarios. In the Republic of Korea and the Netherlands, co-payments are means-tested to reduce the economic burden for the poor (Won, 2013; Wouterse, Hussem and Wong, 2022). In Germany, social assistance covers additional care costs if recipients cannot bear them (European Commission, 2017).

How can costs be controlled without compromising service quality?

Countries use direct and indirect approaches to control costs and service quality. A direct solution is to regulate care contracts. In Israel, for example, the National Insurance Institute issues tenders for care contracts, which specify employment conditions and wages for home care (Hasson and Dagan Buzaglo, 2019). This approach effectively controls costs because only the National Insurance Institute can issue tenders. However, the system has also been criticized for imposing adverse working conditions and forcing wages below levels that would emerge in competitive markets (Hasson and Dagan Buzaglo, 2019; Cohen, 2020). Similarly, the Netherlands has decentralized the provision of non-residential care to insurers and municipalities under the assumption that they organize long-term care more efficiently than regional care offices and thus reduce costs (Maarse and Jeurissen, 2016).

Another direct solution is to regulate the types of care to which recipients have access. Historically, residential care in nursing or residential homes has been widespread in the Netherlands. Since 2015, individuals receive residential care only if home care and non-residential care are infeasible, not only because residential care is more expensive, but many people prefer to "age in place" (Da Roit, 2013; Maarse and Jeurissen, 2016).

An indirect solution to controlling costs and service quality is competition among care providers. If consumers choose services according to their price and

quality, providers will compete to offer these services at the lowest cost while adhering to adequate service quality. As stated, a concern is that without quality controls, providers will compete over quality rather than prices, thus diminishing service quality. Therefore, competition policies are usually complemented by quality standards that are monitored regularly. While each of the discussed long-term care systems promotes competition among providers, evidence on cost reductions and quality is sparse. Evidence from Sweden, the United Kingdom and the United States indicates that competition lowers prices but that the effect is modest (Nyman, 1994; Forder and Allan, 2014; Bergman et al., 2016). Likewise, competition has modest positive effects on care quality (Zhao, 2016; Bowblis and Applebaum, 2017; Hackmann, 2019). However, supply shortages – which may increase due to population ageing – can stifle competition and thus counteract beneficial effects on prices and quality (Nyman, 1988; Ching, Hayashi and Wang, 2015; Yang, Yong and Scott, 2022).

An important determinant of costs and care quality is the funding structure. Insufficient integration of health care and long-term care can lead to inadequate service provision. In the Republic of Korea, for example, admission criteria for long-term care facilities and long-term care hospitals are not aligned. This resulted in a situation wherein more than a half of those in long-term care hospitals had only low medical care needs, whereas a fourth of people in long-term care facilities, which are not intended to provide health care, had high medical care needs (Kim, Jung and Kwon, 2015; Kim and Kwon, 2021). Moreover, insufficient coordination of health care and long-term care institutions can incentivize cost shifting between funding sources. In the Netherlands, care is funded from three financing regimes for social care, community nursing, and home health care and institutional care. This taxonomy creates incentives for municipalities, which have a fixed budget for social care, to nudge people into applying for institutional care (Alders and Schut, 2019). Jointly organizing sickness funds and care funds – as in Germany – can mitigate this problem. Nevertheless, reforms to improve coordination and integration of care remain ongoing with a trend toward integrated community-based care systems in the Republic of Korea and Japan (Ga, 2020; Yamada and Arai, 2020).

How can healthy ageing help?

Our evidence on care needs indicates that care demand will grow less in countries with a low share of elderly with disabilities. This suggests that prevention and rehabilitation measures that focus on maintaining functional status and personal autonomy present promising avenues to promote individual well-being and absorb pressure from long-term care systems – a perspective that is fully in line

with the agenda of the United Nations Decade of Health Ageing (2021–2030). While rehabilitation services are common in health care, prevention services in long-term care are much less common. Only a few countries explicitly target disability prevention in their long-term care strategy. One such example is Japan, which in 2015 implemented a community-based population strategy that aims to promote individual autonomy by providing preventive care, health care, long-term care, and welfare and housing services to all individuals at the community level (Yamada and Arai, 2020). Notably, this strategy also comprises community activities, such as salons, that facilitate social activity of the elderly and are open to persons without any support or care level (Yamada and Arai, 2020). In ongoing reform processes, Germany and the Netherlands consider tele-care and redesigning living environments as alternative avenues to promote healthy ageing and to preserve personal autonomy (European Commission, 2019).[4]

Concluding remarks

Population ageing will considerably raise the share of the population that relies on long-term care. This growth in care needs will pose challenges to the sustainability of long-term care systems and require extensive policy reform. To guide this reform process, this article examines the challenges that ageing poses for long-term care.

Our results document that demand for care will, on average, rise by 47 per cent with considerable differences across countries. The size of this increase depends not only on the speed of ageing but also on the health of the elderly population. Therefore, care demand will grow most in Southern and Eastern Europe, where populations are ageing rapidly and disabilities are widespread among the elderly. In contrast, good health among the elderly mitigates some of this growth in Northern and Western Europe.

The growth in care demand will pose and reinforce challenges for long-term care systems with respect to care supply, service quality, and costs of long-term care insurance. We particularly highlight challenges concerning shortages in the long-term care workforce, increasing skill requirements for care workers, barriers to universal and equitable access to care, and cost containment subject to adequate care quality. We identify potential solutions for these challenges by comparing the long-term care systems of Germany, Israel, Japan, the Republic of Korea and the Netherlands. Our discussion indicates that extending the care

4. The public health literature also discusses nudge-type interventions to promote healthy lifestyles. While such interventions improve targeted outcomes – such as diet – in experimental settings, it is unclear whether and to what extent they can be scaled up to the population level (see Ledderer et al., 2020, for a literature survey). To the best of our knowledge, there are currently no major interventions along these lines in Germany, Israel, Japan, the Republic of Korea and the Netherlands.

workforce requires care professions to become more attractive. Moreover, the discussion highlights eligibility criteria for access to care systems as a central determinant for costs and service coverage. We conclude this article by emphasizing prevention and rehabilitation measures as promising avenues to promote individual well-being and absorb pressure from long-term care systems by improving the health of the elderly.

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Understanding the "state of play" of long-term care provision in low- and middle-income countries

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Abstract In this article, we provide an overview of the current long-term care (LTC) landscape across low- and middle-income countries (LMICs), based on an analysis and synthesis of literature review findings. We begin with a brief assessment of LTC needs on the demand side, followed by a supply side assessment of the available mix of formal LTC services vis-à-vis informal care provision. Next, we describe and discuss the role of government policies in LTC provision and governance. We conclude by discussing and offering practical LTC policy considerations for LMICs, drawing on experiences, best practices and lessons learned from high-income countries.

Keywords long term care, ageing population, coverage, developing countries

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Introduction

In virtually all countries across the world the population is ageing and, consequently, both the number and proportion of older people are growing. Notably, the ageing process is accelerating at a more rapid pace in low- and middle-income countries (LMICs) than in high-income countries (HICs). In 2020, older people aged 65+ accounted for roughly 8 per cent of the population in middle-income countries, a figure which is projected to double to exceed 16 per cent by 2050; even in low-income countries that typically have much younger populations, the proportion of older people aged 65+ will jump from about 3 per cent in 2020 to over 5 per cent in 2050 (UNDESA, 2019). In comparison, the proportion of older people aged 65+ in HICs will increase more gradually, from 18 per cent in 2020 to 27 per cent by 2050. In 2020, there were an estimated 727 million people aged 65+ worldwide, of whom over two-thirds (68 per cent) lived in LMICs (UNDESA, 2019). Projections indicate that by 2050, the global population aged 65+ will more than double, to top 1.5 billion, of whom more than three-quarters (77 per cent) will live in LMICs.

While the population is growing older and with life expectancy increasing steadily across LMICs, the burden of non-communicable diseases (NCD) and age-related loss of autonomy (or disabilities) are also on the rise (Kazibwe, Tran and Annerstedt, 2021). Recent research on trends in the loss of autonomy among older adults in 23 LMICs forecasts that the prevalence rate of people living with severe activity limitations will change very little in the next 30 years; however, the absolute number of persons with activity limitations will increase as the sheer size of the older population swells (Weber and Scherbov, 2020). Thus, despite anticipated gains in life expectancy, the number of years in later life in ill health and without full autonomy is expected to increase. Meanwhile, there is growing concern that family-based elder care alone – traditionally the mainstay of old age support and long-term care (LTC) – is no longer sufficient to meet the escalating demand for LTC services for rapidly ageing populations across LMICs (Feng, 2019).

Yet, in most countries, LTC has not been given a sufficiently high priority on the national policy agenda (Scheil-Adlung, 2015). To help all countries address the ageing challenges, the United Nations launched the *Decade of Healthy Ageing 2021–2030*, to promote healthy ageing and improve the lives of older people.[1] It identifies "access to long-term care for people who need it" as one priority area for action, which is crucial for older people with declining physical or mental capacity to optimize their functional ability and live meaningful lives. Baseline estimates indicate that more than 142 million older people, or 14 per cent of the world population aged 60+, are currently unable to meet all of their basic daily

1. See World Health Organization website: UN Decade of Healthy Ageing 2021–2030.

needs due to functional limitations (WHO, 2020). The majority of these older people live in LMICs, where the challenge for meeting their care needs is particularly acute, due to the absence of robust health care and LTC systems.

The LTC research literature, to date, has been dominated by studies in HICs with mature LTC systems. In many LMICs, formal (paid) LTC services are emerging in the public sector and private market, but they are in the early stages of development and not well documented. The lack of a LTC research and knowledge base in LMICs is an impediment to evidence-based policy planning, formulation and evaluation in these countries (Lloyd-Sherlock, 2014; Aboderin, 2019).

In this article, we provide an overview of the current LTC landscape across LMICs, based on an analysis and synthesis of findings from a literature review. We begin with a brief assessment of LTC needs on the demand side. Then, on the supply side, we describe the current availability and utilization of the mix of formal (i.e. paid) LTC services across home, community and institutional (residential) care settings vis-à-vis informal (i.e. unpaid and familial) care provision in LMICs. Next, we describe and discuss government policies on LTC provision and governance (including regulation). Finally, we discuss and offer practical LTC policy considerations for LMICs, drawing on experiences, best practices and lessons learned from HICs.

We note that no consensus definition of LTC currently exists. In the context of this article, we apply one definition used by the European Commission and the Social Protection Committee,[2] whereby LTC refers to:

> a range of health care and social care services and assistance, for people who, as a result of mental and/or physical frailty and/or disability and/or old age, over an extended period of time depend on help with daily living activities, and/or need some permanent nursing care (EC, 2021).

As such, LTC covers both medical care and non-medical aspects of services and support for older adults. However, our focus is primarily on the latter, namely, non-medical long-term services and support to meet the chronic care needs of older adults with physical and/or cognitive impairments that require help by others with daily living activities. Medical or health care for older people is discussed mainly in the context of integrating the full range of services in a continuum of care for older adults with LTC needs. Furthermore, although LTC encompasses both formal and informal care, our focus is on formal LTC

2. The Social Protection Committee is a European Union advisory policy committee for Employment and Social Affairs Ministers in the Employment and Social Affairs Council.

provision, which is typically by paid professionals – in contrast to informal LTC that is typically provided by unpaid family members, friends or neighbours.

Our analysis and discussions are based on a review of the relevant literature, both published and grey, identified through a series of web searches and databases as well as national and international policy documents that are in English and published in the past 20 years (2000–2022). The review covers selected LMICs in Asia, Central and South America, Middle East and North Africa, and sub-Saharan Africa.

Current LTC landscape in LMICs: A demand side assessment

Across LMICs, informal family-based care dominates the elder care systems, where the provision of care and support for elderly relatives is primarily perceived to be the domain of the family, mostly by women. Indeed, even in HICs with mature LTC systems, informal care remains a cornerstone of LTC provision (EC and Zigante, 2018). In some countries, such as the People's Republic of China (hereafter, China), filial piety is written into law (Feng, 2017). Yet, factors such as expanding female labour market participation, smaller family size, urbanization, migration and increasing population mobility are resulting in gaps in caregiving and gradually eroding these traditional elderly care systems (Holmes, 2021; Feng, 2019). As these demographic, social and economic trends continue and the gap between demand and supply of elderly care increases, the need for LMICs to develop comprehensive LTC systems is becoming ever more imperative (Holmes, 2021).

Dependency (loss of autonomy) and LTC needs

The prevalence of dependency is commonly used to gauge LTC needs among older adults, typically through the measurement of functional status – namely, a person's ability to perform activities of daily living (ADLs, such as bathing, dressing, and using the toilet) or instrumental activities of daily living (IADLs, such as shopping, preparing meals, performing housework and managing medication). The measurement of ADLs has been relatively more consistent across different countries than the measurement of IADLs. Greater variability in IADLs could be driven by cultural and geographical variations in those activities that are considered instrumental to daily living (Hu, 2012). Differences in survey questions (wording, types of scales used, etc.) and survey methodology could also impact the comparability of ADL/IADL based dependency measures. Therefore,

cross-country comparison of measures of autonomy loss based on activity limitations is challenging (Weber and Scherbov, 2020).

Some researchers measure loss of autonomy as the inability to perform at least one ADL without assistance, while others categorize difficulties with ADLs and IADLs into different levels of dependency, depending on the level of assistance needed. For example, a severe level of autonomy loss is often defined as being unable to perform at least three of six ADLs, which is used as the eligibility threshold for government-sponsored LTC insurance benefits in some countries such as Singapore (Holmes, 2021). Our review of various studies conducted in ten LMICs shows that the estimates of prevalence of dependency among older adults, based on ADL and/or IADL limitations, vary wildly and defy direct comparison across the countries, depending on the study population and year of data analysed (see Appendix Table A.1 for a summary of findings across the studies, including country, type of ADL/IADL index used to measure functional status, prevalence of dependency, underlying population, and source). The high prevalence of dependency among adults aged 50+, as measured by having difficulty performing at least one ADL, is particularly notable in South Africa (39 per cent), Ghana (44 per cent), and the Russian Federation (43.1 per cent) (Lestari et al., 2019).

Disability adjusted life years (DALYs) can be calculated to quantify the burden of disease, such as dementia, which is associated with very high levels of autonomy loss. The Global Burden of Disease report gave dementia a disability weight of 0.67, which is higher than almost any other condition and signifies a two-third loss for each year lived with dementia (Kedare and Vispute, 2016). LMICs are projected to have the largest rise in dementia prevalence by 2050. In 2019, 55.2 million people were estimated to have dementia globally (with over 60 per cent from LMICs) and that number is projected to grow to 139 million by 2050 (WHO, 2021b). The estimated prevalence of dementia in Southeast Asia is expected to reach 12.09 million (an increase of 236 per cent) by 2050 (Dominguez et al., 2021). One study assessed the incidence of dementia, DALYs and cost of care among community-dwelling Filipino elderly (Dominguez et al., 2021). It reported a dementia incidence rate of 16 cases per 1,000 person-years and projected an estimated 220,632 new cases in 2030, 295,066 in 2040, and 378,461 in 2050. The study also estimated a dementia-related disease burden of 2,876 DALYs per 100,000 persons and an economic burden of around 196,000 PHP (Philippine pesos) annually per patient (approx. 4,070 US dollars), or 36.7 per cent of average annual family income in the Philippines (Dominguez et al., 2021).

Issues of timely assessment, diagnosis and supporting people living with dementia are compounded in LMICs that lack proper infrastructure to provide these services. Additionally, most research around the validity of diagnostic

assessments come from HICs. Cross-country assessments are subject to variance in sensitivity and validity due to the potential of different data collection procedures, diagnostic criteria and cultural conceptions of the condition (Ferri and Jacob, 2017).

Rising burden of NCDs

While the burden of NCDs continues to increase across the world, it disproportionally affects LMICs. NCDs are accountable for 60 per cent of all deaths worldwide, of which 80 per cent are in LMICs (Ndubuisi, 2021). In 2020, NCDs accounted for an estimated 80 per cent of the global burden of disease and for seven out of every ten deaths in LMICs (Ndubuisi, 2021). NCDs include cardiovascular diseases, chronic respiratory diseases, cancer, obesity and diabetes, among others. The accumulation of preventable and manageable chronic conditions caused by NCDs are increasingly common among older populations in LMICs, driven by factors such as changing lifestyles. For example, in sub-Saharan Africa, older adults are going through a dietary transition, with an increasingly "Western diet" pattern and other health and social behaviours, such as tobacco use, physical inactivity, excess alcohol intake, leading to an increasing prevalence of obesity and hypertension (Gyasi and Phillips, 2020).

In many LMICs, the political, social and economic contexts are often not conducive to health promoting behaviours to prevent NCDs, and health systems are not prepared to manage chronic conditions. Research shows dependency rates are generally higher in LMICs than in HICs (Mitra and Sambamoorthi, 2014). This can cause a significant financial burden of health care costs falling on individuals and families in LMICs (Allotey, Davey and Reidpath, 2014). In addition, health often competes with other priorities related to development including poverty relief, increasing access to education, gender equality and development of infrastructure.

Unmet needs

Unmet needs occur when health and LTC services are unavailable, inaccessible or insufficient to meet older people's needs. Research has shown that older adults with unmet needs have a lower quality of life, greater ADL/IADL limitations, more hospital admissions and readmissions, and a higher rate of mortality (Zhu, 2015). From January 2021 to June 2022, the World Health Organization (WHO) undertook multi-country cross-sectional and longitudinal studies to quantify unmet needs for health and social care among older people. An analysis of unmet health care needs among older persons aged 60+ in 27 countries in the

WHO European Region was conducted using cross-national surveys (the Survey of Health, Ageing and Retirement in Europe wave 8, 2019–2020). Preliminary results show that approximately one in ten older persons (12 per cent) experienced unmet need due to affordability barriers; nearly a third of older persons in Greece reported unmet health care needs, followed by Bulgaria, Estonia and Romania, with nearly one in five; and the difference between rich and poor in unmet health care needs ranged from less than 2 per cent in Poland, Slovenia, Croatia and Switzerland to more than 20 per cent in Romania, Greece and Belgium (WHO and World Bank, 2021).

Data on unmet health and LTC needs in LMICs are limited, but available studies reveal substantial unmet needs among older adults in select countries. For example, one recent study in China analysed 5,166 adults aged 65+ from the 2015 wave of the China Health and Retirement Longitudinal Study (Li et al., 2020). It found that older adults with both multimorbidity and functional impairment tend to use health care services most often, but still reported the highest level of unmet health care needs among all groups. Another study in China that analysed the demand and supply of home-based care for the elderly found that approximately 60 per cent of older adults needed home visit services, and more than a third needed psychological counselling or daily care services, although the proportion of these services provided in the community only accounted for 20 per cent (Wang, 2013). In Greece, 20 per cent of elderly had unmet care needs in 2015, and this rose to 24 per cent in 2017; the majority of those with unmet needs were between 65–79 years of age, female, lived in single households, and had limitations in two or more ADLs (World Bank, 2021). In India, a cross-sectional, community-based study of older people aged 60+ to identify the geriatric health problems in samples drawn from a slum and a village found a large number of unmet health needs, such as unoperated cataract, uncontrolled hypertension and uncorrected hearing impairment (Thakur, Banerjee and Nikumb, 2013).

The convergence of these ongoing trends described above – increases in the number of older people with disabilities (even with the assumption of a constant dependency prevalence rate over time), the rising burden of NCDs, and evidence of unmet needs – is set to heighten the demand for accessible and affordable LTC services in LMICs. Understanding the current supply of LTC services is crucial for identifying gaps in service provision and developing policies to address those gaps.

Current LTC landscape in LMICs: A supply side assessment

Across LMICs, familial (or informal) care remains the primary form of care for older persons. As publicly financed LTC is limited, paid care is funded primarily

by older persons and their families out-of-pocket. There is generally limited availability of and access to formal home care services, community-based services (such as adult day-care centres), and institutional services (such as nursing and residential care facilities). In this section, we briefly review and summarize existing evidence on the availability of formal LTC services and delivery systems in select LMICs across Asia, Central and South America, Middle East and North Africa, and sub-Saharan Africa.

Availability of LTC services

Asia. Asia is home to several LMICs that have the largest and fastest growing older populations in the world, including China, India and Indonesia. To varying degrees, formal LTC services are emerging in these countries to fill the void of family-based elder care. However, these services are still in the early stage of development, far too spotty and fragmented to meet the escalating care needs.

In China, the current LTC landscape, inclusive of public and private, has been shaped by government policies, consumer needs, market forces and tradition. It is characterized by a fast growing residential (institutional) care sector, relatively slow and limited development of home- and community-based services, the shortage of a well-trained professional LTC workforce, weak quality regulations, and a lack of organized financing (Feng et al., 2020). Public LTC financing is minimal and largely limited to supporting a narrowly-defined group of welfare recipients and subsidizing the construction of residential care beds and operating costs. To address the gaps of unmet LTC needs among the majority of older people outside the means-tested social welfare system, China's primary strategy is to encourage the entrance of the private sector in LTC provision, consistent with the transition of the government's traditional role as direct provider to purchaser and regulator of LTC services (Feng et al., 2012). As of 2020, China had 8.21 million residential care beds registered, or 31 beds per 1,000 people aged 60 (Ministry of Civil Affairs, 2021).[3]

China is piloting public social insurance LTC financing models and, concurrently, programmes for integrating health care and LTC services in selected locales across the country, though evaluation of the impact and viability of these pilot programmes is lagging. The ongoing long-term care insurance pilots signal China's move toward using public social insurance as the core financing strategy for LTC for the broad population, following the same strategy it adopts for financing health care. The shortage of well-trained LTC workers and allied health

3. See "Statistical Communique on the Development of Social Services: 2020" of the Ministry of Civil Affairs of the People's Republic of China (in Chinese).

professionals is a major barrier for quality improvement and for the effective integration of medical and LTC services (Feng et al., 2020).

In India, families assume the primary responsibility of care for older people, which is codified in law, as in China. The Maintenance and Welfare of Parents and Senior Citizens Act (passed in 2007) obliges adult children to provide "maintenance" – including food, clothing, medical attendance and treatment – to their parents if in need, and those who do not fulfil this obligation can be prosecuted (Scheil-Adlung, 2015). Few formal LTC services such as old-age homes, day care centres, residential facilities and domiciliary care services are available, and these services are predominantly provided by private and not-for-profit organizations, although a few public facilities also exist (Rajagopalan et al., 2020). Currently, care homes and residential facilities are largely unregulated, with limited data available on their numbers and characteristics (Harbishettar et al., 2021). Some publicly supported LTC services exist, but these are scanty and fragmented under the auspices of multiple government programmes, such as the Integrated Programme for Older Persons, National Programme for Healthcare of Elderly, National Mental Health Programme, and National Programme for Palliative Care (Scheil-Adlung, 2015). Public funding for LTC is limited and, as a result, out-of-pocket payment for LTC is the norm among the few who can afford it, leaving the vast majority of older people without access to LTC services.

In Indonesia, the government is responsible for LTC coordination and delivery, including home and community-based care (ADB, 2021). In 2016, the Indonesian government launched the National Strategic Plan, which stated that government-mandated community health centres were responsible for providing primary health care and LTC for older people, including providing free health check-ups and organizing social activities for older people (Dyer et al., 2019). However, LTC is not yet provided in an integrated and coordinated manner, the minimum requirements for care provision are not met at many state-funded community health centres, and local political commitment and resource availability have limited LTC delivery (ADB, 2021). There are approximately 277 residential homes for older people, with a capacity of 18,100 beds; of these facilities, "three are run by the central government, 71 by local governments, and 189 are private" (ADB, 2021, p. 23). Only a few private organizations provide institutional LTC, and some private companies supply day care and equipment services, estimated to support no more than a few thousand older people mainly in urban areas (ADB, 2021).

In Viet Nam, while the government has issued many policies to support older persons and ensures subsidies and health insurance for those aged 80+ and for the vulnerable elderly, there is no comprehensive LTC-based model or national integration of LTC service provision. While the Ministry of Health provides health care for the elderly in health care facilities and communities, LTC service

provision mainly supports family care with home-based services. Non-government organizations (NGOs) and the private sector also provide LTC, and paid home care is emerging for supporting older people without the means to pay for private care (Van, Tuan and Oanh, 2021). Residential aged care, including care centres, is not widely available. In 2015–2016, of residential care centres available, 36 per cent were public, 36 per cent were NGOs or religious providers, and 27 per cent were private, of which 82 per cent were licenced (Dyer et al., 2019). Nursing homes are mostly located in urban areas and mainly afforded by the wealthy (Van, Tuan and Oanh, 2021). In Viet Nam, the government provides social assistance payments to older, poorer persons without close family or retirement pensions; however, the number of beneficiaries is limited (Dyer et al., 2019).

The LTC system in Thailand prioritizes ageing in place and home- and community-based care. The government has implemented, alongside local authorities, an integrated home- and community-based care model (further described below). Residential LTC is available for those with complex care needs and insufficient caregiving support at home; services for dependent older persons are available at private nursing homes, private hospitals, government residential homes and homes for poor older persons supported by charitable organizations (ADB, 2020). In 2016, there were 442 private facilities offering residential LTC services (ADB, 2020).

Central and South America. Across countries in Central and South America, comprehensive LTC policies and systems are essentially non-existent. Public funding or direct provision of LTC services is scarce. The private market for senior care is emerging in some countries, with access limited by ability to pay for such care.

In Mexico, there is little public funding for LTC services, and the responsibility for service development rests with the states (OECD, 2011). Health care for older people is provided through the Mexican Health System, which also covers all other age groups (Gutiérrez Robledo, López Ortega and Arango Lopera, 2012). The few government-provided services for the elderly that do exist are extensions of poverty reduction or other social service programmes. There are few private (for profit and not-for-profit) institutions offering services, such as adult day care and institutional LTC for non-self-sufficient older people without family (OECD, 2011).

In Costa Rica, recent policy efforts have attempted to formalize a national LTC system (Matus-Lopez and Chaverri-Carvajal, 2022). The government has focused on facilitating access to services, such as long-term residential services, day centres and home care visits, using subsidies to families or non-profit service providers

(IADB, 2020c). In 2010, Costa Rica's National Council for Older People established the Progressive Attention Network for Integral Elder Care, aimed at establishing community-based LTC networks nationwide to conduct activities such as training retired teachers to act as unpaid community volunteer pensioners (Lloyd-Sherlock et al., 2017). Private services are increasing but mostly limited to consumers with higher incomes (IADB, 2020c).

In Brazil, there is no federally mandated coverage for the ageing population in need of LTC. Through a means-tested system, Brazil provides some public LTC services focused on sheltering people in economic deprivation (Giacomin et al., 2021). Brazil's LTC homes are scarce, public LTC expenditure per older adult is minimal, and it is estimated that at least 600,000 formal LTC workers are needed to fill the workforce gap (Giacomin et al., 2021).

In Argentina, there is little public funding for LTC services. While the government does cover a range of publicly operated services for older persons, these services are fragmented and uncoordinated due to the overlapping of functions and services provided by national, provincial and municipal actors (IADB, 2020a). Private schemes are estimated to cover no more than 8 per cent of older people with higher incomes who can afford access to services provided by private and civil society organizations, such as LTC facilities, day centres, rehabilitation centres and home-care services (Dyer et al., 2019).

Similarly, in Chile, a variety of publicly supported LTC services, including residential care facilities, day centres and home care, are offered but a nationally organized LTC system is absent (IADB, 2020b). Private services include those provided in residential care settings, home care and support services, day centres and telecare services, with the non-profit sector, particularly religious organizations, playing a strong role in service provision (IADB, 2020b).

Middle East and North Africa (MENA). There is evidence indicating increased demand for a formal LTC market in the MENA region and the emergence of aged care economies within relatively unregulated structures (Hussein, 2022).

In Turkey, as in most of the MENA region, care for older people is primarily provided informally by the family and the community (Ismail and Hussein, 2021). However, socio-demographic trends, such as changes in family structures, migration and increases in women's formal employment, are undercutting the availability of such care. There exists LTC at home provided by informally employed domestic and migrant live-in care workers, funded either through cash-for-care schemes or out-of-pocket. Home care is viewed as a culturally appropriate option while residential care is stigmatized. In recent years, the Ministry of Family and Social Policy has piloted some new elderly care interventions, such as shared living and elderly care centres, organized by the

State for groups of older people to live together with support workers attending to their needs during the day. Since 2010, the Ministry of Health has implemented a new national community-based palliative care programme in line with the National Turkish palliative care policy, making Turkey the only country in the MENA region (besides Israel) to have such policies (Ismail and Hussein, 2021).

The Arab region is characterized as having primarily residual social welfare systems that rely heavily on family or community-based social support, especially for social care which has long been neglected in social policy in the region (Hussein and Ismail, 2017). Policy attention to LTC needs is scant, given deeply-rooted cultural norms emphasizing the role of the family (particularly women) in the elderly care provision and support system. Although informal LTC continues to dominate, there is evidence of increased use of formal care by older people, such as care homes or home care services, which are mostly initiated and covered by civil society and religious organizations, sometimes subsidized by public funds (Hussein and Ismail, 2017).

Sub-Saharan Africa. In sub-Saharan Africa, most organized care is provided in urban areas, and the two most common models for LTC delivery are through charitable organizations (faith-based, civil society or public welfare bodies) or private services for higher-income populations, provided mainly in residential homes (WHO, 2017). Institutional care is relatively new and often not available. In Kenya, there were approximately 16 LTC facilities in 2017 and the main providers were religious organizations (Dyer et al., 2019). In South Africa, limited publicly funded LTC exists. Residential care is provided mainly by NGOs or religious organizations, and only 2 per cent by government (Dyer et al., 2019).

LTC delivery systems

A variety of LTC provision and delivery models are emerging in LMICs where some forms of formal LTC services exit. As described in the country examples below, these models may serve as useful examples for other countries looking to develop and integrate feasible LTC models.

In China, government-run social welfare homes and residential care facilities continue to function as the traditional safety net by providing housing, full costs of living and LTC services for people who qualify as welfare recipients – those who have no ability to work, have no source of income and have no families or relatives to support them. In rural areas, these welfare recipients are also known as *wubao* (which literally translates as "five guarantees"), for whom the local government guarantees food, clothing, housing, medical care and burial expenses (Feng et al., 2020). While traditionally these public facilities exclusively served

welfare recipients meeting stringent eligibility criteria, over time they have opened their doors to private-paying individuals who have the means and who can no longer be cared for at home by family members. Indeed, nowadays private-paying customers make up the majority of the resident population in most government-run residential care facilities in urban areas, although the clientele of rural facilities continues to be dominated by *wubao* elders (Feng et al., 2013).

Over the past 20 years, the number of residential care facilities in the urban private sector has grown rapidly in China, in response to the surge in consumer demand for LTC services and policy support (Feng et al., 2020). This development has been driven by real estate developers, venture capitalists, investors and other businesses interested in tapping into China's booming senior care market. The government has leveraged various financial incentives (e.g. lump-sum subsidies for new constructions and recurrent subsidies for occupied beds) and other preferential policy treatment (e.g. tax breaks, land allotment or leasing, and reduced utility rates) to incentivize entry of the private sector. Ranging from senior apartments to assisted living facilities and retirement communities, these facilities provide various levels of personal care assistance and professional services. Virtually all residents in these facilities are paying privately for the services.

The Chinese national and local governments encourage various types of public-private partnership LTC service delivery models, whereby the government contracts with a competent private-sector company that delivers the desired services or operates a government-built facility, or both (Feng et al., 2020). A similar approach is used for government purchasing of home- and community-based services, which are mostly operated by private-sector providers. Under the government-contractor model, resources for organizing in-home care services are allocated by various levels of government, including districts, subdistricts and local communities. The services are provided to eligible older people residing in these settings, with various levels of government initiating, funding and supervising these services. The providers are typically engaged through a government procurement process. Most of them are non-profit organizations because the reimbursement rates are low.

In other LMICs, policy efforts and private-sector initiatives have put an emphasis on fostering the development of home- and community-based LTC services – aptly so, to meet older people's needs and preference for such services. In Thailand, for example, through a pilot programme established in 2016 and managed by the National Health Security Office and local authorities, the government is working to increase access to and availability of home- and community-based services. The programme operates through a care-management system, providing 2 to 8 hours of home-based care support a week, depending on need, through caregivers with 70 hours of training who

are supervised by a care manager (ADB, 2020). Medical services, including preventive services and physiotherapy, are also available through the LTC pilot programme and the Thailand universal health coverage package (ADB, 2020).

Another community-based model of LTC provision and delivery is driven by organizations of older people. In Cambodia, China, India, Indonesia, Nepal, Myanmar, Sri Lanka and Viet Nam, these are called Older People's Associations (OPAs), which are membership organizations led or managed by older people to facilitate activities and deliver services for older people. By partnering with government service providers, OPAs provide a social protection function that complements existing mechanisms.[4] OPAs have been involved in organizing medical check-ups, conducting home visits, and providing health education for older people. Additionally, OPAs play an important role in campaigning and promoting the interests of older people to policy-makers (Petsoulas, 2019).

In Ghana, the Care for Aged Foundation provides individualized care plans developed in collaboration with the older people they serve and their families, as well as in-home care visits and assistance with personal care errands (Petsoulas, 2019). Services such as geriatric training and medical supplies are funded by donors through cash or in-kind donations; volunteer workers receive free health care in exchange for their service (Petsoulas, 2019).

In Kenya, a private nursing agency provides individualized, in-home care from professionals to those who can afford to pay for such care or who have medical insurance that covers home-based care (Petsoulas, 2019). While this type of private-sector driven model is growing in popularity, gaps in access exist for older people without insurance.

In the United Republic of Tanzania, HelpAge International implemented the Better Health for Older People in Africa programme (2014–2017), funded by the Department for International Development of the United Kingdom[5] and aimed to improve access to home-based services for poor older people in need. The programme, which supported approximately 4,500 older people, was delivered by 425 trained volunteers who were selected in consultation with the local community and supervised by registered nurses and clinical officers (Petsoulas, 2019). Within this programme, care plans were developed to assist with ADLs and social support programmes provided, such as programmes to aid in socialization with other older people and workshops from volunteers to learn about topics such as nutrition (Petsoulas, 2019).

4. For more information on Older People's Associations (OPAs), see the HelpAge International website here.

5. The Department for International Development of the United Kingdom (DFID) has since been replaced by the Foreign, Commonwealth & Development Office (FCDO).

The role of government policies

Government stewardship functions across LMICs vary as they are a result of the interaction of numerous factors, such as political and economic contexts, social and cultural factors, as well as existing health and social welfare system structures (Walker and Wyse, 2021). The main functions of the government in LTC include policy planning and implementation, regulation through developing and monitoring quality standards and fostering the LTC market, and workforce development. Below, we briefly review these themes drawing on the limited experiences of LMICs, with occasional reference to those of HICs, as appropriate.

As noted above, comprehensive LTC policies and systems are non-existent in virtually all LMICs. Many of these countries struggle with a lack of a clear definition of the tasks, roles and responsibilities of different ministries, agencies, and organizations in caring for older people. As a result, the inappropriate use of acute care hospital services and emergency departments is high among the elderly (Giacomin et al., 2021).

LTC policy planning can include many goals, such as analysing demand and supply, identifying necessary changes for improvements in the system and the reallocation of resources, containing care costs, and improving the quality of services. Described below are select country examples.

Asia. In many countries in Asia and the Pacific, the first legal mention of LTC was through laws for older people, and several subsequent national policies or plans have used these laws as foundations (Walker and Wyse, 2021). For example, in Mongolia, the revised Law for the Elderly in 2017 was the building block for the development of a draft Strategic Plan on Long-Term Care for the Elderly led by the Ministry of Labour and Social Protection (Walker and Wyse, 2021). In Singapore, LTC was originally included within ageing laws covering social welfare, and the current LTC strategy is part of the Successful Ageing framework led by the Ageing Planning Office within the Ministry of Health (Walker and Wyse, 2021).

To assist in policy development, governments utilize, to a certain extent, advisory groups and associations for input. In Cambodia, China, India, Indonesia, Nepal, Sri Lanka, Myanmar and Viet Nam, Older People's Associations (OPAs) play an important role in campaigning and promoting the interests of older people to policy-makers (Petsoulas, 2019).

In most countries of Asia and the Pacific, LTC is operated in a decentralized or partly decentralized system, and responsibilities for different elements of LTC are divided among national, provincial, city and local levels (Walker and Wyse, 2021). A key question for policy-makers in these countries is whether to set up a standalone LTC system or cover LTC within the existing public health care systems (UNESCAP, 2018).

Central and South America. In much of Central and South America, ageing policy has followed a progression from a charity- to a rights-based approach (Calvo et al., 2019). In Argentina, Chile, and Costa Rica, with continued progress and success in the development of pensions as well as a growing emphasis on older people's rights, ageing policy has begun to slowly make its way up the policy agenda (Calvo et al., 2019).

In Argentina, throughout the 2000s, the National Direction of Policies for Older Adults (DINAPAM) was responsible for implementing and coordinating ageing policies and supporting the training of ageing professionals. The creation of a Federal Council of Older Adults encouraged older adults' participation in policy design (Calvo et al., 2019). Chile's government followed a similar path. After implementing its national pension system in the 1980s, Chile created the National Service for Older Persons (SENAMA), a public decentralized service located within the Social Development Ministry, responsible for promoting the health, quality of life, rights and autonomy of older Chileans (Calvo et al., 2019).

Costa Rica is in the midst of creating and implementing a national LTC system and is one of the first middle-income countries to do so. The LTC system consists of three benefits, including care services, cash for care (only in specific cases), and caregiver training (Matus-Lopez and Chaverri-Carvajal, 2022). The Ministry of Human Development is responsible for establishing the guidelines and organizing the system, while it is implemented by different public institutions working in social, health care, labour and educational areas. The system is funded through general tax revenues and co-payments and is centralized in that local governments do not participate in the design or financing of the programme.

Middle East and North Africa. There has been some recent acknowledgement in the region that policies and strategies should be put in place to address the need for formal LTC provision (Ismail and Hussein, 2021; Hussein and Ismail, 2017). Recent developments such as cash-for-care schemes and social assistance schemes are a result of these discussions. These efforts are framed mainly within the traditional family-based care structure, with the goal of enabling the family to continue caring for older relatives. For example, Turkey has developed plans to address LTC within the context of maintaining the family's central role and ensuring care delivery at home and in the community. The most recent aged care plan (2017) prioritized home-based care services with responsibilities at the municipal level (Ismail and Hussein, 2021).

Sub-Saharan Africa. LTC policy development is lagging in sub-Saharan Africa, relative to other parts of the world. However, countries in this region have begun to form a range of policy frameworks encompassing aspects of LTC, both

directly and indirectly, including older person-focused conditions in policies or constitutions, dedicated bills on older adults or, as in the United Republic of Tanzania and Zimbabwe, national strategies on healthy ageing (Aboderin, 2019).

Examples of government mechanisms for quality monitoring from HICs include inspection, regulation, and/or reliance on market forces. England and Australia utilize inspection-based surveillance of LTC services against certain standards. The United States of America and Canada utilize data measurement or public reporting as a driver of market forces to maintain quality. Across these countries, the main responsibility for regulating quality remains with government (Mor, Leone and Maresso, 2014).

Governments can play a multitude of roles in ensuring availability and accessibility of services. These include directly providing care, acting as a purchaser of services from qualified providers, and playing a role in fostering LTC markets (Walker and Wyse, 2021). The capacity of governments to foster markets and develop public-private partnerships is dependent on their ability to develop contracts, set prices and monitor and supervise private-sector providers (Block et al., 2009). Governments can also assist providers through subsidies and grants.

It is also important to strike a balance between the government function of regulation and regulation from market forces. In the United States, the government plays a large role in regulation within the LTC industry to maintain a minimum level of quality of care and to provide incentives to improve quality, including regulations pertaining to receipt of payment, staffing requirements and the monitoring and enforcement of care standards (Grabowski, 2008). Simultaneously, public reporting of health care quality data can inform consumer choice. For example, Nursing Home Compare is a recognized resource that reports the ratings of nursing homes in the United States; however, it has been subject to scrutiny due to reliance on self-reported data. As is the case in many European countries as well as in the United States, public reporting mechanisms are more often focused on institutional care.

Another critical function of the government within LTC systems is to build and sustain workforce development. The success of LTC systems is, to a large extent, dependent on the capacity of the workforce and therefore investment in enhancing the skills of the workforce is imperative. The lack of a qualified and professional workforce in LTC is a common challenge across all LMICs. As is the case in China, there is an urgent need for the government to increase investment substantially in education and training programmes, not only to upgrade the skills of direct care workers on the frontline but also to produce a cadre of multidisciplinary professionals, such as geriatricians, pharmacists, therapists, dieticians, nurses, social workers, case managers and LTC facility administrators (Feng et al., 2020).

Discussion and policy considerations

Through this review and analysis, we identify several prominent findings and themes concerning the current LTC landscape across LMICs. Below, we discuss these and suggest potential policy options for LTC policy-makers in these countries to consider.

First, there is evidence of large gaps between rising LTC needs on the demand side and the lack of formal LTC provision on the supply side across LMICs, and it is imperative to increase government policy interventions to address these gaps. LTC provision in LMICs has continually relied on the family as primary caregivers. On a broad scale, this has made sense and continues to make sense, given the lack of formal LTC infrastructure and support available to the majority of older people and the fact that family members know their loved ones and their needs best. Some countries, including Algeria, Argentina, Brazil, Chile, China, India, Mexico, the Russian Federation and Turkey, have gone as far as legalizing and mandating adult children's responsibility for taking care of their elderly parents (Scheil-Adlung, 2015). The issue with such mandates is that they do not always take into account the capacity of the family caregivers and may result in caregiver burden in the context of physical and emotional health, social life and financial status, particularly for women. The enforceability of such laws is also questionable (Feng, 2019).

The centrality of family caregiving is not exclusive to LMICs. Family caregiving is just as widespread in developed countries (EC and Zigante, 2018), and, indeed, it is an integral component of any LTC system (Villalobos Dintrans, 2020). The difference though is that most developed countries provide some form of retirement income to finance elderly care and have policies to support caregivers as well as home- and community-based services to alleviate part of the caregiver burden. In some developed countries, such as Germany, family caregiving has been integrated into the LTC insurance system. Family caregiving is undeniably an irreplaceable and effective method of caring for the elderly, but LMICs must adopt policies to support caregivers so that family caregivers can continue to fulfil this role without having to sacrifice their own needs. Policy-makers in LMICs should develop and implement policies to increase formal LTC service provision and support when family care is insufficient or absent.

Given that the provision of elder care by family members is a feature of the intergenerational social contract that is deeply rooted in cultural values in most LMICs, public policies should not discourage it. What public policies should do is to provide meaningful and affordable options to families so that they can decide whether elderly care will be supplied within the family or whether they will seek it in the market. This is especially important for the middle class because the poor can typically access last-resort, safety net programmes and the

rich can afford to pay for high-end services, while the middle-class majority must often contend with the "missing market" of affordable quality care. The absence of affordable care can lead to spending down savings, the loss of market wages for caregivers and an increased need for medical care for physical and mental illnesses for both the caregivers and care recipients. This is why it is important to have an LTC market with a continuum of care. Furthermore, government involvement in elderly care is necessary, primarily in the form of stewardship, including via support to qualified service providers and subsidies to qualified care recipients. The actual provision of care can come from a combination of the private formal and semi-formal sectors as well as from family members.

Ultimately, a mixed system of informal and formal LTC services would be ideal for LMICs. While informal caregiving can have negative effects on the labour market, the income-generating capacity of families and the health of caregivers, informal caregivers also help contain the formal LTC system's costs (Villalobos Dintrans, 2020). When designing the proper mix of formal and informal elements of LTC provision, policy-makers should seek information for guidance by approaching questions such as: what kinds of needs exist in the population and what kinds of services are in demand; how the system can take into account families' preferences; how much money is available to finance the system; and how the design of the LTC system affects caregivers' behaviour (Villalobos Dintrans, 2020). Policy-makers in LMICs should begin with a review of needs before developing a clear agenda of priorities and strive to create a balanced LTC system of mixed services that reflects older people's preferences and needs.

Second, it is necessary to engage the private sector in developing LTC services, markets and delivery systems in LMICs; at the same time, it is essential to strengthen government stewardship for clear guidance on rules of engagement as well as quality assurance and the regulatory capacity to enforce them. Most countries, inclusive of HICs and LMICs, have opted to contract out LTC services fully or partially to private non-profit or for-profit organizations, and the global trend is a move away from direct public provision of services. Where public funding is involved, the public-private partnership is a commonly used mechanism for engagement of private-sector service providers in the LTC system, as is the case in China.

We suggest two concepts of LTC delivery models for policy-makers in LMICs to consider, which are expected to alleviate financing and supply constraints for service provision. One concept is opening existing public welfare homes and residential aged care facilities to self-paying individuals and providing them with enhanced quality services. These public facilities will continue to serve their traditional clients (welfare recipients) and receive government support to do so while strengthening their revenue base through cross-subsidization from private-paying clients. This model is widely used in China and recently has been

implemented in some facilities in Viet Nam. Another concept is utilizing government-owned buildings and other fixed assets to develop concessional arrangements with private providers who are contracted to operate them as aged care facilities. Providers will set prices, establish fees and collect revenues from their clients. The government will use concession fees to influence the pricing policies of these providers. These concessions can be leveraged for the development of government assets as institutional care facilities with nursing, rehabilitation, palliative or/and hospice services, which may also provide day services and home-based care for nearby communities. This model is widely used in Singapore and is increasingly visible in China. With the "bricks and mortar" of these facilities under firm control of government ownership, this model has one distinct advantage of forestalling real estate speculation for profiteering which is a longstanding concern in countries, such as the United States, where private equity firms are actively involved in LTC facility ownership (Braun et al., 2021).

Given the increasing role of the private sector in the LTC system, policy-makers in LMICs should be wary of the possible risk and unintended consequences coming with it, if implemented without due government oversight. A trend observed in the United States and in many European countries is that of the privatization of LTC provision (Bergman et al., 2016; Stolt, Blomqvist and Winblad, 2011; Polivka and Luo, 2019), particularly in the nursing home industry. Privatization involves the move to private (most often for-profit) delivery of services and managerial practices as well as an increasing emphasis on responsibilization – a transfer of care responsibilities to individuals and their families (Armstrong, Armstrong and Bourgeault, 2020). Privatization can have benefits, including prices being driven competitively in a free market economy rather than controlled by the government, resulting in higher spending but also greater investment in health care providing potential for growth, development and improved quality (Donaldson, 2018). The unintended consequences of privatization can include higher costs, diminished access, less efficiency, the potential for lower quality of care and loss of public control over vital services (Polivka and Luo, 2019). Thus, it is crucial for the government to retain the supervising and stewardship responsibility while delegating the actual service provision and production activity to the private sector.

Developing effective regulatory frameworks takes time and resources. For LMICs, regulatory oversight is often lacking and a low priority on the policy agenda. While the LTC infrastructure and markets are emerging and growing fast in some countries such as China, regulation is lagging. The development of regulatory frameworks can be helped with increased public financing of LTC services whereby the government, with a greater stake in the reimbursement system, can be better positioned to demand regulatory compliance and quality assurance from providers (Feng, 2019). By playing an active role in the purchasing

of services and allowing the private sector to be service providers, the government ensures that the private sector has some stake in ensuring quality of services as well.

Third, the lack of organized financing is a major impediment to both the development of and access to affordable LTC services in LMICs; policy-makers in these countries should take steps aimed at establishing a systematic approach to public LTC financing, ideally following a broad-based social insurance model. In many LMICs, new forms of elder care options outside the familial sphere are emerging in the public sector and private market, but both access to and affordability for such options remain limited, largely due to the absence of organized financing, particularly public financing for LTC. Where limited public support is available, in virtually all LMICs eligibility is narrowly defined and typically restricted to a small number of public welfare recipients who are poor and disabled, without family or otherwise among society's most vulnerable members, through strict means-tests. As such, insufficient public funding for LTC results in high private expenditure in the form of out-of-pocket payments, access gaps, and inequalities (Scheil-Adlung, 2015).

When considering financing options, policy-makers in LMICs should be aware that private or commercial LTC insurance plays a minimal (or supplemental at best) role even in HICs with mature LTC systems, so this is unlikely to be a viable option. Instead, they should aim to develop a systematic approach to public LTC financing, ideally following a broad-based, universal-coverage social insurance model similar to those adopted in Germany, Japan and the Republic of Korea (Feng and Glinskaya, 2020). China's LTC insurance pilots will also offer important lessons as they develop. As with health care and income support for older people, this approach recognizes that LTC needs represent a normal life risk that the vast majority of people cannot address on their own. The guiding principles for building towards such a comprehensive financing model are equity, fiscal sustainability and efficiency. Based on these principles, policy-makers in LMICs could consider taking the following steps and strategies.

In the initial stages, financing from general tax revenue is sensible. These public funds should first finance programmes that provide a safety net for older persons in need and programmes for disease prevention and healthy ageing. Once resources increase for the financing of services to help older persons needing assistance with ADLs and IADLs, these resources should be targeted at those with greater needs in terms of frailty and loss of autonomy. Income considerations are also important, with priority given to those with lower income. Gradually, eligibility expansion can lead to coverage expansion.

An important issue in the development of a robust public LTC financing system is the division of responsibilities between the central and local governments. A centralized system is best for ensuring horizontal equity, but it can be less responsive to local conditions, needs and traditions. A more decentralized

approach runs the risk of creating or institutionalizing disparities across regions and individuals and may result in inefficiencies as each geographic unit designs and manages its own system. On balance, a co-sharing arrangement between the national and local authorities is likely to prove most efficient and equitable.

On the supply side, public financing for the LTC system will also require supporting providers through subsidies. Furthermore, procuring their services through competitive bid processes will greatly improve the efficiency of both the overall system and of public expenditures. In designing the financing of service providers, explicit linkages between financing and delivery models – in-home, community-based, and institutional – are critical. The gold standard is ageing in place, but many countries face enormous residual challenges in containing public expenditures because they initially funded residential care facilities and beds, which heavily skewed their LTC systems toward institutional care rather than home or community-based services.

Demand-side subsidies (e.g. vouchers and cash allowances) are effective instruments for increasing the purchasing capacity of the poor and those with greater needs. They are also compatible with promoting ageing in place; for example, if vouchers can be redeemed for home- and community-based care. Financial incentives to promote ageing in place can also include subsidies for informal care provision (e.g. respite care or vouchers that can be redeemed by family caregivers). Overall, the role of demand- and supply-side financing must be balanced. International experiences show that to develop an efficient and equitable LTC market both are needed. The principle of "money following people" should be followed when channelling financing to providers, rather than subsidizing land, utilities or beds.

LTC financing models should also encourage integration in service delivery across health and social services. It would be premature to include LTC in the package of basic health services because its coverage remains shallow in most LMICs. Instead, it is more realistic to initiate the development of a basic package of LTC services, and pilot it with external financing to develop a robust understanding of the implied costs and benefits.

In addition, cost sharing and private spending are important components of sustainable LTC financing in all countries. Private spending can play two important roles: i) providing additional resources to publicly funded services and ii) growing the market share served by the private sector. Both should be encouraged by the government.

Fourth, drawing on the experiences of HICs, policy-makers in LMICs should consider multipronged strategies to build and strengthen the LTC workforce and to support family caregivers. Some examples are discussed below.

Enacting policies to support training. This should include creating career pathways to allow workers to advance to positions of increased responsibility and

higher wages. Many states in the United States of America have implemented different workforce development policies tied to wage increases, including increasing wages if the worker obtains a specific number of hours of training and works in the field for a specific number of years. By giving workers added responsibility and autonomy, they may be motivated to remain in the job or encourage others to seek these positions (Stone and Wiener, 2001). Germany has recently increased public funding for the third and last year of training of older workers who want to change career into LTC, where it previously only paid for the first two years (Colombo et al., 2011). In Japan, LTC training is free for jobseekers and is organized through the Public Employment Services ("Hello Work"). It includes training at specialized private institutions or training schools. Even though LTC trainees constitute around 10 per cent of total trainees, their employment in the LTC sector is high (Colombo et al., 2011).

Improving recruitment and retention of LTC workers. Issues with staffing shortages and high turnover are not unique to LMICs. Many Member countries of the Organisation for Economic Co-operation and Development (OECD) have developed and implemented measures to improve recruitment and retention in the LTC sector, including publicly funded training, increases in wages and benefits, and improvements in working conditions (Colombo et al., 2011). In Japan, for example, providers receive subsidies for introducing LTC equipment, such as lifts, that promote welfare and reduce the burden of care workers (Colombo et al., 2011).

Supporting informal caregivers. Monetary compensation or financial support to informal caregivers recognizes the value of informal care but should not be the only policy for caregivers as full reliance on informal caregiving may hinder professionalism as well as incentivize the creation of unregulated markets (Villalobos Dintrans, 2020). Instead, these benefits should be combined with in-kind services, such as respite care and labour policies to allow participation of caregivers in the formal labour market (Villalobos Dintrans, 2020). As stated by the WHO, supporting and increasing the capacity of informal caregivers should be a priority, to address inequality and the disproportionate burden on women.[6] The need to support the family caregivers of persons living with dementia is particularly acute, given the rapid increase of older people with Alzheimer's disease and related disorders in LMICs.

Concluding remarks

We conclude with a cautionary note that there is no ideal LTC system that will work in all countries. However, to address impending ageing and LTC policy

6. See World Health Organization website: UN Decade of Healthy Ageing 2021–2030.

challenges, there is much for policy-makers in LMICs to learn from the LTC systems in HICs. The WHO has recently promoted an integrated continuum of LTC framework to guide all countries toward establishing person-centred, primary health care driven, and integrated delivery systems encompassing the full range of acute, post-acute and LTC services in a continuum (WHO, 2021a). The care continuum should ideally also include palliative care and end-of-life care. Person centredness implies and requires the delivery of care and services at or near the place where older people live, consistent with their preference for ageing in place. At present, such integrated LTC service provision and delivery models largely remain a concept in most LMICs. Nevertheless, this gap should not prevent policy-makers and practitioners in LMICs from "aiming high" toward building their own delivery systems that resemble those desirable system features as much as practically feasible. Aided by cross-country learning and a growing knowledge base from international LTC research, leapfrogging to that end through the adoption and adaptation of international best practices, appropriately adjusted for cultural specificities and political sustainability, can be achievable.

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Appendix

Table A.1. *ADL/IADL based measures of dependency (autonomy loss) among older adults in select LMICs*

Country	ADL Index/ domains	ADL limitation prevalence	IADL index/ domains	IADL limitation prevalence	Population	Sources
Argentina	Katz Index	Need assistance with any ADL: 5.8%	Lawton Scale	Need assistance with at least one IADL: 17.6%	3,291 aged 65 and above	*Encuesta Nacional sobre Calidad de Vida de Adultos Mayores* (ENCAVIAM, 2012) (Matus-Lopez and Chaverri-Carvajal, 2021)
Brazil	Katz Index	Need assistance with any ADL: 11.0%	Lawton Scale	Need assistance with at least one IADL: 35.7%	3,903 aged 65 and above	*Estudo Longitudinal da Saúde dos Idosos* (ELSI, 2015/16) (Matus-Lopez and Chaverri-Carvajal, 2021)
Chile	Katz Index	Need assistance with any ADL: 8.2%	Lawton Scale	N/A	31,667 aged 65 and above	Encuesta de Caracterización Socioeconómica Nacional (CASEN, 2017) (Matus-Lopez and Chaverri-Carvajal, 2021)
Colombia	Katz Index	Need assistance with any ADL: 7.7%	Lawton Scale	Need assistance with at least one IADL: 25.8%	17,134 aged 65 and above	*Encuesta Nacional de Salud, Envejecimiento y Vejez* (SABE, 2015) (Matus-Lopez and Chaverri-Carvajal, 2021)
Mexico	Katz Index	Need assistance with any ADL: 10.2%	Lawton Scale	Need assistance with at least one IADL: 13.8%	7,909 aged 65 and above	*Encuesta Nacional sobre Salud y Envejecimiento* (ENASEM, 2018) (Matus-Lopez and Chaverri-Carvajal, 2021)
Uruguay	Katz Index	Need assistance with any ADL: 7.0%	Lawton Scale	N/A	4, 042 aged 65 and above	*Encuesta Longitudinal de Protección Social* (ELPS, 2015/16) (Matus-Lopez and Chaverri-Carvajal, 2021)

(Continued)

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Table A.1. *ADL/IADL based measures of dependency (autonomy loss) among older adults in select LMICs – continued*

Country	ADL Index/ domains	ADL limitation prevalence	IADL index/ domains	IADL limitation prevalence	Population	Sources
India	Bathing, dressing, mobility, feeding, and toileting	Moderate level of dependency: 19%; Severe level of dependency: 3%	Preparing a hot meal, shopping for groceries, making telephone calls, taking medications, doing housework, managing money, getting around or finding an address in an unfamiliar place	Moderate level of dependency: 42%; Severe level of dependency: 6%	31,464 aged 60 and above	*Longitudinal Ageing Study of India* (LASI, 2017/ 2018) (Chauhan et al., 2022)
Sri Lanka	Barthel Index	More than one ADL limitation: 16.9%	Lawton Scale	More than one IADL limitation: 39.4%	723 aged 65 and above	*Community based cross-sectional study* (Wijesiri et al., 2021)
China	Bathing, dressing, transferring, eating (including cutting up food), and continence	Difficulty performing at least one ADL: 16.2%	N/A	N/A	12,085 aged 50 and above	*Cross-sectional data from the World Health Organization (WHO) Study on global AGEing and adult health Wave 1 (2007–2010)* (Lestari et al., 2019)
China	Eating, dressing, moving on and off bed, transferring indoor, washing face and brushing teeth, toileting, bathing, and moving upstairs and downstairs	Any ADL limitation: 14.9%	Cooking, washing clothes, cleaning, taking medicine, nailing, managing money, making phone calls, getting out in the rain, shopping, and going to a physician	Any IADL limitation: 30.1%	2,195 elderly with mean age of 75.1	*Shanghai Longitudinal Survey of Elderly Life and Opinion* (2008) (Feng et al., 2013)

(Continued)

Table A.1. *ADL/IADL based measures of dependency (autonomy loss) among older adults in select LMICs – continued*

Country	ADL Index/ domains	ADL limitation prevalence	IADL index/ domains	IADL limitation prevalence	Population	Sources
Malaysia	bathing, dressing and undressing, eating, transferring, and grooming	1.2%	Preparing meals, shopping, managing money, housekeeping, doing laundry, and taking and managing medication	13.6%	2,980 aged 60 and above	*Mental Health and Quality of Life of Older Malaysians Survey* (MHQoLOM) (2003-2005) (Siop, Verbrugge and Hamid, 2008)
South Africa	Bathing, dressing, transferring, eating (including cutting up food), and continence	Difficulty performing at least one ADL: 38.6%	N/A	N/A	2,806 aged 50 and above	*Cross-sectional data from the World Health Organization (WHO) Study on global AGEing and adult health Wave 1 (2007–2010)* (Lestari et al., 2019)
Ghana	Bathing, dressing, transferring, eating (including cutting up food), and continence	Difficulty performing at least one ADL: 44%	N/A	N/A	4,057 aged 50 and above	*Cross-sectional data from the World Health Organization (WHO) Study on global AGEing and adult health Wave 1 (2007–2010)* (Lestari et al., 2019)
Russian Federation	Bathing, dressing, transferring, eating (including cutting up food), and continence	Difficulty performing at least one ADL: 43.1%	N/A	N/A	3,422 aged 50 and above	*Cross-sectional data from the World Health Organization (WHO) Study on global AGEing and adult health Wave 1 (2007–2010)* (Lestari et al., 2019)

Notes: ADL = activity of daily living, IADL = instrumental activity of daily living, LMIC = low- and middle-income country, N/A = not available.

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Integrated long-term care partnerships between government social care and health agencies in Brazil: The Belo Horizonte model

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Abstract The article sets out key elements of the policy agenda for enhanced integration between health and social care for older people in high-income countries and demonstrates its wider relevance to low- and middle-income countries (LMICs). The article then explores the context for this agenda in Brazil, including growing demand for long-term care (LTC) and current institutional arrangements. It goes on to discuss a case study project of partnering for LTC between local social assistance and health agencies in the Brazilian city of Belo Horizonte. It identifies challenges and potential benefits of this partnership model, offering policy insights for LTC policy in Brazil and other countries.

Keywords long term care, ageing population, elder care, medical care, social services, social protection, Brazil

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Introduction: Long-term care as a global agenda

Research and policy relating to population ageing in low- and middle-income countries (LMICs) usually refer to people over the age of 60 as a single category of interest. This category is particularly relevant for pension and labour policies, since it broadly matches the retirement age for many groups of workers. However, there is considerable diversity within this broad age category, in terms of gender, socioeconomic status and, also, age itself. Over the past 20 years, the number of "old older people" (aged 70+) in less developed regions has grown rapidly (Table 1). By 2020, this represented 62 per cent of the global population aged 70+, and it is projected to reach 73 per cent in 2040.

As well as making a quantitative contribution to overall population ageing, this rapid increase in population aged 70+ is generating profoundly different public policy issues. The prevalence of chronic, comorbid health conditions, disability, frailty and functional impairment is considerably higher for this age category than for people in their sixties (WHO, 2015). This leads to much greater demand for health services and for long-term care (LTC). The consequences of this rapid trend are felt across societies and economic sectors: in terms of gender inequality and reduced access to paid work for a largely female care-force, as well as in terms of fiscal pressures. Until recently, these challenges were thought to be the exclusive concern of high-income countries. However, there has been growing recognition among international agencies of their global significance, and this has prompted a limited amount of research on LTC systems in LMICs (ILO, 2015; WHO, 2021; UN Women, 2019).

Table 1. *Population aged 70+ for selected regions and Brazil, 2000, 2020 and 2040*

		Population aged 70+ (1000s)
Less developed regions	2000	150,684
	2020	285,186
	2040*	649,857
More developed regions	2000	118,305
	2020	172,777
	2040*	248,733
Brazil	2000	5,717
	2020	12,961
	2040*	28,827

Note: *Median variant projection.
Source: UNDESA (2022).

The large majority of those older people in LMICs who have care needs continue to live at home and receive support from family members on an unpaid basis (WHO, 2021). Nevertheless, access to family support is far from complete. A growing proportion of older people are living alone or without adult relatives (UNDESA, 2020). In the People's Republic of China (hereafter, China), for example, the proportion of older people living with children fell from 73 per cent to 57 per cent between 1982 and 2005 (Herd, Hu and Koen, 2010). Even living with other adults does not guarantee support. A national survey in Brazil found 51 per cent of older women and 45 per cent of older men with care needs and who lived with younger adults reported that they received no support (Camarano, 2017).

Evident gaps in the willingness and capacity of families to provide care to older members on an unpaid, unsupported basis have spurred a growth in other types of LTC provision. These include the rapid extension of residential LTC facilities (LTCFs), such as care homes and nursing homes. For example, residential capacity in China's LTCFs grew from 2.3 million to 7.3 million people between 2008 and 2018 (Feng et al., 2020). In 2010, Argentina's Union of Gerontological Service Providers estimated that the country contained 6,000 care homes for older people (Lloyd-Sherlock, Penhale and Redondo, 2018). Typically, responsibility for these facilities is shared between government agencies, with ministries of social development/assistance/welfare often taking the lead role.

There is, however, growing evidence that LTCFs do not represent the best option for meeting the care needs of many older people. First, the great majority of older people prefer to remain in their own homes or live with relatives, whenever possible (WHO, 2015). Second, there is emerging evidence of poor quality and weak regulation of LTCFs, many of which are operated by the private sector. According to a local official in Thailand:

> There are thousands of them. You can find them at every corner of Bangkok … There are places set up by non-experts who lack professional knowledge … It's unclear who is responsible for registration or control (quoted in Lloyd-Sherlock et al., 2020a).

Furthermore, the cost of establishing and running LTCFs, while ensuring they comply with acceptable norms and standards of care is considerably higher than most older people in LMICs can afford (Lloyd-Sherlock et al., 2021a). Over the past 25 years, in response to similar concerns, many high-income countries started to develop alternative approaches to enable older people to remain at home, while ensuring their needs are still met (WHO, 2015). In LMICs, national and local governments are now starting to consider similar strategies (Lloyd-Sherlock et al., 2020b).

As part of this new thinking about LTC policy, there is increasing awareness about the potential benefits of strongly integrating LTC and other health services for older people (The Kings Fund, 2018). Evidently, there are strong connections between poor health, frailty and care needs in later life. Chronic and comorbid conditions are associated with gradual functional decline, while more acute health episodes (for example falls or strokes) usually trigger a more sudden onset of care needs (WHO, 2015). Good health care in later life can reduce overall demand for LTC. For example, effective treatment of chronic conditions like hypertension significantly reduces the risk of acute episodes such as stroke, which in turn is one of the main causes of disability and hence care dependency among older adults (Campbell et al., 2019). Similarly, effective collaboration between primary health care workers and family caregivers can reduce the risk of falls, as well as conditions such as urinary tract infection (a leading cause of hospitalization of older people in LMICs) (de Souza and Peixoto, 2017).

Even before the onset of the COVID-19 pandemic, there was emerging evidence of the benefits that can result from integrating LTC and mainstream health services for older people (Sempé, Billings and Lloyd-Sherlock, 2019). These can include more efficient use of health services and improved health outcomes for both older people and their caregivers. During the early months of the COVID-19 pandemic, a number of egregious policy failures resulted from mis-coordination between LTC and health services. These included, in some countries, the transfer of large numbers of COVID-positive older people from hospitals into LTCF settings without taking due precautions (Gibson and Greene, 2021). They also included failures to prioritize the provision of protective equipment to LTC staff, since they were not categorized as health workers (Nyashanu, Pfende and Ekpenyong, 2020).

These experiences have prompted calls for a deep or "structural" integration of health and care services for older people, so that they become parts of a single system (Harvey et al., 2018; Lloyd-Sherlock et al., 2019). In recognition, most high-income countries have embraced integration of some sort, albeit with mixed results (The Kings Fund, 2018). More superficial and cosmetic forms of integration have been relatively easily implemented. For example, in 2018, the United Kingdom's Department of Health was renamed the Department of Health and Social Care, and this was shortly followed by a new plan for service integration (National Audit Office, 2019). However, merging institutional structures that had developed independently over decades has proven a very challenging agenda (The Kings Fund, 2018). There is growing awareness that effective integration requires fundamental changes to models of training, provision, and professional behaviour and must resolve multiple, deep-rooted professional, cultural, and institutional disconnects across health care and LTC.

LMICs could benefit from these lessons while their services for older people are at earlier stages of development. To date, however, there remains a tendency to

view LTC and health provision for older people as essentially separate spheres of activity. This can be seen in institutional arrangements, where responsibilities are usually divided between health and social departments at both national and local government levels. For example, Chile's national Ministry for Social Assistance funds LTCFs run by private organizations, yet responsibility for visiting and regulating the quality of care provided lies with the Ministry of Health and there is little coordination between the two agencies (Villalobos Dintrans, 2017). A similar division occurs between the Departments of Health and Social Development in South Africa. A study of local LTCF regulation in Argentina asked different agencies if they ever met with their counterparts in other agencies in the same city (Lloyd-Sherlock, Penhale and Redondo, 2019). All responded that this had not even been considered, despite the proximity of their offices and strong informal networks (for example, several informants had been trained in the same department of the local university).

There is an evident need for government social security and social development agencies to think about how they can promote and fit into a more coherent set of cross-departmental institutional arrangements. Among other things, this is likely to include enhanced collaboration between primary health care professionals and social workers operating at the community level. In what follows, this article examines an unusual example of cross-departmental collaboration in the Brazilian city of Belo Horizonte. It examines how community-level integration has been achieved and the challenges it has faced over the past decade. Key lessons are identified with a view to informing policy in other LMICs.

Health and long-term care for older people in Brazil

The increase of the population aged 70+ will be especially rapid in countries such as Brazil. Table 1 shows a projected rise from 5.7 million in 2020 to 28.8 million in 2040 – more than quadrupling in the space of just 20 years. Consequently, the issues discussed above are emerging as urgent public policy concerns.

Compared to other middle-income countries, Brazil has an embracing and well-developed health service infrastructure, centred on the Unified National Health System (*O Sistema Único de Saúde* – SUS). The SUS is mainly managed by municipal governments and includes a strong focus on community-based primary health care (Paim et al., 2011; Macinko and Harris, 2015). Family Health Teams are responsible for referral and coordinating across SUS services, as well as acting as a bridge between the health system and local communities. The institutional hub for this service is the Community Health Centre (*Centro de Saúde*). Despite investment in these community-based health teams, population ageing is leading to a rapid growth in demand for inpatient hospital care. By 2015, older people accounted for 39 per cent of the total adult inpatient budget of public

hospitals (Dias and de Barros, 2019). The leading causes of admissions for older people in Brazil are urinary tract infections, falls, and poor management of chronic conditions: much of which could be averted through effective home care. It has been calculated that 31 per cent of inpatient hospital spending on people aged 60+ in Brazil's National Health System between 2000 and 2013 was for conditions suited for ambulatory treatment (de Souza and Peixoto, 2017). This amounted to around 275 million US dollars (USD) of hospital spending in 2013. It is evident that this pattern of health service use will not be sustainable as Brazil's population rapidly ages, increasing the importance of new, integrated models of care.

Brazil has a National System of Social Assistance (SUAS) that is structured along broadly similar lines to the SUS, albeit with far fewer resources or reach. The main focus of SUAS is the provision of non-contributory cash transfers, including a social assistance pension, the *Benefício de Prestação Continuada* (BPC). Alongside this, it is responsible for providing a diverse set of social service and social work programmes for vulnerable population groups, including older people living in poor neighbourhoods. Similar to SUS, SUAS has a highly decentralized management structure, with services provided in deprived neighbourhoods through Community Social Assistance Centres (*Centros de Referência Especializado em Assistência Social* – CRAS) (Borges, 2012). A third area of SUAS responsibility, of particular relevance to older people, is the oversight of residential long-term care facilities (LTCFs). The number of these facilities in Brazil has grown very quickly in recent years, reaching over 7,000 by 2021 (Lacerda et al., 2021). The large majority are operated by for-profit private organizations and NGOs, rather than directly by state agencies. Along with SUS, SUAS has responsibilities for oversight and quality control of these facilities. In practice, however, coordination between the two agencies is weak and regulation minimal. This disconnect became especially evident in the early stages of the COVID-19 pandemic, prompting agencies in some cities to develop emergency coordination plans (Lloyd-Sherlock et al., 2021b). As with hospital service use, there is growing recognition among Brazilian policy-makers that LTCFs should not be the main form of care-provision for older people, given the expense and the desire of most older people to remain in their own homes (WHO, 2015).

Integrated health and social care in Belo Horizonte: A new model

Since 2011, the Brazilian city of Belo Horizonte[1] has been running an innovative scheme to support care-dependent older people in disadvantaged communities:

1. With a population of around 2.4 million, Belo Horizonte is the capital city of the state of Minas Gerais.

Older Person's Care Programme (*Programa Maior Cuidado* – PMC). As elsewhere in Brazil, the city government had been concerned about the limited capacity and sometimes very low quality of care provided by local long-term care facilities and by evidence of rapidly growing numbers of care-dependent older people living in poor neighbourhoods. It was also concerned about rapid increases in hospital spending on older people.

Before PMC was established, various alternatives were considered. This included developing specific schemes of cash transfers to support the needs of poor, care-dependent older people, along the lines of those provided in several high-income countries (OECD, 2011). Such schemes have been advocated as a LTC strategy for Latin America (Caruso Bloeck, Galiani and Ibarrarán, 2017). However, policy-makers in Belo Horizonte had misgivings about this approach. First, there were concerns about the complexity and operational costs of such a scheme. Experience with targeted cash transfer schemes for people with disabilities has demonstrated that targeting is usually an expensive and imperfect process (Mishra and Kar, 2017). Where this includes evaluating care needs, the costs are likely to be considerably greater. Second, there were doubts about the extent to which families had sufficient knowledge about LTC to make informed decisions about buying care, as well as concerns that payments might be appropriated by other family members for their own use. These fears are supported by studies showing a strong correlation between dependency in later life and the risk of financial abuse by family members (Johannesen and Lo Giudice, 2013). These concerns are equally valid in Latin America where public understanding about the pros and cons of different forms of LTC is limited and there is evidence of widespread financial abuse of older people (Giraldo-Rodríguez, Rosas-Carrasco and Mino-León, 2015). In the case of Brazil, there is substantial evidence that relatives of older people have sometimes taken advantage of low-interest loans that are secured against assistance pensions, leaving the older person with large debts (Santos, 2018).

Instead of cash transfers, the government of Belo Horizonte opted to develop a new programme of community-based health and social care for poor older people. From the outset, the PMC has had a number of unusual but significant features. It was developed jointly by the municipal departments of health and of social assistance, and they continue to run it in partnership. This inter-sectoral approach is unique in Latin America, where the norm is service fragmentation and an abrupt disconnect between health and social care.

Local health and social assistance centres have joint teams, which meet monthly to screen new potential participants and to review existing cases. A key PMC philosophy is to consider the wider circumstances of older people and their families, not just the older person's health and functional status. This is especially relevant in the communities where PMC operates, where many families are facing

multiple problems and deprivations. Their difficult circumstances affect the chances that older people will get good quality care at home and require support from social assistants as well as health workers.

A second unique element of the PMC is that participating families receive support from trained PMC carers, who are recruited from similar communities and are paid a basic wage. PMC carers work 40 hours a week, caring for between one and three families. Each family receives between 10 and 20 hours of care support a week, depending on the level of need of the older person and the family's wider situation. PMC carers wear a uniform and are jointly supervised by staff from the local health and social assistance centres.

PMC carers are not expected to completely replace family care responsibility for dependent relatives. Instead, the focus is on providing primary carers some respite from what is often an exhausting 24/7 activity. At the same time, PMC carers are expected to work with family members to build their own care skills and competence. Together with the older person, the PMC carer and family agree a care plan that seeks to involve all household members. As well as providing daily support, PMC carers monitor the situation of the older person and report back to the inter-sectoral case reviews.

Integration in practice: Challenges and responses

In 2018, an independent evaluation of the PMC was initiated. The full evaluation is ongoing because of delays caused by the COVID-19 pandemic. However, preliminary qualitative data indicate that the PMC operates largely as planned, is widely popular in the communities it serves, as well as among the professionals who provide the service, and is effective in both reducing the burden on family caregivers and enhancing the quality of life of older people (Lloyd-Sherlock and Giacomin, 2020; Aredes et al., 2021).

Quantitative analysis of older people included in the PMC and older people with similar characteristics who are not in the PMC, shows important effects on health service use. These included less use of outpatient services on an emergency, unplanned basis, as well as cost savings of around 17 per cent for older people admitted to hospital (Lloyd-Sherlock, Giacomin and Sempé, 2022). Interviews with PMC staff illustrate how the programme was able to achieve these effects:

> A typical case is an older woman who needs a lot of support and lives with her husband who is also quite frail. They weren't in a position to look after themselves properly. Before they joined PMC, she was admitted into hospital several times, mainly due to dehydration. PMC can prevent these unnecessary hospital admissions because the PMC carer can intervene sooner. They get in touch with the health centre which can then deal with

> the problem without anyone needing to be hospitalized. I think that woman would be dead by now if she weren't in PMC (Lloyd-Sherlock and Giacomin, 2020).

Similar accounts were provided by the older people themselves, as well as their families:

> The PMC carer sets up his oxygen supply and stays with him chatting about this and that … She's always on the look-out in case there is anything different about him. She notices little things and then she'll tell me: "Look, there must be something going on with him. I'll have word with the people at the health centre" (Lloyd-Sherlock and Giacomin, 2020).

The evaluation of the PMC included repeated non-participant observation of monthly case review meetings, which often demonstrated the benefits of combined action between local health and social assistance agencies. This could be seen with reference to specific cases, such as that of an older man whose assistance pension had been stopped because his care-giver daughter had been too over-burdened by meeting his needs to be able to go to the pension office to renew his paperwork (Brazil's BPC pension requires annual proof that the older person is still alive, to prevent families from receiving the benefit after they die). The joint case review team was able to resolve the issue on the family's behalf, put the daughter in touch with a local carer support group, and referred the older man to physiotherapy due to an ongoing problem with a badly swollen leg.

In 2019, the evaluation team became aware of a separate international study of older people in deprived urban neighbourhoods. This covered a network of cities, including Belo Horizonte, but not neighbourhoods where the PMC was then operating. The study collected older people's views about what they thought would most improve their lives. Without prompting, the most frequent response was that they wished they lived in one of the neighbourhoods where the PMC was operating.[2]

A key initial focus for the evaluation was the effectiveness of collaboration between health and social assistance agencies (especially the Community Health Centres (*Centros de Saude)* and Community Social Assistance Centres (CRAS) operating at the community level) (Aredes et al., 2021). This found a high level of willingness to collaborate across both local agencies, but that this collaboration was sometimes hindered by pre-existing bureaucratic barriers. For example, the geographical areas served by the *Centros de Saude* did not match those served by

2. For more information, visit the website of the PlaceAge Project.

the CRAS, which impeded cooperation at the local level. Also, not all parts of Belo Horizonte are served by CRAS: these social assistance posts theoretically focus on the poorest parts of the city. This sometimes created a situation where part of an area served by a *Centro de Saude* was covered by a CRAS, but another part was not. This frequently led to a situation where older people were recommended for inclusion in the PMC, only to find that this was not possible due to the absence of a local CRAS. A second area of difficulty was a lack of clarity about the specific roles of the CRAS and the *Centros de Saude* in the local management of the PMC. For example, there was not a shared manual clarifying roles, responsibilities and modes of cooperation. More specifically, records for older people included in the PMC were kept separately by each agency, using data and formats that were not mutually compatible.

More generally, cooperation was challenging because both the CRAS and the *Centros de Saude* were generally under-staffed, with few resources and many other competing demands beyond the PMC. Monthly case reviews usually took place in the CRAS, but attendance by local health workers was sometimes limited and often involved junior and less experienced staff. Inevitably, this situation became more problematic during the COVID-19 pandemic, when there were additional pressures on health workers. A policy of regular staff rotation at the *Centros de Saude* meant that those who attended PMC meetings were often unfamiliar with the programme and lacked experience of inter-sectoral collaboration. The monthly case reviews were able to refer older people to more specialist health services when appropriate, but the limited availability of these services often led to long delays in accessing them. Making repeated requests and facilitating referrals was time-consuming and sometimes frustrating. As well as referrals, scarce resources in the wider health and social assistance systems limited access to basic care items for older people in the PMC. According to a PMC carer:

> There are a lot of very vulnerable older people in this programme, and they can't afford to buy essential medicine or items for hygiene like incontinence pads or even things like soap or toilet paper. It would be great if PMC could help with that. Also, many people live in places with lots of steps and no ramps or handrails. Why can't PMC help with that too?[3]

In mid-2019, the findings of this first phase of the evaluation were shared with representatives from the city departments of health and social assistance, as well as other stakeholders. On the basis of these findings, it was decided to carry out some reforms to the PMC's operational and information systems. These included the first ever formal legal agreement between the departments of health and social

3. Quotation taken from unpublished qualitative data.

assistance in Belo Horizonte's municipal government,[4] the development of a joint operational manual and a new shared referral and information system. At the same time, the city government decided to substantially extend the PMC so that it was operating in every CRAS in Belo Horizonte.[5] This process of extension began in early 2020, coinciding with the start of the COVID-19 pandemic.

The first cases of COVID-19 in Belo Horizonte were reported on 8 March 2020. Like other cities in Brazil, rates of infection were thought to be especially high in more deprived neighbourhoods and older people were at particular risk of COVID-19 mortality. As such, the pandemic posed major challenges for the PMC's continued operation, at a time when its participants needed it most. Due to risks of infection, most home visits were initially suspended, and efforts were made to substitute these with telephone calls and other forms of remote communication. Nevertheless, during the most severe phase of the pandemic, the PMC was able to continue to support around 85 per cent of participating families, and full services were rapidly restored (Lloyd-Sherlock and Giacomin, 2020). Coordination between local health and social assistance staff ensured that PMC carers had good access to information about the pandemic and to personal protective equipment. However, this coordination did not extend to giving PMC carers the same status as front-line health workers in COVID-19 vaccine prioritization, as this was a decision taken at a much higher administrative level, where collaboration between health and social assistance is much more limited. This was widely criticized by local key informants, but they were powerless to resolve the problem. A typical comment was:

> Our PMC carers are still unvaccinated. They feel afraid and uncertain. They have to take crowded buses to visit families and are worried that they will be infected and pass it into the older people they support (Saddi, 2022).

All PMC carers were eventually vaccinated, as part of the general adult population. Recognizing the stress facing PMC carers during the pandemic, some local health centres offered psychological counselling for them. A local social assistance worker commented:

> Our PMC carers need caring for too. They are dealing with very tough situations – many PMC families have problems with drugs, abuse and violence. The PMC carers need to share and discuss these issues (Saddi, 2022).

4. See Belo Horizonte municipal government.
5. Initially, PMC was operating in 28 out of 34 CRAS in the city; it has since been rolled out to all 34. There are plans to further extend its coverage of the city, in tandem with the creation of new CRAS.

Lessons

Rapid population ageing in middle-income countries will be paralleled by increased demand for LTC and for health services specifically related to the needs of frail older people with multiple health conditions. Business-as-usual or incremental responses will not be adequate. Instead, the rapid pace of demographic change calls for a transformative approach, both in terms of scale and strategy. This will require state agencies to play a key role – the health and care needs of older people cannot be largely left to an unregulated private sector – but the nature of that role requires fundamental change. Existing policy models may be less challenging to implement but they do not represent sustainable or effective responses. For example, some countries have mainly limited their LTC policies to cash transfers paid to older people in addition to their pensions (Lloyd-Sherlock, 2018). At first sight, this would appear to be an attractive policy option, building on existing systems and expertise in social protection. However, as discussed above with reference to Belo Horizonte, the likelihood that these payments would support the development of a strong supply-side mix of suitable health and social care services available for purchase is remote. The average per capita income for PMC households is 373 reais (approx. USD 73), which is less than one third of the basic value of the universal assistance pension (1,212 reais). Both spouses are entitled to this pension independently of each other. Consequently, this indicates a very high level of dependence of younger family members on this basic pension. In this context, it is likely that any increase in the value of the pension would be allocated to general family consumption, rather than to the specific care needs of older people.

Instead of demand-side strategies, there is a need for States to engineer the establishment of an appropriate services mix. This necessitates a more direct model of state resourcing and management than cash transfers, and one that does not simply focus on building or funding additional LTCFs. Likewise, health agencies should recognize that existing service models, which emphasize hospital-based care for older people, will no longer be tenable. Part of the response should be to rapidly reorientate primary health care services away from a historical focus on issues such as mother and child health and infectious disease control. At the same time, primary health care should be integrated with social care services provided at the community level, recognizing the inseparability of health and LTC.

Belo Horizonte's PMC programme largely embodies this integrated community-level strategy. Intersectorality runs through all PMC operations, including joint case review meetings, combined inputs into personal care plans and communication with PMC carers. Rather than focus exclusively on the health and functional status of older people, the PMC considers their wider

family situations. The situations of many PMC families are far from ideal and require more comprehensive forms of support. Nevertheless, as in other countries, the experience of the PMC demonstrates that effective intersectoral cooperation is a major challenge, especially in contexts of high clinical and social vulnerability. Notwithstanding stakeholders' positive statements about the scheme, problems were identified. These included a lack of clear documentation setting out agreed roles and responsibilities for the various agencies, inconsistent reporting and data sharing, some disagreement about the roles of non-health professionals, and imperfect coordination with other parts of the health system. These issues are in line with studies of integrated health and social care interventions in high-income countries (Hutchinson, Young and Forsyth, 2011; MacInnes et al., 2020; de Bruin et al., 2020). Despite these challenges, the PMC has been able to establish a strong partnership between local departments of health and social assistance and to sustain this partnership over nearly a decade.

Alongside this "deep intersectorality", a key feature of the PMC is the payment of a basic wage to carers, rather than relying on community volunteers. Experiences of volunteer carer schemes in countries such as Costa Rica and Thailand show that, though they provide some support, the contributions made by carers are limited and inconsistent (Lloyd-Sherlock et al., 2017). With the payment of a wage comes an element of professionalism for PMC carers, with contractual roles and responsibilities, including fixed hours and specified duties. If they under-perform, PMC carers are removed from the programme. There are other examples of schemes in Latin America that train and pay home carers, but these are usually standalone ad hoc initiatives and carers do not operate as part of wider health and social work teams (Flores-Castillo, 2012; Gascón and Redondo, 2014). This shows the importance of integrated community institution-building, rather than piecemeal interventions.

Relatedly, PMC is an intervention that addresses poverty and inequality in LTC. The average per capita incomes of PMC households are less than half the national poverty line. There is growing evidence that LTC services in many countries mirror and sometimes exacerbate wider patterns of inequality. Care needs are not evenly distributed across older populations, with significantly higher rates of disability and care dependency among poor older people reported for a wide range of LMICs (Rodríguez López, Colantonio and Celton, 2017; Hu, Si and Li, 2020; Sudré et al., 2011; Custodio et al., 2017). Most LTC services focus on servicing wealthier segments of the older population. There is a broad global trend towards the marketization of LTC, with increasing private sector participation relative to the role of the State (Malley et al., 2014; Chen et al., 2018). The scope for the State to compete in this market is very limited due to the high costs of running nursing homes and other residential LTCFs. Based on its operating budget and the number of older people included in the PMC, its average annual

per capita cost is around the equivalent of USD 1,500. This is not an insubstantial amount and does not include costs that are subsumed within wider activities undertaken by health and social work staff. However, the largest part of these costs is allocated to minimum wage payments to the PMC carers, which should be considered a form of social protection for these women, rather than a sunk cost. The average annual cost per resident in Belo Horizonte's not-for-profit care homes is around USD 5,400, more than three times the cost per person included in PMC. And it should not be forgotten that most older people would prefer to remain in their own homes rather than live in a residential care facility.

As well as offering women from low-income neighbourhoods a valuable basic salary, the PMC can also be understood as a capacity-building and empowering livelihood programme for economically vulnerable groups. According to one social assistant:

> Some of the PMC carers tell me that their work has helped them know more about their own rights and entitlements for social assistance. Some said they had no idea what community social assistance centres did before they started to work in the PMC.

A typical testimony from the PMC carers is:

> When my own father fell ill, I saw how he needed looking after and that was what made me think about working as a caregiver. I did the PMC training course which really helped … Before I was a carer, I just sold things on the street.

Conclusion

Across Brazil and similar countries, rapid increases in the numbers of older people in need of care call for new approaches to health and social policy. Existing models are not sustainable and will fail to meet the needs of most older people and their family carers. Cash transfers and long-term care homes do not offer substantive solutions. Instead, responses will require collaboration between primary health care providers and social assistance agencies operating at the community level. This collaboration will be very difficult without structural integration of health and social care responsibility at the national level.

PMC offers a unique example of how this community level collaboration can work. Over the past decade, the evaluation team have searched for programmes in Brazil or other LMICs that share common features with PMC. They have found none, either in the published literature or through extensive stakeholder

engagement in different countries. As a result, a recent World Health Organization (WHO) report on integrated health and social care for older people was only able to offer a single example of good practice in a LMIC, and that was the PMC (WHO, 2021). Its uniqueness may imply that the conditions that enabled PMC's development, including the close partnership of health and social assistance were highly unusual. The COVID-19 pandemic prompted collaborations between local health and social care departments elsewhere in Brazil to protect long-term care facilities, albeit mainly on a largely ad hoc and informal basis (Lloyd-Sherlock et al., 2021b). Nevertheless, Brazil's Federal Ministry of Health has now committed to supporting the establishment of similar programmes in other Brazilian cities. Not all aspects of the Belo Horizonte model may be perfectly suited to all settings, but it offers a valuable example to other cities in Brazil and beyond.

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Providing long-term care: Options for a better workforce

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Abstract Older people and their care workers have been disproportionately affected by the COVID-19 pandemic. Many OECD Member countries have taken measures to contain the spread of the infection and improve the care workforce. Yet the health crisis is highlighting and exacerbating pre-existing structural problems in the long-term care (LTC) sector. In many OECD Member countries, recruiting enough workers in LTC remains a challenge and care workers experience difficult working conditions. Skills mismatch and poor integration with the rest of health care lie at the root of preventable hospital admissions even in normal times. Such challenges are likely to become ever more acute if no further action is taken given the speed of population ageing. Policies to improve recruitment and which also address retention through training, improvements in coordination and productivity, leveraging the effect of digital technologies, are needed.

Keywords health expenditure, health policy, ageing population, labour cost, labour force, long term care, working conditions, work organization, wages, OECD

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Introduction: Major challenges ahead

In virtually all countries, and especially in advanced economies, populations are ageing rapidly due to declining fertility and increasing longevity. On average, across the Member countries of the Organisation for Economic Co-operation and Development (OECD) in 2019, people at age 65 could expect to live a further 19.9 years. The old-age dependency ratio – the number of people aged 65 or older as a percentage of the number of people aged 20 to 64 – is projected to jump from 30 per cent in 2015 to more than 50 per cent in 2050 across OECD Member countries (Kim and Dougherty, 2020). This will create unprecedented pressures on economies, societies and governments.

As people grow older their physical and mental health deteriorate, and they may struggle with everyday activities that were once second nature, such as getting dressed, shopping, or going out for a walk. Older people are thus increasingly likely to need help from other people to carry out the activities that make up their daily lives. These activities include washing and getting dressed – grouped under what is referred to as personal care, or Activities of Daily Living (ADLs) – as well as housekeeping tasks, such as cleaning and shopping – grouped under what are known as Instrumental Activities of Daily Living (IADLs). As people become more dependent, they may also find it difficult to maintain social relationships and participate in their community. The range of personal care and assistance services that these older people require is commonly referred to as long-term care (LTC). LTC is defined as the range of medical/nursing care services, personal care services and assistance services that are consumed with the primary goals of alleviating pain and suffering or reducing or managing the deterioration in health status in patients with a degree of long-term dependency (OECD, Eurostat and WHO, 2017, p. 517).

This article discusses the challenges and policy issues that must be tackled to ensure that the LTC workforce is fit for purpose now and in the future. Having an effective and efficient workforce is crucial to the quality, productivity and sustainability of LTC services. LTC workers are individuals who provide care to LTC recipients at home or in LTC institutions (other than hospitals). Following the OECD definition, two main professional categories comprise formal LTC workers and are the primary focus of the analysis: nurses and personal care workers. The analysis also discusses informal carers, defined as family, friends or neighbours, who might receive income support or other cash payments from the care recipient as part of cash programmes and/or consumer-choice programmes, but who are not formally employed, or paid for, by the care recipient. The article maps out previous trends in the LTC workforce and how the COVID-19 pandemic has impacted LTC workers. In turn, it discusses the current

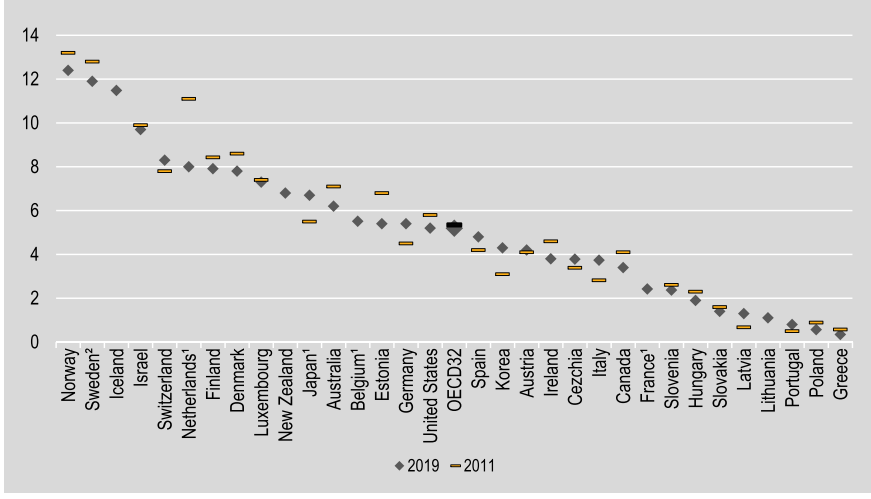
challenges in terms of working conditions and skills. Finally, it outlines possible policies to address such challenges.

Stagnating numbers of carers

LTC is a labour-intensive service and LTC workers are the backbone of the LTC system. Formal LTC workers are defined as paid staff – typically nurses and personal carers – who provide care and/or assistance to people limited in their daily activities at home or in institutions, excluding hospitals.

In 2019, there were on average five long-term care workers per 100 people aged 65 or older in 28 OECD Member countries, ranging from 13 workers per 100 older people in Norway to less than one per 100 older people in Greece, Poland and Portugal (Figure 1). In more than half of OECD Member countries, population ageing and thus the likelihood that a greater share of the population will require support to carry out ADLs has been outpacing the growth of LTC supply. The LTC workforce has stagnated or declined, even in countries where LTC supply is much higher than the OECD average (such as in Norway and Sweden). Nine countries experienced a small overall increase in their LTC supply between 2011 and 2019, but only of about one LTC worker (or less) per 100 people aged 65 or

Figure 1. *Long-term care workers per 100 people aged 65 or older, 2011 and 2019 (or nearest year)*



Notes: 1. Break in time series. 2. Data for Sweden cover only public providers. In 2016, 20 per cent of beds in LTC for people aged 65+ were provided by private companies (but publicly financed). [Colour figure can be viewed at wileyonlinelibrary.com]
Source: OECD (2021).

older. This is raising concerns about future shortages in the coming years. OECD Member countries need to increase their pool of LTC workers significantly by 2040 to care for their ageing populations. For OECD Member countries to keep the current ratio of caregivers to the elderly population, this will demand, on average, that they more than double the current number of LTC workers (OECD, 2020). The projected needs for LTC workers are likely to be lower in a context of healthy ageing and productivity increases, but they would be substantially higher if countries wish to improve current ratios to enhance quality or because of higher needs among the future population.

Concerns also relate to the effect that staff shortages have on providers' performance. Employees' turnover and vacancies in LTC are much higher than in other industries and evidence has shown that low staffing levels impact the quality of services (Allan and Vadean, 2021; Towers et al., 2021).

The COVID-19 pandemic highlighted weaknesses but led to improvements for the workforce

The COVID-19 crisis has hit the LTC sector very hard, given the large numbers of people dependent on care falling ill as well as the added exposure of LTC workers to infections. Across 21 OECD Member countries, 93 per cent of COVID-19 deaths have occurred among adults aged 60 or older, including close to three-fifths among people aged 80 or older. Residents of LTC facilities have been particularly impacted: across the OECD, 40 per cent of total COVID-19 deaths come from long-term care (Rocard, Sillitti and Llena-Nozal, 2021).

Poor safety in LTC is in part due to lack of resources: access to appropriate staffing, supplies and treatments can pose a challenge for the delivery of safe and quality LTC. Before COVID-19, research had shown that over half of the harm that occurs in LTC settings is preventable, and over 40 per cent of admissions to hospitals from LTC are avoidable (de Bienassis, Llena-Nozal and Klazinga, 2020).

Following the outbreak of the pandemic, many OECD Member countries took steps to mitigate the impact of COVID-19, both on elderly people and on LTC workers. Initial guidance for the sector concentrated on containment and mitigation strategies in LTC, aiming to minimize the risk of transmission of infections and to slow down the spread of the virus. Yet, despite the pandemic disproportionately affecting the elderly, the LTC sector was typically not prioritized for personal protective equipment (PPE) and testing across many OECD Member countries at its onset (with some exceptions), creating many challenges for workers and residents. After initial challenges, at least 30 countries developed policies to improve access to PPE and 24 have prioritized the testing of care home residents and staff. The measures included

increasing funding for PPE and tests, creating special provision channels of PPE in LTC, training LTC staff on the use of PPE and testing, and providing mobile units to test LTC residents.

Containment measures included both banning and restricting visits inside facilities and reducing contacts among residents by limiting group activities and isolating those with COVID-19. Such measures were coupled with environmental cleaning and disinfection, and promoting hand and respiratory hygiene among residents, staff and visitors.

Reducing staff movements has been key to reduce the spread of the virus, as workers have often been one of the key vectors for introducing the virus into LTC facilities. Policies comprised the creation of COVID-19 wards where possible, reduced multiple-site work, reduced staff rotation within LTC facilities, and single-site policies.

Since the start of the pandemic, nearly all surveyed countries have introduced measures to recruit LTC workers or provide funds to LTC facilities that they could use independently, including to recruit staff. Over half of surveyed countries provided financial help to LTC facilities to recruit unemployed or former LTC workers (Czechia, Denmark, Finland, France, Germany, Ireland, Republic of Korea, Lithuania, the Netherlands, Norway, Portugal, Slovenia, Spain and the United States) by 2021. About 40 per cent of countries supported the recruitment of LTC students through financial support (Austria, Czechia, Denmark, France, Germany, Lithuania, the Netherlands, Norway, Portugal, Slovenia and Spain). Many countries decided to reward LTC workers for their exceptional efforts and improve their working conditions. About 40 per cent of surveyed OECD Member countries provided one-off bonuses to reward LTC workers for their exceptional efforts, particularly after the first wave.

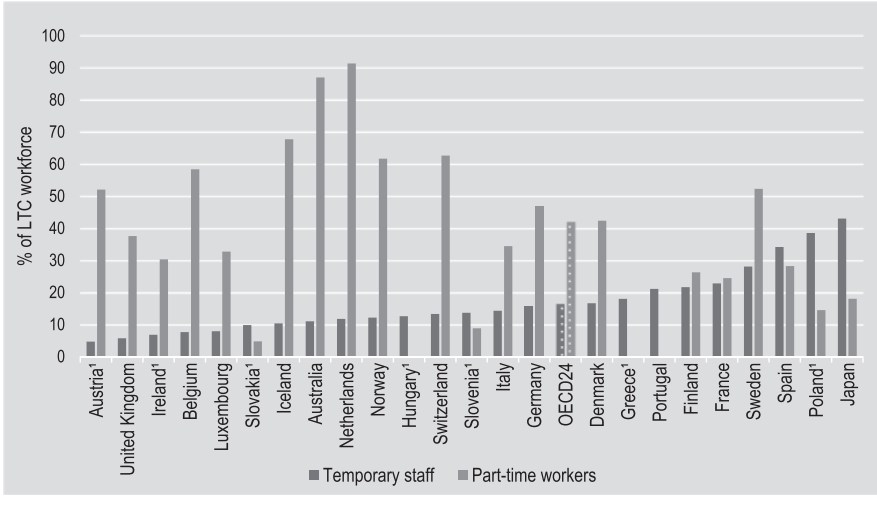
Some countries also introduced changes in staff-to-resident ratios progressively and reduced staff movements. Staff ratios have become a renewed source of debate in 40 per cent of surveyed OECD Member countries since the beginning of the pandemic, especially because higher LTC staffing rates were strongly associated with lower LTC death rates as of May 2020. Since the pandemic's onset, four countries have introduced guidelines on staff ratios (Japan, Lithuania, the Netherlands and Slovenia).

Preliminary evidence suggests that the COVID-19 pandemic has accentuated shortages in some countries. Sickness absences and the additional staff requirement to implement isolation and restriction measures have taken a toll on staff and limited the capacity to respond effectively to the pandemic. While vaccination and testing have helped to control outbreaks, the Omicron wave has led to very large numbers of staff being positive or a contact case. Long-term care workers are also suffering burnout due to the additional workload and pressure of repeated waves of infection.

Poor working conditions limit recruitment and retention of LTC workers

Working conditions in the LTC sector tend to be poor. About 42 per cent of LTC workers worked part time in OECD Member countries in 2019. In many northern and central European countries, more than half of LTC workers are employed on a part-time basis (Figure 2). Part-time work is particularly widespread among personal carers and home-based workers. The fact that basic LTC services are mostly needed for reduced hours at specific times of the day may contribute to explaining such high rates. Temporary employment is also common, contributing to job insecurity in the sector. About 17 per cent of LTC workers held a temporary contract in OECD Member countries in 2019. Shares were about 40 per cent or above in Japan and Poland, while they were below 10 per cent in Australia, the United Kingdom, Ireland, Belgium and Luxembourg. However, nearly a quarter of care workers have zero hours contracts in the United Kingdom. Workers under this type of contract typically have less access to training, do not always have benefits such as paid annual leave, suffer from low job security and have less access to social protection (OECD, 2021). This affects women disproportionately as, on average across the OECD, women hold about 90 per cent of the jobs in the LTC sector.

Figure 2. *Share of long-term care workers who work part-time or on temporary contracts, 2019 (or nearest year)*



Note: 1. Small sample sizes, data should be interpreted with caution.
Source: OECD (2021).

The nature of work is also evolving, with non-standard forms of employment on the rise. The small but rising numbers of people with new forms of employment, such as digital platform and casual work, may have less access to social protection and may make fewer social contributions over their careers.

On average across the OECD over a fifth of declared formal carers are foreign-born, whose profiles show longer working hours and better retention rates. The share of foreign-born workers varies across countries, with Israel reporting by far the highest share of foreign-born workers among its LTC workforce (71 per cent) followed by Ireland (48 per cent), Canada (34 per cent) and Switzerland (31 per cent).[1] Foreign-born workers are similarly spread among nurses and care workers, but they usually represent greater shares in institution-based providers than in home-based providers. Nevertheless, in some countries (e.g. the Netherlands and Southern European countries) foreign-born workers often represent a high share of workers in the grey market for live-in home care workers. Foreign-born workers in LTC tend to share common characteristics, usually being young and high-skilled, emigrating because of geographical, language and cultural proximity, as well as higher levels of wealth in the host country. Data from European countries, as well as Canada and the United States of America (hereafter, United States) reveal another common trait in that foreign-born workers are often overqualified for their position. While this phenomenon is common to many sectors, it appears particularly so in LTC compared to other sectors. The country of origin of foreign-born workers in LTC varies by country, and is in line with other sectors, with the primary sources being the Philippines, India, Mexico, Romania, Poland, Bulgaria, Nigeria, Kenya and Liberia (OECD, 2020).

While the work tends to be demanding, both physically and mentally, pay is often low (OECD, 2020). More than 60 per cent of LTC workers across the OECD report being exposed to physical risk factors at work. On average, 46 per cent of LTC workers are exposed to mental well-being risk factors, which generate high psychological stress. At the same time, LTC workers are among the lowest-paid and earn much less than those working with similar qualifications in other parts of the health care sector.

These difficult working conditions explain why it is difficult to retain workers in LTC. In fact, such factors are usually listed as the root cause of LTC workers' intention to leave, as well as for the actual job separation (Vadean and Saloniki, 2021). The average tenure is lower by two years in the LTC sector than in the overall workforce. High rates of staff turnover generate not only a poorer quality of care but also higher costs. Turnover requires hiring replacement staff,

1. Israel and Canada have put in place policies to facilitate the immigration of LTC workers and recognition of their skills.

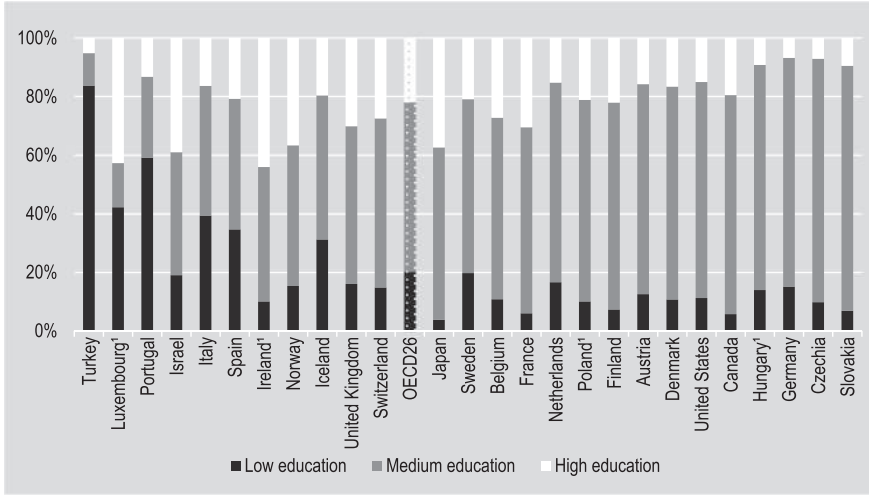
which entails recruitment costs and generates periods of understaffing. Furthermore, high turnover, as well as high staff vacancies, have proven to negatively impact the quality of care (Allan and Vadean, 2021; Towers et al., 2021).

Most of the LTC workers who leave their job quit the LTC sector but remain in the same industry. Such workers usually switch jobs to have higher benefits and opportunities for promotion in other health care facilities. Workers who decide to quit the industry are usually characterized by lower levels of job satisfaction and emotional well-being (Vadean and Saloniki, 2021).

The skills mismatch in the LTC sector

Less than a quarter of LTC workers have received tertiary-level education across OECD Member countries in 2019 (Figure 3). On average across the OECD, over 70 per cent of workers are personal care workers – workers who are less qualified than nurses. Personal care workers include formal workers providing long-term care services at home or in institutions (other than hospitals) who are not qualified or certified as nurses. Personal care workers provide routine personal care, such as support with personal hygiene, to older, convalescent or disabled persons.

Figure 3. *LTC workers by education level*



Note: Small samples, data should be interpreted with caution.
Source: OECD (2021).

Long-term care workers have generally lower qualifications than do health workers, but education requirements for LTC workers vary greatly across the OECD, with very low requirements for personal care workers (Table 1). Very few countries currently require personal care workers to hold minimum education levels, licences and/or certifications. In more than half of OECD Member countries for which data is available, there is no national curriculum for LTC nurses, and geriatric care training remains optional (participation rates can be low) (OECD, 2020).

Despite being mostly staffed by lower-skilled workers, nonetheless, LTC involves spending significant time delivering more complex tasks than basic care. Personal care workers do not always have sufficient knowledge and training, which can affect the quality of care delivered. In more than two-thirds of OECD Member countries, personal care workers' tasks go well beyond helping with activities such as washing, lifting out of bed and feeding – so-called activities of daily living (ADL). They are also involved in health condition monitoring, participating in the implementation of care plans and maintaining records of health status and response to treatment. In addition, communication tasks make demands of much of their time, especially providing psychological support, as they are usually one of the principal groups interacting with the person being cared for. Most care workers do not have sufficient geriatric care knowledge, understanding of safety

Table 1. *Education requirements for LTC workers vary greatly across countries*

Personal care workers	Nurses in the LTC sector
No minimum education level (Australia, Bulgaria, Estonia, Greece, Iceland, Israel, Japan, Rep. of Korea, Norway, Romania, United Kingdom, United States)	High school diploma (Croatia, Greece)
High school diploma (Belgium, Portugal, Slovenia)	Technical degree after high school (Bulgaria, Canada, Greece, Hungary, Rep. of Korea, Latvia, Luxembourg, Poland, Romania, United States)
Technical degree after high school (Austria, Canada, Czechia, Estonia (after 2020), Lithuania, Malta)	Intermediate vocational training (Netherlands, Germany, Greece)
Primary or intermediate vocational training (Finland, Hungary, Latvia, Luxembourg, Netherlands, Slovenia)	Bachelor's degree (Australia, Austria, Canada, Cyprus Czechia, Estonia, Finland, France, Germany, Greece, Iceland, Israel, Lithuania, Malta, Norway, Slovenia, Sweden, United States)
Other (400 hours of training in Lithuania, basic knowledge of Greek language in Cyprus, caregiver course/training in Croatia, 8–10 months of training in workplace in Finland, training varies across states in Germany)	

Source: Rocard, Sillitti and Llena-Nozal (2021).

procedures or caring needs after hospital discharge, stress management skills or soft skills.

A better match between skills, tasks and job roles would be beneficial for LTC workers and for the people receiving care. A higher prevalence of training on dementia and person-centred care are in fact positively associated with care quality (Towers et al., 2021). Workers in LTC are often confronted by the death of care recipients and may be required to provide end-of-life care as patients reach their end of life. Training on end-of-life care is not sufficient in many countries (Box 1).

Box 1. End-of-life care training among OECD Member countries

In most OECD Member countries, professionals involved in the provision of end-of-life care are required to hold care training certifications. Out of 21 surveyed countries, 45 per cent report that general practitioners require certification and 41 per cent report that the same holds for nurses. Costa Rica, Czechia and Hungary require certification for most professionals working in end-of-life care, such as general practitioners, nurses, psychologists, psychotherapists, physiotherapists, paramedics, social workers, personal care workers, pharmacists, nutritionists and respiratory therapists. Nevertheless, a high share of countries (45 per cent) does not require training certification to work in end-of-life care.

While many surveyed OECD Member countries (11 of 25) provide mandatory palliative care education in the undergraduate curricula of medical schools, in a high share of countries (28 per cent) this is not yet the case and in 24 per cent of countries such a requirement varies across regions. In contrast, nursing schools provide mandatory palliative care education more often (58 per cent of surveyed OECD Member countries), with 21 per cent of countries reporting regional differences, while 17 per cent of countries are without mandatory palliative care education in nursing schools.

With palliative care education often optional, the role of on-the-job training becomes even more important. Such training is available in 54 per cent of surveyed OECD Member countries, but only a minority of countries (29 per cent) make it mandatory to work in end-of-life care.

Furthermore, opioids are paramount in the provision of end-of-life care, as they represent a crucial symptoms management tool. In more than half of OECD Member countries (52 per cent), health care professionals are not required to hold specific licences to prescribe opioids.

Source: OECD. *Better dying: Improving end-of-life care for all* (forthcoming)

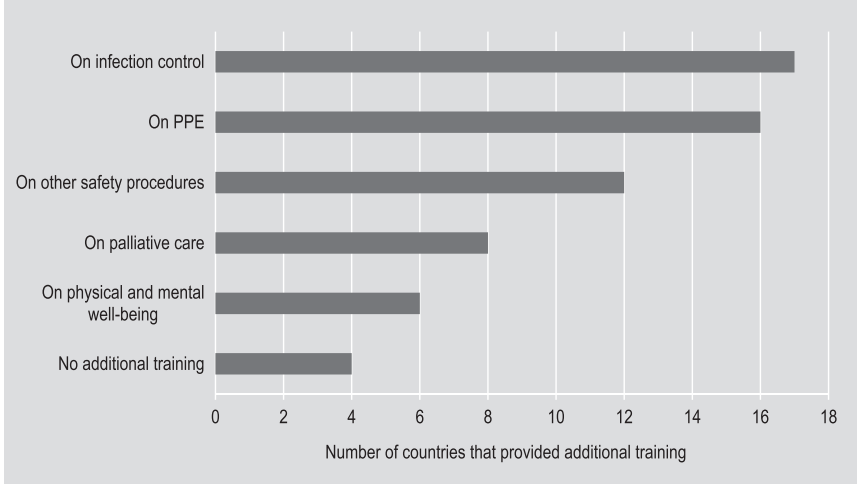
Continuing investment in human resources is crucial

The pandemic has highlighted the importance of ensuring avenues for LTC workers' recruitment, training and addressing issues of adequate pay and job quality.

During the pandemic, several countries made efforts to provide exceptional training to LTC workers to implement infection protocols or other prevention and care activities. Seventeen countries provided additional training on infection control, 16 countries on the use of PPE, and 12 countries on other safety procedures. In addition, eight countries offered exceptional training on palliative care during the pandemic and six countries on physical and mental well-being (Figure 4) (Rocard, Sillitti and Llena-Nozal, 2021).

The scope of training material and programmes varied across OECD Member countries. For example, in Canada, the federal government committed 38.5 million Canadian dollars (CAD) over two years, to rapidly recruit and train up to 4,000 new personal support worker interns through an accelerated 6-week online training programme combined with a 4-month work placement, to address acute labour shortages in LTC facilities and home care. At the provincial level, Manitoba provided in November 2020 a condensed one-week training for health sciences students to work as uncertified health care aides in LTC. In June 2020, Québec launched a 3-month accelerated training programme for LTC support workers to

Figure 4. *Most countries introduced exceptional training for LTC workers*



Note: N=22.
Source: Rocard, Sillitti and Llena-Nozal (2021).

address staff shortages. In January 2021, Ontario launched a pilot training programme for over 300 personal support workers, with a fund of CAD 2.4 million (Rocard, Sillitti and Llena-Nozal, 2021).

In the following we discuss the policies used by different countries to recruit and attract workers in the last decade. In addition, promoting the use of technology and other ways to improve productivity will be essential avenues for addressing staff shortages while enhancing care quality.

Recruitment and the retention of staff will remain challenging without addressing the need for adequate pay and improving job quality. OECD Member countries have implemented several measures to improve the attractiveness of the LTC sector. Such policies can be summarized under four headings: i) "get back to work" policies, to attract students and workers back to the LTC sector, ii) policies to improve the image and attractiveness of the LTC sector, iii) financial support and training for unemployed people or caregivers willing to obtain licenses and certification as LTC workers, iv) recruitment from the non-traditional labour pool, e.g. attracting men into the LTC workforce.

Measures to attract students and workers back to the LTC sector mainly rely on the offer of training, placement and opportunities for progression. Australia, Estonia, Germany and the United States have put such measures in place in recent years (Table 2).

Other countries (Belgium, Czechia, the Netherlands, Portugal, United Kingdom) have launched campaigns and programmes to improve the attractiveness of the LTC sector and attitudes about LTC workers. Such measures include, among others, campaigns to improve the general population's information regarding LTC, fighting stereotypes linked to the sector and sharing information on LTC among teachers and job centres (Table 3).

Table 2. *Policies to recruit students and attract workers back to the LTC sector*

Recruiting from the traditional pool	
Aged Care Workforce Strategy mentions the possibility to improve retention and recruit nurse students into LTC	Australia
Nurse Back to Health Care Programme aims to attract back nurses who work in other fields	Estonia
Concerted Action on Nursing proposes full-time funding for training	Germany
Retaining nurse students during placement, through professional mentoring and academic progress	Germany
Geriatric Workforce Enhancement Program provides funding to 29 states to provide training and experience in geriatric care, including through collaboration with a variety of professions and partners	United States

Source: OECD (2020).

Table 3. *Measures to improve the image and attractiveness of the LTC sector among the population and students*

Improving attractiveness of the sector	
The Normale Helden and Proud to Care campaigns aim to improve the attractiveness of LTC among young people	Belgium (Flanders)
Caregiver of the Year Award to publicly reward LTC workers	Czechia
TV campaign showing positive aspects of LTC through a cartoon, including male characters to fight stereotypes that represent LTC as "women's work"	France
Ambassadors, We have Something for You, Care Xperience and Open Days to spread knowledge, propose training, attract students to the sector	Netherlands (at the local level)
Local programmes to improve the image of LTC workers	Portugal
Proud to Care initiative to improve general population understanding of LTC	United Kingdom
Care Ambassadors spreading information regarding LTC among teachers and staff in job centres	United Kingdom

Source: OECD (2020).

Table 4. *Attracting and training unemployed people and informal caregivers to recruit them into LTC*

Financial support and training for unemployed people or caregivers	
Initiative by the Ministry of Labour, Welfare and Social Insurance and the Human Resource Development Authority to provide training and attract unemployed people	Cyprus
Schemes to train and attract unemployed Roma women into LTC	Hungary
Training courses for beginners and for middle-aged people willing to return to the job market after a long break	Japan
We have Something for You campaign offering unemployed people a job in LTC	Netherlands
Job Winner campaign offering unemployed people a job in LTC	Norway

Source: OECD (2020).

Another set of measures to increase the LTC workforce is focused on attracting unemployed people and informal caregivers. Indeed, some of the latter might be interested in receiving certification and licenses to become professional caregivers. Among OECD Member countries, Cyprus, Hungary, Japan, the Netherlands, Norway and the United Kingdom have applied initiatives to recruit unemployed people and informal caregivers (Table 4).

The majority of LTC workers are females, a datum that has contributed to the stereotype of careers in LTC being "women's jobs". Nevertheless, males working in LTC are more likely to work more and longer hours than women

Table 5. *Recruiting men and foreign-born workers through training and skills recognition*

Recruitment from non-traditional pool	
Skilled migration programme includes a list of jobs for which demand is not met by local workers, including for LTC	Australia
Home Support Worker Pilot to recruit foreign workers and allow them entry with their family	Canada
Concerted Action on Nursing to make nursing jobs more attractive, for both men and women	Germany
Triple Win programme provides placement in LTC in Germany for migrant workers coming from Serbia, Bosnia, the Philippines and Tunisia. Another programme aims to recruit workers from Viet Nam, providing professional training, language courses and a permanent residence permit after 3 years.	Germany
Care worker permit provides permits for a temporary stay to foreign-born workers	Israel
Men in Health Recruitment Programme provides 8-weeks' training to recruit young unemployed men into LTC	Norway
Skills for Care attracting men into LTC	United Kingdom

Source: OECD (2020).

(OECD, 2020). Germany, Norway and the United Kingdom have implemented measures to train and attract more males into the sector.

Moreover, the demand for LTC labour cannot always be met by the local market. Some OECD Member countries have made efforts to recruit from a pool of foreign-born workers, providing training and work permits to attract migrant workers into LTC. This is the case for Canada, Germany and Israel (Table 5).

To facilitate the recruitment of foreign-born workers, countries have eased migration regulations and allowed for the recognition of workers' skills. Canada implemented the Prior Learning Assessment and Recognition Process, which improves immigrants' employability and facilitates their entry into post-secondary educational institutions. The programme eases visa requirements and allows the recognition of foreign workers' skills. Similarly, Israel has facilitated the legal employment of an important share of foreign workers as LTC caregivers, by creating a list of sectors within which foreign-born workers are allowed to obtain a permit to stay in the country, which includes LTC. Furthermore, older people and their family members who wish to hire a foreign caregiver can do so through a recruitment agency that facilitates the recruitment process for foreign care workers (Naylor, Hirschman and McCauley, 2020). Japan has implemented a specific regulation for LTC workers to allow them to obtain residency status if they work in LTC.[2]

2. OECD, *Beyond applause* (forthcoming).

In addition to the easing of immigration regulation and skills recognition, foreign workers often also need to improve language skills and gain confidence in the use of their skills set. Germany has put in place several programmes to attract nurses from southern European countries as well as Serbia, Bosnia, the Philippines, Tunisia and Viet Nam. The German Triple Win programme resulted in the recruitment of a thousand nurses between 2017 and 2020, with a separate programme in place to recruit nurses from Viet Nam. The programme has been successful, with nurses remaining with the same employer after the training programme (OECD, 2020). Denmark also provides relevant training and intensive language courses to foreign-born workers to facilitate their inclusion in the Danish labour market (Tahan, 2020).

A greater focus on coordinating workers' roles could ensure more people-centred care arrangements

Older people have complex needs that require integration within health care services as well as between the health and social services. Coordination between health and social care workers has been one key priority in the policy agenda for LTC for a number of years, with a third of OECD Member countries having policies in place to address the issue. Some countries (e.g. Australia, Canada, Portugal and the United Kingdom) had implemented hospital-at-home services providing complex health care services at home prior the pandemic. Such services may improve patients' satisfaction and reduce costs, but they require strong co-ordination. Other good practices to improve coordination of care for older people include the integration of geriatric care within hospitals. In Australia, the Dementia Behaviour Management Advisory Service helps meet the needs of people affected by dementia who are admitted to hospital. Similarly, in Ireland, Slovenia and the United Kingdom professionals specialized in the treatment of dementia are available in acute care settings. Norway, the Netherlands and the United Kingdom have intermediate care facilities that have proven successful in reducing readmissions and maintaining patients' autonomy (OECD, 2020).

Responses to the COVID-19 pandemic demonstrate the advantages of integrated care practice. Most hospitalized and COVID-positive older care recipients have been older people confronted by multiple risks. Given their health and disability status, some might have had preference for palliative care rather than curative care. Yet, limited in-person contact with caregivers and overwhelmed hospital staff made identifying what matters to older adults and aligning care plans with their preferences and values particularly difficult. The rapid engagement of transitional care nurses can contribute to meet the needs of older carees and their caregivers (Naylor, Hirschman and McCauley, 2020; Rocard, Sillitti and Llena-Nozal, 2021).

In the United States, for those hospitalized who have not been informed about the goals of care, transitional care nurses can ensure that caregivers are contacted and receive appropriate information as well as ensure that a discussion of treatment options takes into consideration older adults' goals (Naylor, Hirschman and McCauley, 2020). For this to happen, transitional care nurses have to be trained in communication skills, leadership roles, ICT skills and more advanced clinical skills (OECD, 2020). In the majority of OECD Member countries, nurses already undertake some co-ordinating tasks (OECD, 2020; Rocard, Sillitti and Llena-Nozal, 2021).

Case managers can also act as a contact point to anticipate, plan and coordinate care with relatives. They are well-positioned to play a key role in discharge planning, transitions of care, care coordination and palliative and end-of-life care (Tahan, 2020; Rocard, Sillitti and Llena-Nozal, 2021).

COVID-19 responses have led workers to new ways of working, with more digital tools

The COVID-19 pandemic has highlighted the value of digital technologies in improving the delivery of high-quality care in the sector. The scaling-up of digital technology has also been essential to ensure care continuity for older people.

Some assistive technology was already in place before the pandemic, to assist workers in their tasks and to improve patients' safety. For instance, Estonia implemented a government-funded service allowing older people to have a personal alarm button service at home. Robots and artificial intelligence have been used in LTC to assist patients, owing to the ability of these to interact with human emotions, respond to interactions, memorize personality traits and play games. They can also help older people deal with loneliness. Some examples of such technology are Pepper and Paro. The former was designed by a Japanese company (Softbanks) and used in Belgium to facilitate activities usually performed by social workers. Paro was developed by the Japanese National Institute of Advanced Industrial Science and Technology and is used for therapeutic needs (OECD, 2020). Services for remote care also existed before the pandemic, such as the Helix software used in Australia to allow professionals to access documents remotely and through their smartphone. Other uses of technology in place before 2020 included self-management technologies and social technologies. In Canada, older people with cognitive challenges could use the CanApp on their smartphone to receive support in task management. The app provided a sequence of photos to assist people performing tasks, step by step. Sweden previously implemented remote health care visits through the Giraff platform (OECD, 2020). Yet, over half of surveyed OECD Member countries did not have programmes or

guidelines on the development of telehealth services in LTC before the COVID-19 outbreak.

Since then, the overwhelming majority of OECD Member countries report having developed digital technologies to ensure continuity of care. Six countries (Belgium, Denmark, France, Hungary, Ireland and Norway) set up coverage rates or fee-for-consultation for telehealth services. Two-thirds of surveyed countries developed teleservices to maintain contact between LTC recipients and their relatives, for example through tablets. In Navarre, Spain, the vast majority (82 per cent) of nursing homes organized videoconferences for elderly people to communicate with their relatives, with high demand for these (Fresno et al., 2020). Over 40 per cent of surveyed countries have increased their use of remote management, data sharing and monitoring technologies. Digital teleservices included teleconsultations, as well as triage before hospital admission in Hungary (Rocard, Sillitti and Llena-Nozal, 2021).

In Australia, LTC needs assessment became virtual, while online interpreting services ensured that services could be accessed by all cultural minorities. In addition, home-based recipients received comprehensive support to use tablets (involving the distribution of tablets with pre-installed apps, help to connect to Wi-Fi at home, training, etc.). The take-up from the elderly was rapid. In parallel, Australia supported providers (e.g. meal providers) to develop online services so that the older people could perform their daily activities online as much as possible (groceries, meals, social activities, etc.). Additional support was provided for those living in remote areas (e.g. online monitoring of health conditions, personal alarms in the event of a fall) (Rocard, Sillitti and Llena-Nozal, 2021).

In Germany, the state of Lower-Saxony launched an initiative to develop digital health and social services. About 1,400 nursing homes received tablets to enable regular medical consultation by video call and maintain contact with relatives. Lower-Saxony paid around 200,000 euros (EUR) to supply the tablets and platform used for medical consultations. In addition, general practitioners involved with medical consultations for residents of these nursing homes also received the necessary medical software free of charge (Lorenz-Dant, 2020; Rocard, Sillitti and Llena-Nozal, 2021).

Digital technology was also used to connect LTC facilities with geriatric specialists. In France, a hotline and an email dedicated to LTC workers was implemented in each region, with a geriatric specialist available during working hours every day of the week. A similar hotline and email system was implemented for palliative care (Sénat, 2020). France also introduced a financial incentive to ensure the availability of medical expertise in LTC facilities, whether virtual or in-person. A new top-up has been introduced for doctors visiting patients in LTC facilities or providing a teleconsultation in case of emergency (at least

EUR 57.60 is paid per visit or teleconsultation, compared with a "standard" consultation fee of EUR 25) (Rocard, Sillitti and Llena-Nozal, 2021).

However, it is possible to make further advances in the adoption of digital tools to better connect providers, care recipients and caregivers. For example, the Caregiver Advise, Record, Enable (CARE) Act in the United States is a model state legislation designed, in part, to make sure that the names of family caregivers (who will assume primary responsibility for hospitalized older adults' care following their transition to home) are documented in the older adults' medical records. Immediate access to this basic information is central to effective transitions during a time of crisis, with 40 states and territories having enacted CARE Acts as of 2019 (Naylor, Hirschman and McCauley, 2020; Rocard, Sillitti and Llena-Nozal, 2021).

Promoting smarter use of technology could dispense professionals from completing tasks that are possible to automate, allowing them more time to focus on activities that are most important for the people in need of care. Further promotion of the use of new technologies by LTC workers will require improving their digital skills, promoting better understanding of how technologies can support carers' tasks as well as tailoring regulation. In this sense, championing digital skills development and showcasing the benefit of technology will be paramount. Heightened use of technology in the sector can bring benefits in terms of coordination and, of great importance, it can promote the status and value of care workers.

Countries should also carefully consider other ways to increase productivity, such as developing task delegation and promoting preventive approaches

With continued pressure on public finances, policies that can improve LTC worker productivity may make it easier to meet the needs of ageing populations in countries with limited budgets and a limited workforce.

Nurses often perform work for which they are overqualified (e.g. dressing elders). Yet, only a third of countries allow task delegation from doctors to nurses, and from nurses to personal care workers. It would better permit nurses to focus on their core competencies, which are health care provision and care co-ordination. Task delegation would require additional training for personal care workers who would need to be better equipped with skills to manage chronic diseases and complex needs such as dementia. Given the concern of overburdening personal carers, as well as the potential challenge in them being able to appropriately recognize needs and changes, task delegation is not common. Task delegation within interdisciplinary team management programmes was associated with a higher quality of care for LTC conditions in

community practices. It may also help to enhance productivity, especially through the delegation of administrative tasks. In home-based settings, the delegation of medication administration (pills, eyes-drops, etc.) from nurses to personal care workers can lead to greater efficacy when, for instance, it reduces unnecessary travel time and allows more time and effort to be dedicated to providing care to elderly people with complex needs.

Task delegation may also have drawbacks and require additional training. Personal care workers would require the necessary training and monitoring skills to be able to recognize changes in a patient's condition and to provide the patient with appropriate care. In the United States, medication aides (unlicensed personnel who can administer medication) can be delegated to administer medication in LTC settings (assisted living, nursing homes, adult day care, etc.). Regular evaluation of the carers' skills and capabilities would be necessary to avoid risks to safety.

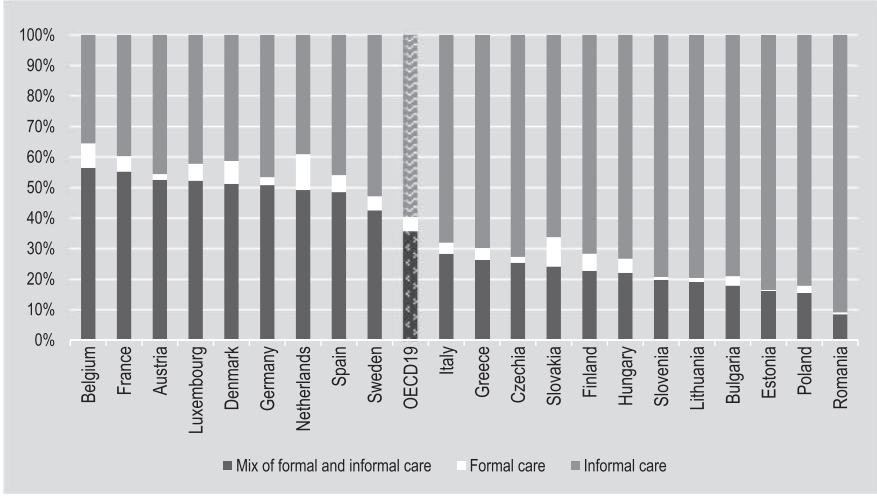
When task delegation has been coupled with a broader strategy of integrating health and care and enhancing prevention and healthy ageing, there are some examples of successful practices. One is the Enhanced Home Care pilot programme in California in the United States, where the training of personal care workers in medication management, mental health and nutrition resulted in improved health (OECD, 2020). Japan is developing an integrated community care system that emphasizes preventive care and activities to promote longer healthy life expectancy. In other countries, such as Denmark, reablement and rehabilitation, which usually consists of a short-term intervention (3–12 weeks), is used and there is some evidence that it is cost-effective. The focus is placed on training in daily functions, thus reducing and postponing the need for further care and by helping people regain autonomy.

Greater consideration in workforce strategies should be given to informal carers

Over the longer term, economies and societies evolve, creating possible challenges to the financing and provision of long-term care. Social structures are changing, with childless couples, single-parent families, divorce rates and single-adult households all on the rise. These trends could lead to fewer people being able, or willing, to care for their older relatives. Yet, informal carers currently provide the bulk of care. Across OECD Member countries, about 60 per cent of people aged 65 or older report receiving only informal care (Figure 5).

On average in OECD Member countries, about 14 per cent of people older than age 50 provide informal care on a daily or weekly basis. Across the countries, rates of informal care provision vary, as do patterns of care. Across the OECD, three out of five daily carers are women. Carers are predominantly caring for a spouse, a

Figure 5. *About 60 per cent of older people report receiving only informal care across OECD countries*



Note: Older people refer to those aged 65 or older.
Source: OECD calculations based on the Survey of Health, Ageing and Retirement Survey in Europe (SHARE), wave 8 (data refer to 2020).

parent or a parent-in-law, but patterns of care tend to change with age. Carers between ages 50 and 65 are much more likely to be women, caring for a parent on a weekly or monthly basis. Carers older than age 65 are more likely to be caring for a spouse on a daily basis and the gender gap in caregiving is generally smaller (OECD, 2021).

Informal care by family and friends makes a substantial contribution to societies. A European Commission funded study estimated that the value of the number of hours of informal care provided for older people and disabled adults ranged overall from 1.4 per cent of European Union (EU) GDP to 5.2 per cent of the EU GDP, depending on the methodology and the assumptions, with the most likely values being between 2.4 per cent and 2.7 per cent of EU GDP. In comparison, the cost of public expenditure on LTC is estimated at 1.7 per cent of 2019 EU GDP (EC, 2021).

Relying on informal care is often beneficial for governments as it involves far less public expenditure for a given amount of care than if it were provided in the formal sector. However, such reliance on informal carers comes with a cost. Informal carers – mostly women – may see their lives impacted in terms of lower levels of employment and wages, while also negatively affecting their health and the social rewards, such as status, that participation in the public sphere

confers. For working-age carers, the intensity of care can impact their labour force participation and the number of hours worked. Labour force participation is impacted when caring for 20 hours per week or more, with the impact being much stronger for those proving care for over 40 hours per week. In addition, informal caregiving is associated with part-time work (Rocard and Llena-Nozal, 2022). Informal care has also an "opportunity cost" in terms of lost revenues from social contributions and taxes. In EU countries, estimated lost revenues accounted for 0.76 per cent of EU GDP in 2019, driven mostly by the lower employment of women aged 45–64 (European Commission, 2021).

The COVID-19 pandemic has exacerbated challenges for carers, as many have had to provide care in a context of limited availability of health and social care services. Only Canada, Germany, Japan, Republic of Korea, Luxembourg, the Netherlands, Norway and the United Kingdom (Scotland) and the United States (some states) provided additional support specific to some informal carers during the COVID-19 crisis, mostly in the form of extended leave and/or additional in-kind or financial support. In comparison, all OECD Member countries implemented at least one measure to tackle COVID-19 in LTC facilities (Rocard and Llena-Nozal, 2022).[3]

Looking beyond the COVID-19 pandemic, in the context of population ageing, with the pool of informal carers reducing and the number of those of working-age who pay social contributions and taxes declining, it remains essential to improve public support for informal carers. Many countries should re-think their fragmented LTC systems, to create one comprehensive system in which informal carers are better included. Given the potential shortage of LTC workers, facilitating the work of carers and collaboration between formal and informal carers is essential. This requires a full set of policies, starting from a carer's need assessment, access to information and advice, respite, training, financial support to flexible work arrangements.

Over the past decade, countries have taken steps to facilitate access to information – mostly using digital tools – counselling, training and respite. In most OECD Member countries, training and counselling typically depends heavily on the voluntary sector. One country example is Germany, which has a well-established system for counselling and training services tied to cash benefits to informal carers. Among OECD Member countries, respite measures are typically insufficient, with low rates of uptake due to low compensation, low availability of services and organizational challenges. The vast majority of countries provide in-kind respite care.

3. The remainder of this section draws heavily from Rocard and Llena-Nozal (2022).

About two-thirds of 33 OECD Member countries provide cash benefits to informal carers. These are either paid directly to carers through a carer's allowance (67 per cent of countries) or paid to those in need of care, at least part of which is in turn used to formally compensate registered informal carers (39 per cent of countries). The Netherlands, Sweden and the United Kingdom (England) provide both types of cash benefits. Germany and the Netherlands have comprehensive cash benefits, with a registered contract between the care recipient and the carer and social security coverage is provided for the carer.

Social security benefits are essential to ensure that carers have a decent income when they retire, that they can afford health care and that they can claim unemployment benefits. About a third of the surveyed countries that provide a cash benefit to carers do not provide social security coverage, and where countries do it is often tied to specific strict conditions.

More positively, there is a growing commitment to support informal carers who combine work and care. Four countries have introduced paid care leave over the past decade or so: Austria, Czechia, Germany and Luxembourg. Nearly two-thirds of OECD Member countries surveyed have paid or unpaid leave entitlements to provide informal care. About half of countries offer some form of paid leave for caring, which tends to be restricted to a shorter duration. Nordic European countries and Poland generally have the most generous compensations. Belgium has the longest publicly paid leave for a non-terminally-ill care recipient – a maximum of 12 months – which employers may refuse only on serious financial grounds.

Flexible work-arrangements also enable to support informal carers who combine work and care. While COVID-19 policy responses led to a general uptake of telework, flexible work-arrangements specific to carers remain uncommon. Across OECD Member countries, over half of employees have working hours strictly set by their employer.

In addition, formal care arrangements should involve more informal carers and high-quality formal care provision should be sufficiently available to make sure that informal carers provide care as a matter of choice without constraints. In at least some countries, a high proportion of carers feel constrained to care – out of normative and societal pressures or necessity. A British study found that while 81 per cent of surveyed carers reported caring by choice, 65 per cent of all surveyed carers said that their choice was constrained (regardless of whether they felt that caring was their choice) (Al-Janabi, Carmichael and Oyebode, 2018). In Canada in 2018, two-thirds of older women and 58 per cent of men reported that they felt they had no choice but to take on care responsibilities (Rocard and Llena-Nozal, 2022). Formal caregivers may also fail to recognize the contribution of informal carers and do not view them as partners in a shared care arrangement. This can result in informal carers being excluded from treatment decisions and care

planning. Certain countries have started, as part of integrated care, to include informal carers as part of the care team. In Australia, for instance, informal carers have access to shared care planning tools.

Conclusion

The shortcomings of the long-term care sector in terms of insufficient workforce, poor working conditions and training gaps have been exposed during the COVID-19 pandemic. While the pandemic has led to a number of changes, primarily in the adoption of new technologies, and countries have adopted a series of recruitment strategies and workers have received bonus payments, there is a need to go beyond this and address the structural challenges of the sector. Without improving working conditions, such as low pay, high rates of part-time work, high rates of sickness and accidents as well as insufficient autonomy and support for workers, recruitment efforts are unlikely to be fruitful. High turnover and low retention endanger both access and quality of services. Similarly, the pandemic has highlighted the importance of better coordination between long-term care and the rest of the health sector. In this regard, while changes were made in a few countries, more remains to be done. Similarly, improved recruitment policies and training need to be coupled with finding ways to increase productivity in the sector. Finally, while family caregivers are likely to remain a source of care, policies to support them and ensure the coordination of their care with formal carers are necessary to reduce the risks of these caregivers dropping out of the labour market and of generating health problems.

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The role of health and social care workers in long-term care for elders in Poland, Czechia, Hungary and Slovakia: The transition from institutional to community care

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Abstract Care for the elderly is one of the most important socioeconomic issues arising from the ageing of the population. Given the declining workforce in the care and health sectors in many countries, difficulties exist already in fully meeting care needs. Moreover, deinstitutionalization, which involves a transition from institutional to community-based care, requires an increase in human resources in the care and health sectors. The article addresses long-term care systems for the elderly and the conditions affecting the possibility for the Visegrád countries (Czechia, Hungary, Poland and Slovakia) to transition from a post-socialist model (familialism by default/unsupported familialization) to a European care model based on deinstitutionalization. A further aim of the article is to show some differences in the provision of long-term care for the elderly that are observed in Central Europe, and to underline that their specific characteristics should be taken into account when planning and designing public policies and guidelines for social policy at the European Union level.

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Introduction

The populations of European countries are some of the oldest globally, with the share of people aged 65+ in many being among the highest. In 2020, for instance, the percentage of people aged 65+ was 23.3 per cent in Italy and 21.7 per cent in Germany (UNDESA, 2019). Compared to Europe as a whole, the populations of Central and Eastern European countries, including Czechia, Hungary, Poland and Slovakia, are as yet "the youngest among the oldest". However, population ageing will accelerate in the coming decades. For example, by 2060, Poland will become one of the oldest countries with the projected share of the population aged 65+ reaching 34.6 per cent (UNDESA, 2019). Since 1950, the proportion of people in the oldest age group (aged 85+) has been on the rise in all European countries. However, while a linear increase in the share of people aged 85+ was observed until 2000, UNDESA projections suggest that this process will accelerate across the period 2015–2050. In 2020, the highest percentages of the oldest age group were recorded in France and Italy. In contrast, in some of the region's post-communist countries, such as Czechia, Hungary and Poland, it did not exceed 3 per cent in 2020. By the year 2060, the proportion of the oldest age group in Italy will exceed 10 per cent. Among the post-communist countries, Poland will have the largest percentage in the oldest age group, at 5.7 per cent in 2050. In the final year of the forecast prepared by the United Nations (2100), Poland will join countries such as Italy, Germany and France, where nearly one in ten inhabitants will be aged 85+ (UNDESA, 2019).

The percentages and absolute numbers of people aged 100+ will also grow. In Poland, their share in the population will reach 0.26 per cent, or around 81,000 people, in 2060. In Japan, there are already over 100,000 centenarians. Inter alia, the progressive ageing of the population, and especially the rapidly proceeding "double ageing" (declining fertility rates and increasing longevity), feeds an increasing demand for care services (Thomas, 2004; Kane, Kane and Ladd, 1998; National Research Council, 2001).

In the four countries that are the focus of this article (Czechia, Hungary, Poland and Slovakia),[1] the family forms the base of the care pyramid, regardless of the

1. These countries, all four of which are European Union Member States, are referred to as the Visegrád group or the Visegrád four or the V4. See www.visegradgroup.eu.

place of residence (urban vis-à-vis rural areas), and it is family care that enables the functioning of people who require intensive support in everyday living. As part of formal care, people requiring assistance may benefit from community-based or institutional help, but its availability is insufficient. There are municipalities that fail to provide community care services despite existing demand. This may be caused by the reluctance of the authorities to offer these costly services while potential beneficiaries may be unaware about the possibility of using them.

The above-mentioned problems overlap with the implementation of deinstitutionalization – a transition from institutional to community-based care that involves ensuring an independent life for the supported person, enabling her or him to make independent decisions as far as possible. Normally, it is a transition from care provided by large facilities to community-based services offering wide ranging, accessible and tailored care services adapted to the needs of recipients. The deinstitutionalization process is a broad notion that applies both to children in foster care, elderly people, people with disabilities, and the homeless. This article focuses on deinstitutionalizing elderly care. In the context of long-term care for the elderly, deinstitutionalization should facilitate the concept of "ageing in place". However, it is problematic to provide properly trained care and nursing staff and currently there is a shortage of such workers in Czechia, Hungary, Poland and Slovakia. According to previously published estimates, about 350,000 community caregivers are needed in Poland alone for people aged 65+ (Szweda-Lewandowska, 2015).

Taking the above context into account, the article examines long-term care (LTC) systems for the elderly and considers the conditions affecting the possibility of transitioning from a post-socialist model (familialism by default/unsupported familialization) to a European Union model based on deinstitutionalization (Pfau-Effinger, 2005).

The aim of the article is also to outline the specific situation of the countries under study. The members of the Visegrád group were selected for analysis due to the diversity found among these post-communist countries and their different conditions. Poland, Czechia, Hungary and Slovakia do not have a full-fledged network of institutional support (residential care) and a first phase of a process of deinstitutionalization should focus on the development of a system of community-based services, rather than merely closing residential facilities. This is different from Western European countries. The percentage of people aged 60+ living in care institutions in the countries analysed is below 1 per cent. Thus, it would not be expedient to close the already small number of facilities without having first developed an extensive network of community-based services. Rather, the nature of residential care services should be reformed and adjusted to the needs of those persons using these. The second goal should be to develop a community-based support system. The main obstacles here are insufficient

finances and a shortage of professional caregivers (both medical and social care workers). The process of deinstitutionalization also entails a thorough examination of the caring needs of those who require intensive support in everyday living and the need to establish standards of care.

Another goal of the present article is to draw attention to some features of long-term care for the elderly that are specific to Central European countries and to underline that, when planning and designing public policies and guidelines for social policy at the European Union (EU) level, these differences should be taken into account.

The remainder of this article investigates the context of the deinstitutionalization process, the factors that contribute to making care support necessary for everyday functioning and considers LTC systems focused mainly on assisting the elderly. To show the scale of needs (as well as the demand for professional carers), the article also discusses the so-called "care gap," i.e. the difference between the care needs resulting from the health of elders and their level of independence on the one hand and the help and support received by them on the other. These analyses use data from the SHARE study (wave 7) (Börsch-Supan, 2022). Moreover, to show the specific situation of the four Central European countries that are our focus here – which is different from that in Western and Northern European countries – the care gap is presented in a broader context in comparison with other EU Member States.

Factors determining the need for support

There are five major micro factors (Table 1) that influence the need for and the decision to enlist the support of unrelated third parties to help accomplish tasks in everyday living: age/stage of life, cultural resources, family status, health status, and economic status (Lyttle and Ryan, 2010). These are also the main factors influencing the need for long-term care for elders in Europe.

Figure 1 illustrates the factors influencing the types of assistance provided to the elderly and the relationships between these factors. The micro level is associated with individual characteristics affecting one's need for the assistance of others in the performance of daily activities as well as with interactions within small groups (which may provide support to the elderly), such as one's family, network of contacts, or supportive neighbours. It is at the micro level that community assistance is offered by social and institutional services.

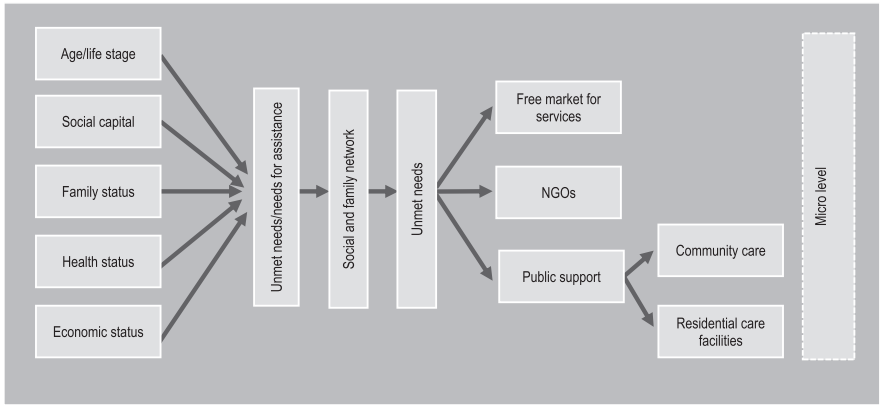
At the micro level, individual components are linked in feedback loops. For example, educational attainment, being part of cultural resources, is correlated with one's income, which is the most important element of one's economic status. Education also affects one's health status – the higher the level of educational attainment, the greater the awareness of potential health problems,

Table 1. *Micro factors determining the need for support*

Health status	- Disability - Dependency - Chronic disease
Cultural resources Social capital	- Cultural capital - Education - Skills, including interpersonal skills
Family status – marital status	- Number of children - Number of siblings - Distant relatives - The quality of relationships with family members - Place of residence of family members - Living with family members
Phase of life	- Social roles
Economic status	- Financial resources: property, ownership of a house or apartment, savings - Income: public transfers, private transfers

Source: Author's elaboration.

Figure 1. *Diagram of elderly care at the micro level*



Source: Szweda-Lewandowska (2017, p. 49).

and the better the understanding of treatment options. Age is an independent variable affecting the other four areas, being their main determinant. In turn, family status determines the possibility for the elderly person of receiving support in the form of care (Baker, 2007). The absence of potential caregivers forces the individual to seek other sources of support. One's health status may require specialized medical or nursing care or infrastructure, such as bathrooms

adapted to the needs of a dependent person. These factors may make care for the elderly person at his or her home impossible.

Elders strive to meet their needs on their own, but it is not always feasible due to a variety of difficulties. The inability to meet certain needs (e.g. shopping) leads older people to seek support from neighbours and friends. In the case of the elderly, it is useful to consider the assistance they need in terms of that which is expected or perceived (perceived social support) and that which is received (received social support) (Ikkink, van Tilburg and Knipscheer Kees, 1999). The first type may be considered as "potential support". The elderly person knows who they can turn to for help and assumes that such persons will give them support. Two factors are relevant here: i) the availability and ii) the responsiveness of support networks for older people. The second type of support is the "actual support" received. It should be borne in mind that support is assessed in terms of the subjective opinions of the recipient and caregiver, and objectively received assistance within a support network may be differently evaluated by the participating individuals. Therefore, it is often difficult to decide whether the support received by an individual is sufficient. The lack of informal support networks or their ineffectiveness means that the needs of an elderly person requiring care cannot be met within his or her natural environment. Elderly persons whose needs are not met through informal support networks may have to enlist the assistance offered by other operators in the public sector, private sector or by organizations in the non-profit sector. In all three sectors, qualified personnel are of paramount importance.

The care system

Long-term care is addressed not only to the needs of the elderly. However, due to the increased percentage of persons unable to perform activities of daily living in the group aged 65+, it is the elderly that constitute the majority of beneficiaries of institutional assistance. The demand for support increases with age. The high percentage of persons requiring help with daily functioning in the oldest age group results from more widespread disabilities among them. LTC includes both community-based and institutional assistance involving health care and social services.

As far as expenditures on LTC are concerned (Eurostat, 2021), Sweden, Denmark and Finland are the top spenders among the most developed countries (Table 2). This is associated with the extensive range of welfare state services offered as well as with the model of social policy pursued. Moreover, increased expenditures on institutional assistance and community-based services are accompanied by changes in the family model. The State assumes the functions that used to be performed by the family. Countries where the family is still

Table 2. *Expenditures on care for the elderly in 2017, % of GDP*

Country[1]	2017
EU-27 [2]	0.4
Sweden	2.3
Denmark	1.4
Finland	1.4
Belgium	1.2
Austria	1.1
Netherlands	0.8
Malta	0.7
Czechia	0.6
Spain [2]	0.6
France	0.4
Lithuania	0.4
Hungary	0.4
Slovakia	0.4
Latvia	0.3
Portugal	0.3
Poland	0.3
Slovenia [2]	0.2
Estonia	0.1
Croatia	0.1
Italy [2]	0.1
Romania	0.1
Bulgaria	0.0
Germany [2]	0.0
Ireland	0.0
Greece [2]	0.0
Cyprus	0.0
Luxembourg	0.0

Note: (1) Methodologies for measuring expenditure on LTC differ across countries. (2) Provisional.
Source: Eurostat (2021).

the main source of care, such as Hungary, Poland and Slovakia, feature some of the lowest spending on LTC. The exception in the Visegrád group is Czechia, with 0.6 per cent of GDP allocated to elderly care. In 2007, that country adopted a

new law on social services (Malý, 2018), which led to a greater involvement of public funds in the LTC system, but also resulted in the further development of residential care rather than the dynamic growth of community care.

Countries with the most substantial expenditures both on institutional assistance and community-based services have the largest percentage of persons aged 65+ benefiting from the former. In 2019, 4.2 per cent of Swedish adults aged 65+ received institutional care, while the same figure for Poland was less than 1 per cent (Table 3).

The family plays a crucial role in LTC provision and bears the main daily burden of looking after elderly family members. However, when an elder's health requires medical assistance, it is the State's obligation to ensure care, with two public systems sharing the responsibility for LTC:

- the public health insurance system (National Health Fund);
- the social welfare system.

Typically, among developed economies, entities providing long-term assistance may be divided into public and non-public institutions, nongovernmental organizations (NGOs), faith-based associations, etc.

In terms of LTC for the elderly, social welfare includes mainly community-based and institutional assistance. Social welfare centres determine the amount of payment for community assistance services, depending on the financial situation of the beneficiaries.

Institutional assistance provides elderly persons with either social day care or social welfare homes (residential care). There are also some specialized social day care centres, e.g. for people diagnosed with Alzheimer's disease. Owing to such specialized assistance, the family members of the affected individuals may continue their professional activity while also participating in care provision. In parallel, social welfare homes (residential care facilities) provide round-the-clock care for those who require it. For example, in Poland there are six types of social welfare homes, but the elderly use mainly only two of these:[2]

- social welfare homes for the elderly;
- social welfare homes for the chronically ill with somatic disorders.

However, relatively few people apply for this kind of social assistance – only 2.3 per cent of people aged 75+ in Poland are residents of such facilities.

The types of LTC falling under the health insurance system may be divided into care provided in social welfare homes and home care. Home care is offered in the form of home hospice care as well as services provided by community nurses. In contrast, institutional assistance offered by the National Health Fund is provided within the following (Colombo, 2012):

2. See ILO NATLEX: Social Assistance Act as of 12 March 2004, *Journal of Law*, No. 64. item 593, as amended, Chapter 2 "Social Welfare Homes".

- palliative care departments;
- departments for persons suffering from chronic somatic diseases and hospital geriatric departments;
- hospices;
- nursing homes.

Table 3. *Share of adults aged 65+ receiving LTC in 2019 (or nearest year)*

Country	2019
Sweden ([1])	4.2
Denmark	14.6
Finland	13.4
Belgium	.
Austria	.
Netherlands	11.9
Malta	.
Czechia	12.1
Spain	11.5
France	9.9
Lithuania	.
Hungary	11.8
Slovakia ([1])	3.4
Latvia	.
Portugal	1.9
Poland ([1])	0.8
Slovenia	.
Estonia	10.8
Croatia	.
Italy	.
Romania	.
Bulgaria	.
Germany	18.4
Ireland ([1])	3.2
Greece	.
Cyprus	.
Luxembourg	12.7

Note: ([1]) These values include only recipients of long-term institutional care.
Source: OECD (2020a); dataset: Long-term care resources and utilisation.

Importantly, it is the human resources – social workers, caregivers, nurses, and personal assistants to disabled and elderly persons – that play a crucial role in caregiving, irrespective of the type of care: home-based or institutional, provided by the welfare system or by the health system. As discussed below, when analysing the "care gap" that results from the inability to meet care needs, this gap mainly arises from a lack of qualified social and health personnel.

The care gap

The care gap, or unmet care needs, is the difference between an elderly person's care needs (their type and form) resulting from her or his health issues as well as the degree of independence and the help and support received (see Figure 1) (Pickard, 2015).

The care gap can be defined on two levels (Abramowska-Kmon et al., 2019). First, the care needs not met by the family network – the gap between what a person needs and what she or he receives in terms of support/care from her or his relatives. Second, the remaining gap in required care after obtaining care from the family network and paid care services and after receiving assistance provided by non-governmental organizations and state aid. In this article, using data from the SHARE study (wave 7) (Börsch-Supan, 2022), the care gap is defined as the difference between the needs resulting from one's health and the help obtained from the family, other members of one's social network (neighbours, acquaintances, friends) as well as care services provided by the public sector (community-based services) and those purchased from the private sector. In SHARE, health status is measured using the scales Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL), in addition to a subjective health assessment. The analysis presented below uses information on health status based on the IADL and ADL scales. The available data made it possible to calculate the percentage of people aged 60+ whose care needs are not met in 20 countries (Table 4).

Countries can be divided into four groups in terms of the care gap. The first is formed by those with the lowest degree of unmet needs, such as Germany, the Netherlands, Sweden, Denmark, Switzerland, but also Czechia. Czechia is an exception among post-communist states as its care gap is much lower than elsewhere in the region (only 9.5 per cent, which places it between the Netherlands and Sweden in Table 4). The second group consists of countries with a care gap ranging from 13 to 16 per cent (France, Austria, Belgium, Croatia, Luxembourg and Ireland), while the third comprises Estonia, Italy, Greece, Slovenia and Spain, with a care gap between 16 and 20 per cent. The highest care gaps (above 20 per cent) are found in Hungary, Poland and Portugal.

Table 4. *The care gap among people aged 60+ in selected European countries (%)*

Country	Care gap
Switzerland	7.1
Denmark	8.6
Sweden	9.3
Czechia	9.5
Netherlands	10.5
Germany	10.5
Ireland	13.2
Luxembourg	12.3
Austria	12.1
Croatia	12.4
France	13.9
Belgium	15.1
Greece	17.3
Italy	16.9
Estonia	16.1
Slovenia	18.7
Spain	19.5
Poland	22.7
Portugal	27.5
Hungary	27.6

Source: Author's calculations based on the SHARE (wave 7) survey (Börsch-Supan, 2022).

The latter two groups of countries are characterized by limited involvement of public institutions in caring for people in need of assistance. Here it is the family that plays a key role in providing care, and family ties are a crucial factor mobilizing younger family members to assist their elders. The observed process of change in the family network, which has led to a greater number of living generations with fewer family members belonging to the same generation, alters the proportions of those people who need assistance in their daily living (older generations) and those who can provide it (younger generations) (Dykstra and Knipscheer, 1995). On the one hand, changes in the family network create a need for greater family involvement in caring for elders, but on the other hand the caring potential of families has been diminished (the number of relatives – potential caregivers in the younger generations – has decreased). In addition, the traditional roles predominantly assigned to women, such as running the

household and taking care of family members, are weakening as women have become more active in the labour market, although they are still the main caregivers (Dykstra, 2021). The expectation is that the welfare state should intervene through community care services, fill the care gap and protect the elderly, as well as provide elders with optimal opportunities to meet their individual needs when the family can no longer do so (Lynch, 2006). Still, often the public authorities step in so late that community assistance (community care services) is no longer sufficient to meet needs. In such cases, it may become necessary for an elderly person to move into a facility that provides 24/7 care.

Given the existence of a care gap even in the richest EU Member States and the size of that gap in countries such as Poland, Hungary and Slovakia, consideration should be given to the impact of deinstitutionalization – the transition from institutional care to community-based care – on the ability to meet the needs of those who require assistance. Differences in terms of the care gap should also be considered when designing measures for this process. The next section explores in greater detail the concept of deinstitutionalization and the possibility of its implementation in Central European countries.

The concept of deinstitutionalization

As already mentioned, deinstitutionalization is defined in the EU as the transition from institutional care to community-based services (European Expert Group on the Transition from Institutional to Community-based care, 2021). The UN Convention on the Rights of Persons with Disabilities (UNCPRD), the UN Convention on the Rights of the Child and the European Convention on Human Rights support the empowerment of people who reside in institutions by facilitating their transition to a place of residence tailored to their needs.

An important objective of deinstitutionalization, as stated in article 19 of the UNCRPD, is "living independently and being included in the community" (UN, 2007). Article 19 emphasizes the right of people who require support in everyday life to choose their place of residence ("persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement"), to access services ("persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community"), and to a service tailored to their needs ("community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs").

Deinstitutionalization is a broad concept that covers not only issues related to individuals with disabilities and the elderly requiring support, but also concerns children and foster care, homeless people, etc. However, this article considers deinstitutionalization only in terms of the issues of elderly people requiring support and the possibility to deinstitutionalize LTC for the elderly. One of the most important issues in this process is to ensure independent living, as set out by the UNCRPD. As stipulated in the Convention, living independently is understood as the ability to make choices and decisions about one's own life situation. In this context, services that enable everyday functioning should be individualized and tailored to the needs of the person using them. Deinstitutionalization understood in this way should lead to a gradual reduction in the number of residential care facilities and the expansion of community-based services provided at the place of residence of the care recipient. Public authorities should not build new facilities or expand the existing ones. Both central and local governments should increase the range and availability of community-based services tailored to the needs of people requiring support, which will enable them to remain independent for longer. The Committee on the Rights of Persons with Disabilities emphasizes that the implementation of the assumptions and goals of deinstitutionalization requires a systemic change. This means effecting change in virtually all areas of social life: laws and policies, awareness raising, the construction and development of community-based services, the implementation of service standards, and the monitoring and evaluation of the process, which also requires data collection and analysis (Uldry and Degener, 2018).

A checklist has been prepared to ensure that EU funds in the 2021–27 programming period are used to achieve the above-mentioned goals of deinstitutionalization and to help Member States move from institutional care to community-based services. According to the European Expert Group on the transition from institutional to community-based care and Hope and Homes for Children, there are four fields that should be taken into consideration (European Expert Group on the Transition from Institutional to Community-based care, 2021):

- Transition from institutional to family-based and community-based services for children, persons with disabilities, persons with mental health problems and elderly persons.
- Development of quality family-based and community-based services.
- Prevention of separation of children, including with disabilities, from their families.
- Prevention of segregation and institutionalization of children, persons with disabilities, persons with mental health problems, older people and homeless people, regardless of the residence status.

Thus, deinstitutionalization covers a wide variety of groups. To implement the idea of deinstitutionalization in the EU, it is necessary not only to increase outlays on community-based services, but also to find financial resources for care and medical staff. For instance, in the case of community-based services, the need for staff to travel to provide care at the beneficiary's own home requires more staff as compared to institutional services. The second important issue is to have sufficient human resources with appropriate skills, competences and training. On the one hand, there is growing demand for care workers who do not require in-depth knowledge, and, on the other hand, for trained physiotherapists, nurses, psychotherapists and occupational therapists. In the context of shrinking labour resources and ongoing changes in family functions and structure, implementing the deinstitutionalization process in the EU will be a major challenge (Eurostat, 2022). At the same time, one must also consider EU diversity, especially in terms of the social policy model implemented in any given country, the prevalent model of care, and the possibility of building a system based on community-based services.

Human resources, and particularly nurses and carers, play a key role in the deinstitutionalization process, which cannot succeed without sufficient qualified personnel.

The question to be addressed in this article is whether Poland, Hungary, Czechia and Slovakia have the capacity to pursue deinstitutionalization in line with the assumptions contained in the EU documents and in the context of a declining workforce size (Eurostat, 2022). The presented assumptions of deinstitutionalization formulated at the EU level result from the experience of Western European countries, but do not consider the different models of care developed in post-communist countries. This raises important questions about the likely pace of deinstitutionalization as well as the likelihood of its success in these four countries.

Transition from institutional to community-based services in Central Europe

Systemic transformations in Central European countries have led not only to an economic transition, but to significant social changes. The fertility rate in the region has declined much more rapidly than in Western Europe (Sobotka, 2004). Changes in the family structure have also accelerated as the socio-demographic evolution, which had occurred in the West across several decades, gathered pace during 1990s in Central Europe. The economic transformation also resulted in less government involvement or the withdrawal of the State from the provision of social and public services (Spasova et al., 2018). This is due to the care model that arose during the transformation, which is the combined result of the legacy

Table 5. *Beds in residential LTC facilities per 1,000 population aged 65+*

Country	2005	2019
Netherlands	74.5	72.1
Belgium	70.9	68.7
Sweden	88.4	68.1
Switzerland	73.9	63.6
Finland	51.6	54.2
Germany	49.3	54.2
Canada	61.6	51.9
France	47.3	49.1
Slovakia	46.7	48.6
Hungary	48.1	44.5
Norway	60.5	43.5
Denmark	54.5	37.7
Czechia	48.0	35.6
Italy	15.0	18.8
Poland	17.7	11.3

Source: OECD (2020a); dataset: Long-term care resources and utilisation.

of the institutional system of the centrally planned economy and of the neoliberal reforms that occurred in these countries following the collapse of the communist system (Mladenov and Petri, 2020). This confluence of factors has given rise to a model in which the main burden of care lies with the family, while public care institutions do not play a significant role and assistance for the family is insignificant. In contrast, Western European countries have developed a model in which institutional solutions support the family in providing care (supported familialism) or elderly people are assisted in fulfilling their right to care and independent living (de-familialization). Poland, Hungary, Slovakia and Czechia have created systems where there is very little assistance offered to families carrying out caregiving functions (unsupported familialism) (Saraceno and Keck, 2010). The number of available places in residential care institutions in these countries is small as compared to Western Europe; indeed, the numbers of beds in residential LTC facilities per 1,000 population aged 65+ in the four analysed countries are among the lowest among OECD Member countries (Table 5).

As a consequence, Central European countries have seen the emergence of private residential care facilities filling the care gap that results from an insufficient supply of public services (both institutional and community-based).

However, these private facilities are not always subject to formal supervision by public bodies (Siska and Beadle-Brown, 2020), and the quality of caregiving they provide varies greatly: there is no standardization of services and no requirements as to the number and competences of the personnel they employ. In the last two decades, post-communist countries have experienced the largest growth of private residential care facilities among EU Member States (Eurofound, 2017). Thus, in these countries, as a result of the philosophy adopted during the political transformation, the market has filled the care gap that arose after the State's withdrawal from the provision of public services addressing the needs of the elderly. The growth of private institutions is also a consequence of the insufficient development of community-based services. In Poland, about 20 per cent of municipalities fail to provide any care services. It may be assumed with a high degree of certainty that this is not because of a lack of demand, but rather due to fact that social welfare centres do not offer these services (Supreme Audit Office, 2018).

However, the increasing demand for assistance due to population ageing and the changes taking place in the family structure that affect caregiving make it necessary for the State in these countries to become more involved in care issues. The declining potential of families to provide care calls for public intervention, which requires appropriately trained staff in both the health care and social care sectors. One challenge is to define the types and numbers of workers necessary for these two sectors. In the case of health care, the challenge is less, because employees must have appropriate, formally certified competences. In the case of social care, this is more difficult, because there are different care professions in different countries, and also the grey economy (non-registered workers, often migrants providing community care) makes it impossible to reliably estimate the number of people working in this sector. Estimates are likely to underreport the actual figure.

When it comes to health care employees, while in Western Europe the number of nurses and midwives per 1,000 inhabitants has increased, in three of the four Eastern European countries it has decreased, with the exception being Poland (Table 6).

Attention must also be paid to the negative impact of population ageing on the size of the workforce, including numbers of nurses and caregivers for the elderly, which, combined with a significant increase in the demand for care, will contribute to the care gap (Lovell, 2006). In addition, young nurses entering the profession are reluctant to work in LTC (McGilton et al., 2014).

Deinstitutionalization requires increased human resources both in terms of the health care workforce and social workers and carers providing community-based services. This also means that municipal governments, which are responsible for providing community-based services and running care homes, must shoulder a greater share of the responsibility. However, there are already considerable

Table 6. *Nurses and midwives (per 1,000 people)*

Country	2005	2018
Netherlands	8.3	11.5
Belgium	9.4	11.8 (2015)
Sweden	11.2	12.6 (2017)
Switzerland	13.0	17.9
Finland	17.1	14.9 (2017)
Germany	12.5	13.5
Canada	9.9	10
France	8.1	11.5
Slovakia	6.3	6.0
Hungary	7.6	7.2
Norway	14.1	18.2
Denmark	9.8	10.5
Czechia	8.5	8.4
Italy	5.2	5.9
Poland	5.6	6.8

Source: OECD (2020a); dataset: Long-term care resources and utilisation.

difficulties in recruiting community carers (OECD, 2020b). LTC caregivers are mostly women who are low paid, and personnel turnover is considerable, especially in community-based services. In fact, low pay, high turnover and part-time work remain key features of many LTC labour markets, which makes this sector unattractive for workers. Therefore, it is difficult for the LTC system to recruit and retain employees, and especially caregivers. Western European countries, which offer higher remuneration, compete to hire Polish, Czech, Slovak and Hungarian nurses and caregivers. As already mentioned, due to the multitude of elderly care professions (assistants, personal care workers, caregivers) it is impossible to estimate the exact number of workers in this sector. In addition, in Central European countries, there is an informal care services market (grey economy) employing many migrants from Ukraine and Belarus, who do not need to have formal competences and their skills and quality of work are neither checked nor regulated. Grey economy workers fill the gap resulting from the shortage of sufficient human resources with adequate qualifications in the formal LTC system, as well as avoiding the higher employment costs associated with working in the formal system. According to OECD data (OECD, 2020a), Hungary, Slovakia and Poland belong to countries with the lowest

Table 7. *LTC workforce (per 100 people aged 65+)*

Country	2019
Netherlands	8.0
Belgium	5.5
Sweden	11.9
Switzerland	8.3
Finland	7.9
Germany	5.4
Canada	3.4
France	2.4
Slovakia	1.4
Hungary	1.9
Norway	12.4
Denmark	7.8
Czechia	3.8
Italy	3.7
Poland	0.6

Source: OECD (2020a); dataset: Long-term care resources and utilisation.

number of LTC workers per 100 people aged 65+. Czechia is in a relatively better situation (as in the case of its care gap) with 3.8 care works per 100 people aged 65+ (Table 7). As mentioned, not only is it difficult to estimate the actual number of care workers due to the large grey economy but, additionally, there are difficulties in coordinating the care provided by formal workers and informal caregivers (both family members and those employed in the grey economy).

Due to the lack of comparable data on the number of people working in LTC, it is difficult to construct indicators that would fully reflect the situation in this sector in EU Member States. However, based on the presented data, the case of Czechia suggests it is possible for a post-communist country to build a model that largely satisfies the needs of the elderly and assists the family in its caring functions. In terms of nearly all the indicators, Czechia was closer to Western Europe than to Central Europe, despite the fact that it is also grappling with the same legacy of communism followed by a neoliberal transformation. Accordingly, the deinstitutionalization process should be less challenging for Czechia than for the other three countries analysed in this article. Czechia's favourable situation can be explained by the fact that elderly care issues were addressed there earlier than in the other Visegrád countries, with a significant reform implemented in 2007 to

increase financing and access to care services (Łuczak, 2018). Czechia also has the highest GDP per capita among the analysed countries as well as the most advanced urbanization process. However, even there the full implementation of the deinstitutionalization process is likely to be hindered by a shortage of skilled workers, both in the health and social care sectors.

Concluding remarks

When discussing the deinstitutionalization process, one should consider the socioeconomic context of a given country, its history, the role of the family, the pace of cultural change, the design of the LTC system, and the role of public institutions within it. Significant differences in the development of LTC can be found not only between the "old" and "new" EU Member States, but also among the "new" Central and East European EU Member States.

The presented data show that Poland, Hungary, Czechia and Slovakia have different starting points in the process of deinstitutionalizing long-term care for elderly people as compared to Western European EU Member States, with a much lower proportion of people living in care institutions. Post-communist countries have not increased the number of public residential care institutions, despite the growing demand for care. The resulting gap has been filled by private institutions over which public authorities often have little control. This outcome is also the result of seeking cost reductions in public expenditure. Meeting all statutory requirements in the field of residential care requires significant financial outlays, which translates into high costs for residents. In contrast, in the analysed countries, networks of community-based services are largely underdeveloped.

Thus, differences in national circumstances must be considered when designing policy proposals and directing EU funds towards deinstitutionalization (European Expert Group on the Transition from Institutional to Community-based Care, 2014). In Central European countries, deinstitutionalization should consist in developing a network of community care services and ensuring independent living for those in need of assistance. This is particularly difficult in the more isolated rural areas, where long distances increase the time necessary for the provision of services. The urbanization rate in the four analysed countries, and especially Slovakia, is below the European average. In practical terms, one caregiver will be able to provide support to fewer people in rural settings than in more densely populated urban areas. This geographical reality requires increased financial outlays and a larger caregiving workforce. However, given an ageing population and an ageing workforce, this will be an extremely difficult challenge to meet. Accordingly, a reduction in residential care for the elderly should take place only when their care needs can be met in a community setting. In the meantime, data on the care gap reveal a high percentage of people whose needs

are not being met. If the extent of residential care is reduced without a real increase in the supply of community-based services, the percentage care gap will further deepen leading to counterproductive outcomes with deteriorated rather than improved access to care.

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Long-term care in India: Capacity, need and future

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Abstract The family is the dominant player in India's current long-term care (LTC) system. Yet informal family-based arrangements will be insufficient to accommodate India's growing need for LTC due to increasing longevity and geographic mobility, the prevalence of chronic disease and disability among the elderly, and the decline of extended family living arrangements. Addressing the growing need for LTC will require a robust expansion of the current LTC system, especially its non-familial components. This overhaul will require investments in infrastructure, human resources and legal and regulatory environments. The objectives of this study are to i) provide a descriptive summary and analysis of the LTC system in India, with attention to cross-state heterogeneity and to the financial, social and cultural factors that impede the operation of India's LTC system; ii) estimate and assess the current and future need for LTC and its critical financial and human inputs; and iii) critically analyse and discuss the institutions and policies, technologies and behaviours needed to bring capacity comfortably into conformance with the need for LTC.

Keywords elder care, ageing population, medical care, long term care, social services, social protection, India

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Introduction

India, with a population of 1.3 billion people, is considered a relatively young society, with a median age of 28 years. However, with decreasing fertility and mortality rates, and increasing life expectancy, a large cohort is expected to reach older ages. The share of population aged 60+ in India is expected to double from 10 per cent in 2020 to around 20 per cent in 2050. The growth rate of the population aged 80+ is even higher, with their share of the total population projected to rise by 160 per cent between 2020 and 2050 (UNDESA, 2019). With population ageing, the incidence and prevalence of chronic conditions and disabilities are also expected to dramatically increase. It is estimated that by 2030, nearly half of the total disease burden in India will be borne by its older population (Chatterji et al., 2008), substantially increasing the need for long-term care services. Moreover, India has an average of nine doctors and four nurses/midwives per 100,000 population, which is far below the benchmark of 44.5 health workers per 10,000 persons recommended by the World Health Organization (Karan et al., 2021), presenting a dire situation for the country's health care workforce. Additionally, factors such as vast inequalities in income and health, the low coverage of social security benefits (10 per cent of the total population) and health insurance (~20 per cent), low investments in health and particularly in elder care, a large proportion of informal workers with no entitlement to social benefits, and an inadequate public health infrastructure will only intensify the ramifications of ageing in India (Sahoo et al., 2021; Kumar and Duggal, 2022; Mehrotra and Parida, 2022). In the absence of a formal long-term care system, in less than a decade, state and federal governments will be under immense pressure to finance, organize and deliver coordinated health and social services to India's ageing population.

In this article, we first assess the existing health services available to Indian elderly, who provides those services, and how these services are financed and organized in the country. We then assess and estimate the future long-term care needs of the population by using population projections and data from Wave 1 of the Longitudinal Aging Study in India (LASI), collected in 2017–2019 (USC, 2021). LASI Wave 1 collected comprehensive data on the health, social, and economic aspects of ageing from over 73,000 individuals aged 45+ across all 36 states and union territories of India. Finally, we discuss the policy implications of the changing health needs and potential policies, institutions, technologies and behaviours needed to bring capacity into conformance with a need to develop a sustainable and equitable LTC system.

Current capacity of the LTC system in India

The World Health Organization (WHO) defines long-term care as activities "to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms, and human dignity" (WHO, 2015). Further, the WHO defines a long-term care system as an integration of all organizations, people, and actions (such as laws, rules and regulations) whose primary intent is to promote, restore and maintain the health or abilities of those who have significant limitations in functional ability and need care, or are at risk of needing care (WHO, 2017). This system includes in-home care – by family members as well as professional care providers – community care, and care provided at institutions or nursing homes (Mor and Maresso, 2019).

India currently has a fragmented LTC system with no organized long-term care policy, plan or strategy. Multigenerational cohabitation (also known as joint family or extended family), which was traditionally a social norm in India – and still is in most of the states – has served as the primary institution responsible for providing basic existential social, economic and health support to the elderly. However, with family structures changing, increasing migration within and outside the country, and the evolving roles of women, the existing informal family-based elder care system is not sustainable (Agarwal et al., 2020a).

Over the last two decades, although there have been continued efforts by the government to make provisions for elder care, these efforts have not been coordinated. In 1999, the Ministry of Social Justice and Empowerment (MoSJE) formulated the National Policy on Older Persons (NPOP), which recognized the provision of social care and support by state governments and directed the states to provide financial security, health care, shelter, welfare schemes, protection against abuse, and livelihood opportunities to the elderly (Irudaya Rajan and Mishra, 2011). In 2011, the MoSJE revised and replaced the NPOP with the National Policy for Senior Citizens (NPSC), prioritizing the needs of the population aged 80+. The NPSC promoted the concept of "ageing in place" and focused on building formal and informal support systems for the elderly population through a judicious mix of public health services, health insurance, health services provided by not-for-profit organizations including trusts and charities, and private medical care. However, the implementation of these policies was left to state governments (MoSJE, 2011), a situation that is still pending. Another elder-focused act – the Maintenance and Welfare of Parents and Senior Citizens (MWPSC) Act of 2007 – legally protected the rights of senior citizens and held their legal heir responsible for providing social, financial and health care support (Issac et al., 2021). The focus of these policies was more on promoting auxiliary support from the community, government and the private

sector to families, so that the care of senior citizens remains vested in the family and institutional care was considered as a last resort (MoSJE, 2011).

Since 2011, there has been a marked shift in India's health and social policies for the elderly, with a renewed focus on formalizing the long-term care support to this population. In 2020, the MoSJE launched the National Action Plan for Welfare of Senior Citizens, a policy document that outlines current schemes and future strategies along with their implementation plan and expected outcomes to provide financial security, food, health care, and a life of dignity to the elderly population (MoSJE, 2020). In June 2021, the MoSJE launched the "Senior Care Aging Growth Engine" project to fund and promote entrepreneurs and start-ups to contribute toward the "Silver Economy".[1] Under this programme, the ministry will allocate 100 crores of rupees[2] (INR) (approx. 14 million US dollars (USD)) to build capacity and care facilities for senior citizens. Further, the ministry plans to develop model senior care projects in partnership with the private sector, with appropriate regulations and standards, policy support, tax structure, subsidized financing and appropriate governance mechanisms (IBEF, 2021).

In addition to government-sponsored programmes and services, in recent years private and charity-based organizations have also sprung up to cater to the varied care needs of the elderly. Most of these private service providers charge fees and are located in tier 2 and 3 cities,[3] where only 40 per cent of the country's elderly population resides. A 2009 study by HelpAge India listed a total of 1,176 senior living facilities in India, with the highest proportion of these institutions located in Kerala. There exists vast heterogeneity in health and social systems and outcomes across states in India, given health is a state matter in the country. Kerala has the most advanced social and health care systems in India, owing to its strong government institutions, policies recognizing the changing needs of the population, well-established primary health care infrastructure, continuous improvement in secondary and tertiary care, and a growing network of community-based workers and volunteers (Kutty, 2000). In recent years, the Kerala government, while recognizing the changing needs of its population, has launched several senior care programmes, such as an online service portal called e-Sevanam,[4] which integrates 509 government services for the elderly, including social security payments. The government has also focused on the provision of home-based health

1. MoSJE defines the silver economy as the system of production, distribution and consumption of goods and services aimed at utilizing the purchasing potential of older and ageing populations, as well as satisfying their consumption requirements, living essentials and health care needs.
2. One crore equals 100,00,000 (1 crore; seven zeros, using the Indian system of digital group separators).
3. The Government of India defines cities with a population in the range of 50,000 to 100,000 as tier 2 cities, and those with a population of 20,000 to 50,000 as tier 3 cities.
4. The e-Sevanam portal can be accessed here.

and social services for the disabled elderly, an expansion of the social safety net, and increments to the monthly social security pension for old-aged persons, unmarried women above 50 years, widows and disabled people (Moideen, 2021). Kerala's rights-based approach towards health care and social protection is being followed by some states in the country and could prove to be a possible pilot model for others (Thomas, 2021).

Table 1 lists some of the elder care organizations across India with details on their ownership, the type of services they provide, and their sources of funding.

How are current LTC services financed?

The total health expenditure (THE) as a share of gross domestic product (GDP) for India was around 3.3 per cent in 2017–18. In comparison, on average the Member countries of the Organisation for Economic Co-operation and Development spent 8.8 per cent of their GDP on health in 2019 (OECD, 2021). The share of private out-of-pocket health expenditure in the total health expenditure has dropped in recent years, but still accounts for around 50 per cent of total health spending (MoHFW, 2021). Of the 3.3 per cent of GDP spent on the total health expenditure in India, only 0.16 per cent is spent on rehabilitative and long-term care services, which is quite low as compared to an average of 1.25 per cent in OECD Member countries (OECD, 2020).

The very first step taken by the Indian government towards providing social security protection to its population was the promulgation of the Employee's State Insurance Act, 1948 (No. 34), followed by the launch of the Employee's State Insurance Scheme in 1952, under which employees (and their dependents) of state governments were covered for medical expenses. Similarly, an insurance scheme for the employees of the central government was launched in 1985: the Central Government Health Scheme. Until recently, these are the only social insurance schemes available for employees, pensioners, and their dependents in India.[5]

The launch of the national public health insurance scheme – *Pradhan Mantri Jan Arogya Yojana* (PM-JAY) – in 2018 was a step towards attaining universal health coverage (UHC), currently planned to be achieved by 2030. PM-JAY particularly targets low-income families and provides coverage of 5 lakhs Indian rupees (INR) (equivalent to USD 7,150) per family per year for secondary and tertiary care hospitalization. Although out-of-pocket expenditure on health has reduced in recent years, it is still high enough (~50 per cent of the total health

5. Under the Employees' Provident Funds and Miscellaneous Provisions Act, 1952 (No. 19), India also operates provident funds, mandatory public savings schemes, which in their simplest form provide lump-sum cash benefits for covered contingencies (old age, disability and survivorship).

Table 1. *Examples of elder care organizations in India*

Name of the organization	Type of organization	Type of services	Price range	Locations
Elderaid	Private	At-home health, wellness, and concierge services	INR 3,000 per month for independent or partially dependent elder care, and INR 25,000 per month for fully dependent elder care plan	Bengaluru, Ahmedabad, Coimbatore, Jaipur, Chennai, Kochi, Mysore, Hyderabad
Little Sisters of the Poor	Charity-based	Institutionalized care for 65+	Free	Bangalore, Chennai, Conoor, Erode, Goa, Guntur, Jabalpur, Kolkata, Mangalore, Mumbai, Mysore, Sawantwadi, Secunderabad, and Tuticorin
Advantage Elder Care	Private	Runs a palliative care centre; offer home-based nursing services		two centres in Bengaluru
Medos	Private	Home-based care services		Bhubaneshwar
Samarth eldercare	Private	Home- based care services including in-person care management, healthcare and hospitalization support, emergency care, convenience services, engagement assistance; premium plan also includes on-demand doctors, in-person doctor consultation, in-person physiotherapy consultations	INR 7,500 to INR 15,000 per month	Indore, Delhi, Jamshedpur, Pune, Chennai, Kochi, Jaipur
Elders and Seniors	Private	Provide home-based care including patient attendant, in-home nurse, physiotherapy	INR 28,500 for a nurse per month	Goa and Tamil Nadu
Ashiana Utsav Care homes	Private	Provide institutionalized care that covers medical as well as daily needs of elderly	INR 40-80,000 per month	Delhi NCR, Jaipur
Antara Care Homes	Private	Provide both institutionalized and home-based care services; care centres include both short- and long-term care, pre- and post-operative care, and memory care	Care homes - INR 4,000-10,000 per night depending on needs.	Gurugram, Delhi, Dehradun

Note: INR = Indian rupees.

Source: Compiled by the authors based on the literature review.

expenditure) to push marginalized people into extreme poverty (Sarwal and Kumar, 2020; Scheil-Adlung and Bonan, 2013).

Even after all these efforts, only around 20 per cent of the population is currently covered under some kind of health insurance, as there are both socioeconomic and systemic barriers to accessing health insurance (Kumar and Sarwal, 2021). Elders are often explicitly excluded by insurance companies due to their age and their pre-existing conditions, such as diabetes, high blood pressure and history of cancer (Dey et al., 2012). This results in further estrangement of the elderly from the health care system and puts heightened financial pressure on families.

Recently, both government and private insurance companies have launched insurance schemes specifically targeting senior citizens. However, these schemes have very minimal insurance coverage, most do not include long-term or palliative care in their plans, and the waiting period to avail of benefits for those with pre-existing conditions is usually 12–24 months from the start of the policy (without any lapse). Though these plans seem to be moving in the direction of providing health insurance to the elderly population, the schemes are still far from comprehensive, as no policy includes coverage of long-term care and rehabilitative services. Table 2 lists currently available senior citizen insurance schemes in India.

Future LTC needs in India

The estimates presented in this section are subject to a number of assumptions. The projections are determined by the expected changes in size and structure of the population and do not consider changes in disease prevalence, which are believed to be influenced by policies and programmes related to the prevention, cure and rehabilitation of diseases (see Kotschy and Bloom in this issue).

We used data from the Longitudinal Aging Study in India (LASI) Wave 1, 2017–2019, and state population projections by the Government of India's Ministry of Health and Family Welfare (MoHFW) (which used Census 2011 data) to estimate the current number of people with long-term care needs and to project these to 2036. LASI asked respondents if they have difficulties with activities of daily living (ADLs such as dressing, walking, bathing, eating, getting in and out of bed, and using the toilet) and instrumental activities of daily living (IADLs such as preparing a hot meal, shopping for groceries, making telephone calls, taking medications, doing house chores, managing money, and getting around unfamiliar places). ADLs and IADLs are used as indicators of the functional status of the individual and help clinicians identify if the individual needs assistance to maintain a decent quality of life. These indicators are considered reliable predictors of health outcomes in older ages, and thus helpful in predicting future admissions

Table 2. *Currently available elder insurance plans in India*

Name of the scheme/plan	Provider type	Provider name	Eligibility and coverage
Employee's State Insurance Scheme (launched in 1952)	Government		Eligible for state government employees, pensioners, and their dependents; there are no exclusions for pre-existing diseases or any cap or limit on the coverage.
Central Government Health Scheme (started in 1985)	Government		Eligible for central government employees, pensioners, and their dependents; there are no exclusions for pre-existing diseases or any cap or limit on the coverage; contributions from employers and employees
Pradhan Mantri Jan Arogya Yojana under Ayushman Bharat Scheme	Government		Health insurance scheme for low-income families; INR 5 lakhs per family per year for secondary and tertiary care hospitalization
United India Senior Citizen Health Insurance	Private	United India Insurance Company	Entry age 61 to 80 years for sum insured ranging from 1-3 lakhs and covers hospitalization expenses for treatment and surgeries for stays above 24 hours
Health of Privileged Elders	Private	Oriental Insurance Company	Entry age 60 years and above, sum insured ranging from Rs 1 lakh to 5 lakhs, covers specified diseases and hospitalizations only; compulsory 20% co-payment
Senior Citizen Mediclaim Policy	Private	New India Assurance	Entry age 60-80 years; sum insured of Rs 1–1.5 lakhs; limited cover for hospitalization; pre-existing conditions such as hypertension and diabetes are covered after 18 months of continuous insurance with additional premium
Aditya Birla Active Care Senior Citizen Health Insurance Plan	Private	Aditya Birla Health Insurance Company	Entry age 60-75 years; sum insured from Rs 1–25 lakhs; out-patients consultation, health check-ups and hospitalization coverage included; pre-existing conditions covered after 12 months of continuous coverage
Senior Citizens Red Carpet Health Insurance Policy	Private	Star Health and Allied Insurance Co. Ltd.	Entry age 60-75 years; sum insured from Rs 1-25 lakhs; out-patients consultation, health check-ups, day-care procedures, and hospitalization coverage included; pre-existing conditions covered after 12 months of the waiting period; eligible for tax benefits.
Care Senior Health Insurance Plan	Private	Care Health Insurance	Entry age 60 years; annual sum insured ranging from Rs 3–10 lakhs; covers day surgeries; hospitalizations
Senior First Health Insurance Plan	Private	Niva (Max) Bupa	Sum insured ranges from Rs 1 lakh to 1 crore; covers hospitalizations; pre-existing conditions covered after a waiting period of 24 months.
Universal Sompo Health insurance for Senior Citizens	Private	Universal Sompo general Insurance Co. Ltd.	Entry age 60-70 years; coverage amounts Rs 1–5 lakhs; covers hospitalizations; option to cover critical illness

Note: Rupees 1,00,000 (1 lakh; five zeros, using the Indian system of digital group separators) is equivalent to ~USD 1,300. Rupees 100,00,000 (1 crore; seven zeros, using the Indian system of digital group separators) is equivalent to ~USD 130,000.

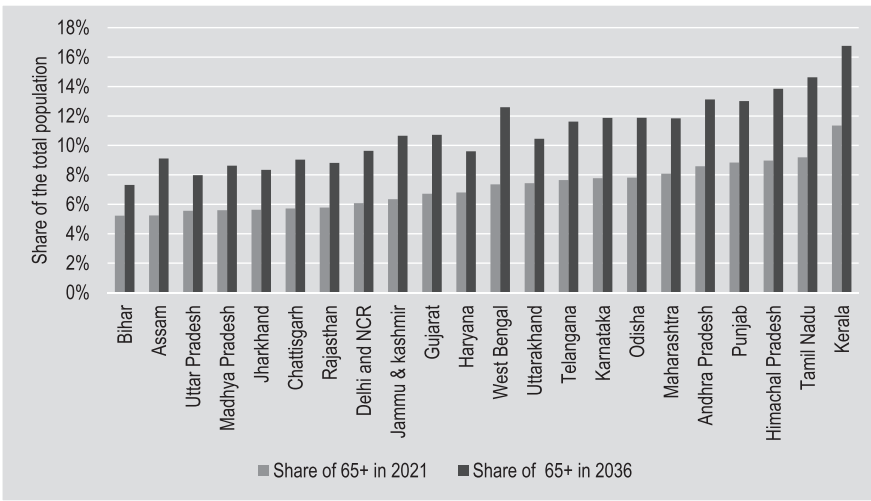
Source: Compiled by the authors.

to nursing homes, the need for alternative living arrangements or hospitalization, or the use of paid home-based care (Holmes, 2021; Schiltz et al., 2020).

According to the population projection estimates, the population share of people aged 65+ in India is expected to increase from 7 per cent in 2021 to 10 per cent in 2036 (MoHFW 2020). In absolute terms, there will be more than 156 million people aged 65+ by 2036. As Figure 1 shows, there is noticeable heterogeneity in the demographic structure across states in India, with a population share of those aged 65+ ranging from 5 per cent in Bihar to more than 10 per cent in Kerala in 2021. Additionally, in most of the southern states of India, the share of the aged 65+ population is expected to pass 10 per cent by 2036. Such current and ongoing dramatic demographic shifts in India indicate the scale of population ageing challenges that the country is expected to face in the near future (Agarwal et al., 2020a).

To measure disability and dependence, we used data on ADLs and IADLs from LASI Wave 1 (Bloom, Sekher and Lee, 2021) (Gateway to Global Aging Data). We found that around 42 per cent of the older adults aged 65+ and 60 per cent of those aged 80+ have at least two ADL or IADL limitations. There was a huge variation in the prevalence of disability in the group aged 65+ (defined as the presence of at least two ADLs or IADLs) across India's 35 states and union territories (except Sikkim), with 15 per cent in Arunachal Pradesh compared to 60 per cent in Jammu and Kashmir. In the age group 80+, the heterogeneity in the prevalence

Figure 1. *Projected increase in population aged 65+*



Note: Figure shows share of population aged 65+ in the total population for 22 major states in India.
Source: Ministry of Health and Family Welfare (2020).

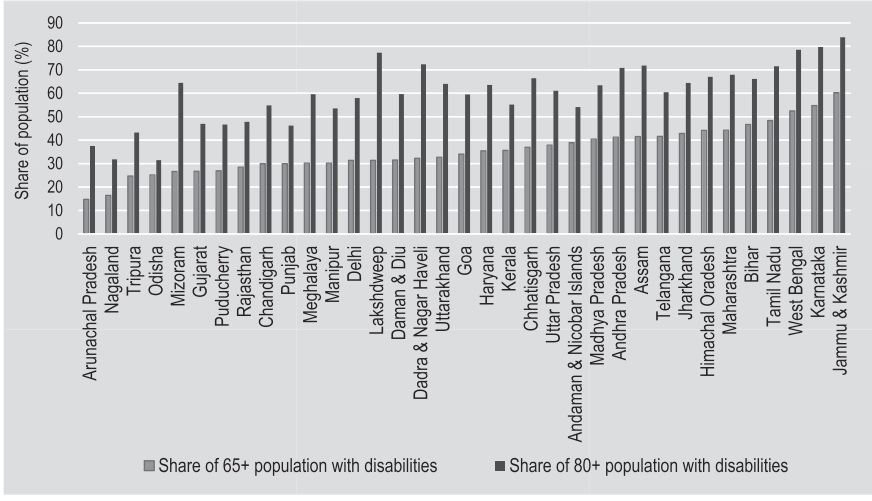
of disability across states was glaring, with 31 per cent prevalence in Odisha and 84 per cent in Jammu and Kashmir. These differences in the prevalence can be attributed to the socioeconomic divide, as well as the disparities in the provision and utilization of health care services across the states (Figure 2).

We estimated a 34 per cent cumulative increase in demand for long-term care between 2021 and 2036 across the country, with individual states (as shown in Figure 3) experiencing an increase in the range of 0.9 per cent to 2.7 per cent. These figures highlight the potential magnitude of rising dependency and the need for long-term care across all states in India. Many states will be profoundly affected by the increasing number of people with disabilities and will need to identify the human and financial resources necessary to support them. The improved longitudinal collection of data on disability and caregiver needs would help in guiding the future provision of health and long-term care and inform labour and macroeconomic planning.

Policy implications and solutions

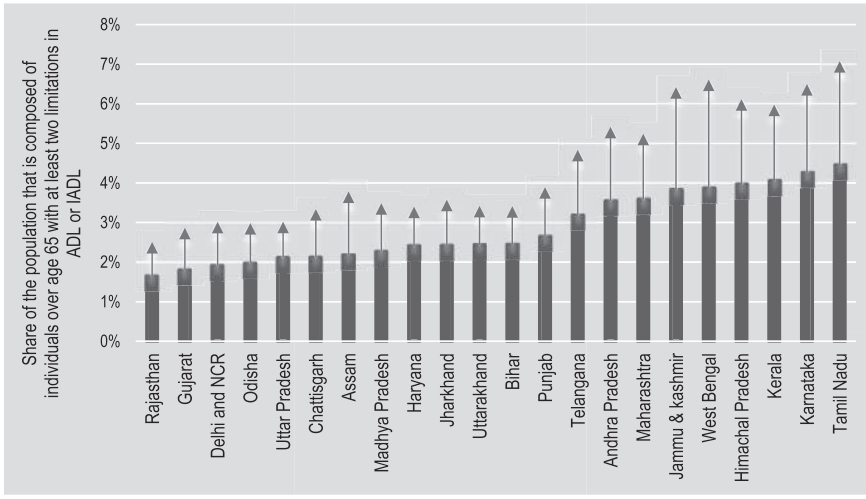
Provision of long-term care has been a priority for most high-income countries for decades. However, the COVID-19 pandemic has highlighted flaws in the existing

Figure 2. *Share of population with disabilities*



Note. Figure shows the share of population aged 65+ and aged 80+ with at least two limitations in ADL or IADL for 35 states and union territories (except Sikkim) of India.
Source: LASI Wave 1 (2017–19).

Figure 3. *Projected demand for long-term care needs*



Note: The figure shows the increase in demand for long-term care between 2021 and 2036 among those aged 65+ in 22 major states of India.
Sources: MoHFW (2020); LASI Wave 1 (2017–19). The LASI Wave 1 data is available here.

long-term care system across these nations, as the residents of LTC institutions suffered the disproportionate burden of COVID-19 morbidity and mortality. In a study of 21 developed countries, nearly half of the COVID-19 deaths occurred among the residents of long-term care settings (Comas-Herrera et al., 2020). Many experts argue that current LTC systems need a major structural and financial revamp (Grabowski, 2021). Along with its enormous challenges, the COVID-19 pandemic has also provided an opportunity to both developed and developing nations to reconsider the components of a robust and sustainable LTC system. Reimagining LTC homes in these developed nations invites an intense debate (Davidson, 2020); some even argue that nursing homes should be abolished and investments should be targeted toward home- or community-based care (Luterman, 2020). Additionally, as most of the elderly across the globe would like to "age in place", home- and community- based care are gaining renewed attention (WHO, 2022; Grabowski, 2021). In this section, we will discuss some of the promising options for an improved LTC model for India and its components, including financing, governance, technology and infrastructure, and human resources.

The care model: Home care versus institutional care

An important feature to consider while developing a LTC system is the preference of the elderly and their families. In a country such as India, where the elderly prefers to stay, being cared for, and die at home (Brijnath, 2012), care homes might not be an optimum pan-India solution. Additionally, there exists vast heterogeneity among the individuals in need of care, not only in terms of the type of care they need, but also in their religion, cultural habits, rituals, diet, clothing, and social habits. Given such a large heterogeneous population, it will be difficult to establish facilities that have a fixed set of standard operating protocols. Thus, in our view, investing in home- and community-based care might be a more viable and culturally appropriate option for India, which would also align with the vision of ageing in place. Institutionalized care should focus more on providing specialized care to older people – those who are completely dependent, with multiple morbidities, and in need of continuous medical attention that cannot be delivered at home or in a community setting. Additionally, there should be a mechanism (such as regular follow-up with physicians or community health workers) to identify the people with disabilities and morbidities who need or would need institutional care in the future (Turner and Clegg, 2014). Ideally, for a continuum of long-term care, there should be seamless transitions between home, community and institutions (WHO, 2021).

In the following section, we discuss some of the policy options that can be adopted by India to develop the specific components of the care system.

Human resources for LTC

Family is and will remain central to elder care across the globe. In the United States of America, it has been estimated approximately USD 17,000 per year per person would be needed to substitute informal with formal home care for older people (Cecchini, 2018). With such savings, it seems prudent to invest in supporting informal caregivers to maintain a sustainable LTC system, which can both provide affordable care as well as supplement formal institutional care (Cecchini, 2018; Adelman et al., 2014; Rodrigues et al., 2013). Investments in training informal (mostly family members) caregivers are needed. Along similar lines, an integrated community-care programme, Older Person's Care Programme (*Programa Maior Cuidado* – PMC), is being successfully implemented in the Brazilian city of Belo Horizonte, under which local (community) carers/volunteers are trained and paid to provide social and health care services to elderly patients (Aredes et al., 2021; see also Lloyd-Sherlock et al. in this issue). Similar programmes could work in India as well.

Additionally, India has successfully built a network of community health/social workers such as auxiliary midwives, *anganwadi* workers,[6] and accredited social health activists (Scott, George and Ved, 2019), who have become the backbone of the primary health care system in rural India (with some presence in urban areas as well). Utilizing these community workers to identify the care needs and provide basic geriatric care to older people could work as the primary level of an LTC workforce (Torres et al., 2017; 2014).

Furthermore, many observers have suggested improving geriatric education, training and research programmes in India since 1999, but to date no real progress has been made (Ingle and Nath, 2008; Chaubey and Aarti, 1999; Dharmarajan and Pitchumoni, 2002). Unfortunately, there are only a handful of academic institutions that provide specialization in geriatrics; thus, investing in the establishment of undergraduate and graduate programmes in geriatric medicine in existing medical institutions would result in the needed expansion of the geriatric workforce (Rao, Mathur and Dey, 2020). Investments are also needed in both the capacity building and retention programmes for health professionals to stay and work in India, as a large proportion of nurses from India migrate to developed countries for the latter's better employment conditions (Oda, Tsujita and Irudaya Rajan, 2018).

Financing

For designing and implementing the financing of LTC systems, policy makers need to consider the population coverage, service coverage, financial coverage or financial protection for LTC services, and the ability of families (working and non-working) to contribute in an affordable and sustainable manner. Additionally, identifying the division of financial responsibility among individuals, families and government, the fairness of these contributions, and equitable access to quality health care services need to be part of the financing plan. A fiscally affordable and sustainable system would also need to identify sustainable sources of revenue for the LTC system and its governance structures.

In India, the majority (~55 per cent) of health financing is private (World Bank, 2022),[7] including through unpaid family labour (mostly females), volunteer care, and out-of-pocket expenditure for health and social care services. Though informal care might seem to be a more cost-effective solution to governments than providing formal care, the opportunity costs of informal care are often

6. Community health workers in rural care centres that provide childcare and development support for mothers and young children.

7. Health expenditure date for India was sourced originally from the World Health Organization Global Health Expenditure database (apps.who.int/nha/database).

overlooked. As the notion of ageing in place gains ground (not only in developed but in developing nations as well), financing informal caregivers will be of utmost importance. Care allowances (as in England and Poland), subsidies, extended paid leave and government transfers could be adopted to financially support the informal caregivers/family members of the elderly (EC, 2022; Age UK, 2021). Additionally, innovative programmes and policies are needed to provide social protection services to the large pool of informal workers, who currently do not qualify for any social benefits (Guven, Jain and Joubert, 2021).

PM-JAY has laid the foundation for the public financing of care services for poor and low-income elderly people; however, long-term care and rehabilitation services are still not part of any of the publicly funded programmes. Private senior care insurance plans are now available, but at a very high cost. India's burgeoning commitment and efforts to achieve universal health care would be instrumental in providing equity in access and availability of quality health care services to the destitute elderly population (Srivastava, Mueller and Hewlett, 2016). Given that LTC expenditure may be catastrophic for individuals and their families, risk pooling could therefore be a viable option to distribute the risk of these expenses. Risk pooling could involve social insurance (such as in Europe, Japan, and the Republic of Korea), a tax-based system (United States, Australia, and New Zealand), private insurance, or a combination of these three (such as in France) (Wyse and Walker, 2021). An efficient and effective provider-payment mechanism to pay health care workers in both private and public facilities, as well as those providing home-based care, should also be part of the LTC financing system (Srivastava, Mueller and Hewlett, 2016).

Technology and infrastructure

Ageing in place, a shortage of health care professionals, and the changing living arrangements of the elderly have helped to drive the age-tech revolution. Numerous start-ups focusing on technologies to improve the quality of life of elderly people have sprung up over the last few years. Technology-driven assistive devices, such as sleep trackers, heart monitors, speech assist devices, artificial intelligence-based systems, GPS, smartphone applications, telemedicine, etc., have improved the care, independence, safety and quality of life of the elderly and their caregivers (Orlov, 2020; Tun, Madanian and Mirza, 2020; Kim, Gollamudi and Steinhubl, 2017). In India, easy accessibility to simple assistive devices such as eyeglasses, walking aids and hearing aids, could prove to be instrumental in improving the lives of many elderly people. Other infrastructure issues to support ageing, such as age-friendly transportation and public facilities, residential communities, walking paths, and recreation parks or areas in the communities,

need to be urgently attended to by the government. Declaring access to health care as one of the major policy issues (especially in rural areas) and investing in building infrastructure to support that goal would be the easiest first step for many parts of the country (Kasthuri, 2018). Additionally, the use of telehealth/telemedicine, which expanded during the COVID-19 pandemic in India, can be strengthened and leveraged to provide geriatric care to elderly people living in remote areas (Agarwal et al., 2020b).

Governance (laws and regulations)

National approaches to the regulation of LTC quality have been described as professionalism-based (such as in Germany and Switzerland), inspection-based (in England and Australia), and based on data measurement/public reporting systems (in the United States and Canada) (Dyer et al., 2020). At present, there are no laws or regulations around LTC institutions or services in India. India's National Accreditation Board for Hospitals and Healthcare organizations (NABH), which was set up by the Quality Council of India to establish and operate an accreditation programme for health care organizations, could be expanded to include oversight of LTC organizations and services.

The Mental Healthcare Act (MHCA) 2017 has specific guidelines for centres caring for persons with mental illness and requires these centres to be registered with the State Mental Health Authority. Similarly, in 2019, the Government of India's Ministry of Housing and Urban Affairs (MoHUA) proposed guidelines for the development and regulation of retirement homes (MoHUA, 2019). These guidelines could be expanded to include all LTC services (Sivakumar et al., 2019). Compulsory registration, annual filings, and periodic inspections of retirement/nursing homes by state authorities should be enforced, as also suggested by the Tata Trusts group in their 2017 report (Tata Trusts, Samarth and UNFPA, 2017). Furthermore, the development of LTC laws and regulations needs to focus more on the intricacies of home and community-based care (HCBC), which is expected to dominate the LTC industry in India.

Conclusions

India's population is ageing at a rapid pace and is expected to present, within the next decade, enormous challenges that stem from the changing and growing health and social care needs of the older population. A formal national framework (policy) to respond to the evolving needs for long-term care is needed, one which outlines the structure, financing, human resource, law, rules and regulations of the long-term care system.

To promote a high quality of life and autonomy among older people, healthy ageing (WHO, 2022) should be central to framing these policies. Strengthening core elements of health and social care systems, including the strengthening of their public financing is vital. In this regard, and in line with the objectives of the 2030 Sustainable Development Goals, the realization of universal health coverage and the progressive extension of social security coverage should be given high priority in the coming years.

The involvement of the community is crucial for the provision of health and social care services. Existing community-based programmes should be promoted and supported by the Government to include elder care and supplement the secondary and tertiary levels of the health care system.

Following international good practices, a life-course approach to care, with a growing focus on prevention, as well as curative care and rehabilitation, would benefit the population at large, reduce the financial burden, and help to avoid preventable diseases. Considering India's culture, social norms and availability of resources, a regulated home-based and community-based care system should be strengthened. This system should be integrated with the mainstream health care system to offer a continuum of care.

Most of these changes are urgently needed and should be implemented as soon as possible to realize the vision of good health and a better quality of life for India's elderly population.

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Index 4. *Index by keywords*

Corrigendum: Universal Health Coverage and Social Health Protection: Policy relevance to health system financing reforms

In Bayarsaikhan et al., 2022, the affiliation 1 and correspondence address were published incorrectly and should read as follows:

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Moreover, the name of "Joe Kurtzin" was incorrectly mentioned in the acknowledgement section, hence, it was removed and should read as:

Christina Behrendt and Justine Hsu are acknowledged for having motivated the authors to write this article. Appreciation is expressed to Aurore Iradukunda for having provided valuable technical input.

The online has been corrected.

Reference

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