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Supporting informal carers of older people: Policies to leave no carer behind

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Abstract and Key Points

1. Informal care by family and friends makes a substantial contribution to societies. Informal caregiving supports widespread preferences among older people to stay at home and it helps contain the costs of long-term care. However, informal carers - mostly women – can see their lives impacted in terms of employment and wages, let alone their health and the social rewards that participation in the public sphere confers, like status. It has also an "opportunity" cost for the countries, in terms of social contributions and taxes lost.

2. A high proportion of carers feel constrained to care – out of normative and societal pressures or necessity. Making informal care a choice without constrains requires a full set of policies, starting from a carer's need assessment, access to information and advice, respite, training, financial support and flexible work arrangements. Formal care arrangements should involve more informal carers and high-quality formal care provision should be sufficiently available. But without additional policies that try to address the gendered distribution of informal care, many of these policies risk reinforcing the gender gap in informal care. In OECD countries, no policy is designed to specifically change the underlying gender distribution of informal care provision to older people.

3. While the population is ageing and the need of care is growing, the working-age population is declining in many OECD countries. With population ageing, the pool of informal carers reducing and the working-age social contribution- and tax-payers declining, many countries should re-think their fragmented LTC system to have one comprehensive system in which informal carers are better included.

4. This paper compiles policies to support carers in OECD countries. It updates previous OECD work *(Help Wanted – Providing and Paying for Long-term care,* 2011). A number of key findings emerge:

- The first line of support for older people is family and friends who provide unpaid non-professional care, often referred to as informal carers. About 60% of older people receiving care report receiving only informal care on average across OECD countries. About 14% of people aged over 50 provide informal care on a daily or weekly basis across OECD countries.
- Informal care is associated with gender inequalities arising from the unequal distribution of domestic and family care between women and men. Three out of five daily carers are women across OECD countries. Carers aged between 50 and 65 are much more likely to be women and care for a parent on a weekly or monthly basis. Among carers aged over 65, the gender gap in caregiving is generally smaller. They are more likely to be caring for a spouse on a daily basis.
- For working-age carers, the intensity of care can impact the labour force participation and the number of hours worked. The labour force participation is impacted when caring

20 hours per week and over. The impact is much stronger for those caring over 40 hours per week. In addition, informal caregiving is associated with part-time work.

- COVID-19 and its responses have exacerbated challenges for carers, as many of them had to provide care in a context of limited availability of LTC services. Many carers have also taken a financial hit. Only Canada, Germany, Japan, Korea, Lithuania, Luxembourg, Netherlands, Norway, the United Kingdom (Scotland) and the United States (some states) provided additional support specific to informal carers, mostly in the form of extended leave and/or additional in-kind or financial support. In comparison, all countries implemented at least one measure to tackle COVID-19 in LTC facilities.
- Over the past decade, countries have taken steps to facilitate access to information - mostly with digital tools - counselling, training and and respite. In most OECD countries, training and counselling relies heavily on the voluntary sector. One country example is Germany - it has a well-established system for counselling and training services tied to cash benefits to informal carers. Among OECD countries, respite care remains insufficient, with low uptake due to low compensation, low availability of services and organisational challenges. The vast majority of countries provide in-kind respite care.
- About two-thirds of the 33 studied OECD countries provide cash benefits to informal carers. These are either paid directly to carers through a carer allowance (67% of countries); or paid to those in need of care, at least part of which is in turn used to compensate formally registered family carers (39% of countries). The Netherlands, Sweden and the United Kingdom (England) provide both types of cash benefits. The Netherlands and Germany have comprehensive cash benefits, with a registered contract between the care recipient and the carer and social security coverage.
- Cash benefits which are more tightly regulated tend to offer more protection for vulnerable people, including undeclared workers in the “grey” labour market. More regulated benefits were found in the Netherlands and in Sweden. Increased regulation of cash benefits would reduce the “grey” labour market and enable better monitoring of care –especially home care.
- Eligibility criteria should be carefully weighted to ensure an adequate trade-off between the generosity of the cash benefit and the breadth of the eligible population. Cash benefits are an adequate tool to prevent poverty and social exclusion. At the same time, policies on cash benefits should ensure that the compensation does not trap carers into low-paid roles.
- 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 one-third of surveyed countries do not provide social security coverage tied to the cash benefit, and if countries do, it is often tied to specific strict conditions.
- There is growing commitment to support informal carers who combine work and care. Four countries introduced paid care leave over the past decade or so: Austria, the Czech Republic, Germany and Luxembourg. Nearly two-thirds of countries provide some rights to leave to care for a family member – either paid or unpaid. 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 business grounds.
- Across OECD countries, over half of employees have their working hours strictly set by their company. While COVID-19 policy responses led to a general uptake of telework, flexible work-arrangements specific to carers remain uncommon.

Résumé et points clés

5. Les soins informels dispensés par la famille et les amis contribuent substantiellement aux sociétés. Les soins informels soutiennent les préférences largement répandues chez les personnes âgées de rester à domicile et ils aident à contenir les coûts des soins de longue durée (SLD). Cependant, les aidants informels - principalement des femmes - peuvent voir leur vie affectée en termes d'emploi et de salaire, sans parler de leur santé et des récompenses sociales que confère la participation à la sphère publique, comme le statut. Cela a également un coût "d'opportunité" pour les pays, en termes de cotisations sociales et d'impôts perdus.

6. Une forte proportion d'aidants se sentent contraints de s'occuper d'un proche - par pression normative et sociétale ou par nécessité. Pour que les soins informels soient un choix sans contrainte, il faut un ensemble complet de politiques, à commencer par l'évaluation des besoins de l'aidant, l'accès à l'information et aux conseils, le répit, la formation, le soutien financier et des modalités de travail flexibles. Les dispositifs de soins formels devraient impliquer davantage d'aidants informels et l'offre de soins formels de haute qualité devrait être suffisamment disponible. Mais sans politiques supplémentaires qui tentent de s'attaquer à la répartition sexuée des soins informels, nombre de ces politiques risquent de renforcer l'écart entre les sexes en matière de soins informels. Dans les pays de l'OCDE, aucune politique n'est conçue pour modifier spécifiquement la répartition sexuée sous-jacente de la fourniture de soins informels aux personnes âgées.

7. Alors que la population vieillit et que les besoins de soins augmentent, la population en âge de travailler diminue dans de nombreux pays de l'OCDE. Compte tenu du vieillissement de la population, de la réduction du nombre d'aidants informels et de la diminution du nombre de contribuables en âge de travailler, de nombreux pays devraient repenser leur système fragmenté de SLD pour mettre en place un système global dans lequel les aidants informels seraient mieux intégrés.

8. Cette analyse compile les politiques de soutien aux aidants dans les pays de l'OCDE. Elle met à jour des travaux antérieurs de l'OCDE (Help Wanted - Providing and Paying for Long-term care, 2011). Un certain nombre de conclusions clés ressortent de cette analyse :

- La première ligne de soutien des personnes âgées est constituée par la famille et les amis qui fournissent des soins non rémunérés et non professionnels, souvent appelés aidants informels. Environ 60 % des personnes âgées recevant des soins déclarent ne recevoir que des soins informels en moyenne dans les pays de l'OCDE. Environ 14 % des personnes âgées de plus de 50 ans fournissent des soins informels sur une base quotidienne ou hebdomadaire dans les pays de l'OCDE.
- Les soins informels sont associés à des inégalités entre les sexes découlant de la répartition inégale des soins domestiques et familiaux entre les femmes et les hommes. Trois aidants quotidiens sur cinq sont des femmes dans les pays de l'OCDE. Les aidants âgés de 50 à 65 ans sont beaucoup plus susceptibles d'être des femmes et de s'occuper d'un parent sur une base hebdomadaire ou mensuelle. Parmi les aidants

âgés de plus de 65 ans, l'écart entre les sexes est généralement plus faible. Ils sont plus susceptibles de s'occuper d'un conjoint sur une base quotidienne.

- Pour les aidants en âge de travailler, l'intensité des soins peut avoir un impact sur la participation au marché du travail et sur le nombre d'heures travaillées. La participation au marché du travail est affectée lorsque l'aidant accumule plus de 20 heures de soins par semaine. L'impact est beaucoup plus fort à partir de 40 heures par semaine. En outre, la prestation de soins informels est associée au travail à temps partiel.
- La COVID-19 et ses réponses ont exacerbé les difficultés des aidants, car nombre d'entre eux ont dû fournir des soins dans un contexte de disponibilité limitée des services de SLD. De nombreux aidants ont également subi un choc financier. Seuls le Canada, l'Allemagne, le Japon, la Corée, la Lituanie, le Luxembourg, les Pays-Bas, la Norvège, le Royaume-Uni (Écosse) et les États-Unis (certains États) ont apporté un soutien supplémentaire spécifique aux aidants informels, principalement sous la forme d'un congé prolongé et/ou d'un soutien supplémentaire en nature ou financier. En comparaison, tous les pays ont mis en œuvre au moins une mesure pour lutter contre la COVID-19 dans les établissements de SLD.
- Au cours de la dernière décennie, les pays ont pris des mesures pour faciliter l'accès à l'information - principalement au moyen d'outils numériques - de conseils, de formations et de répit. Dans la plupart des pays de l'OCDE, le conseil et la formation reposent largement sur le secteur bénévole. L'Allemagne est un exemple - elle dispose d'un système bien établi de services de conseil et de formation liés aux prestations en espèces versées aux aidants informels. Parmi les pays de l'OCDE, les services de répit restent insuffisants, leur utilisation étant faible en raison de la faible indemnisation, de la faible disponibilité des services et des problèmes d'organisation. La grande majorité des pays fournissent des services de répit en nature.
- Environ deux tiers des 33 pays de l'OCDE étudiés offrent des prestations en espèces aux aidants informels. Celles-ci sont soit versées directement aux aidants par le biais d'une allocation pour aidants (67 % des pays), soit versées aux personnes ayant besoin de soins, dont une partie au moins est ensuite utilisée pour dédommager les aidants familiaux officiellement enregistrés (39 % des pays). Les Pays-Bas, la Suède et le Royaume-Uni (Angleterre) offrent les deux types de prestations en espèces. Les Pays-Bas et l'Allemagne ont des prestations en espèces complètes, avec un contrat enregistré entre le bénéficiaire des soins et l'aidant et une couverture sociale.
- Les prestations en espèces qui sont plus étroitement réglementées tendent à offrir une plus grande protection aux personnes vulnérables, notamment aux travailleurs non déclarés sur le marché du travail "gris". Les prestations les plus réglementées se trouvent aux Pays-Bas et en Suède. Une réglementation plus stricte des prestations en espèces réduirait le marché du travail "gris" et permettrait un meilleur contrôle des soins, en particulier des soins à domicile.
- Les critères d'éligibilité doivent être soigneusement pondérés afin de garantir un compromis adéquat entre la générosité des prestations en espèces et l'étendue de la population éligible. Les prestations en espèces sont un outil adéquat pour prévenir la pauvreté et l'exclusion sociale. En même temps, les politiques relatives aux prestations en espèces doivent veiller à ce que l'indemnisation ne piège pas les aidants dans des rôles faiblement rémunérés.
- La couverture de la sécurité sociale est essentielle pour garantir que les aidants disposent d'un revenu décent au moment de leur retraite, qu'ils puissent accéder à des soins de santé et qu'ils puissent prétendre à des allocations de chômage. Environ un

tiers des pays étudiés ne proposent pas de couverture sociale liée à la prestation en espèces, et si les pays le font, elle est souvent liée à des conditions spécifiques strictes.

- Il est constaté une volonté croissante de soutenir les aidants informels qui combinent travail et soins. Quatre pays ont introduit un congé de soins rémunéré au cours de la dernière décennie : l'Autriche, la République tchèque, l'Allemagne et le Luxembourg. Près de deux tiers des pays accordent des droits à des congés - rémunérés ou non - pour s'occuper d'un membre de la famille. Environ la moitié des pays offrent une forme de congé payé pour s'occuper d'un membre de la famille, qui tend à être limité à une durée plus courte. Les pays européens nordiques et la Pologne ont généralement les compensations les plus généreuses. C'est en Belgique que se trouve le congé payé public le plus long pour un bénéficiaire de soins non malade en phase terminale - un maximum de 12 mois - que les employeurs ne peuvent refuser que pour des raisons professionnelles sérieuses.
- Dans les pays de l'OCDE, plus de la moitié des salariés voient leurs horaires de travail strictement fixés par leur entreprise. Si les mesures prises par COVID-19 ont conduit à une généralisation du télétravail, les aménagements flexibles du travail spécifiques aux aidants restent rares.

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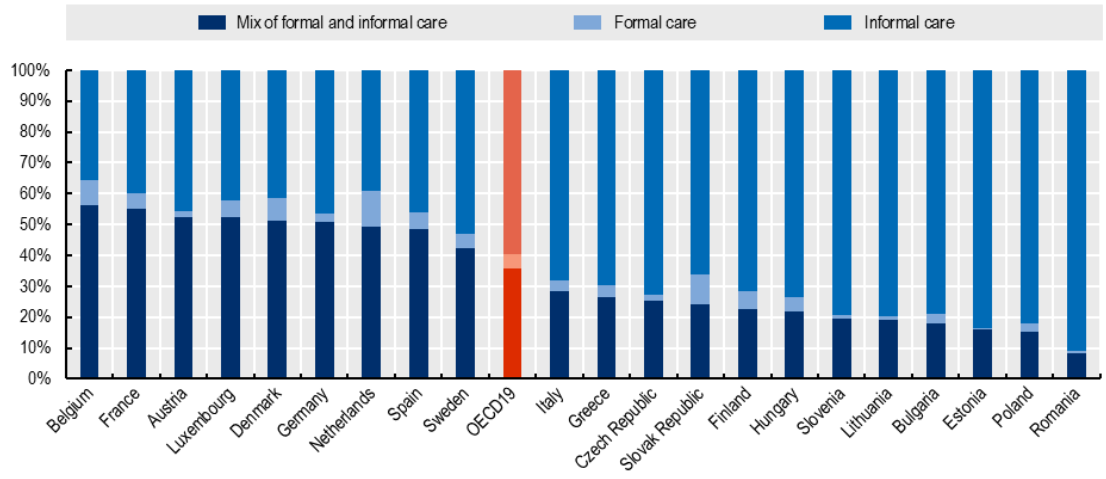
1 Informal care to older people reinforces gender inequalities

9. As people age, they are increasingly likely to suffer from ill health or disability. As a result, older people may find common every-day actions such as washing, dressing, cooking and doing housework, more difficult. The range of personal care and assistance services that these older people require is commonly referred to as long-term care or LTC. LTC needs include help with activities such as washing and getting dressed – grouped under what is referred to as personal care, or Activities of Daily Living (ADL) – as well as housekeeping tasks, like cleaning and shopping – grouped under what are known as Instrumental Activities of Daily Living (IADL). In many cases, the first line of support for older people is family and friends who provide unpaid care, often referred to as informal care. Across OECD countries, about 60% of older people receiving care receive only care from informal carers (Figure 1.1).

10. For the purpose of this report, informal carers refer to family members, friends and neighbours who provide LTC to older people who cannot perform daily activities (ADL and IADL) without support, because of a stable and close relation with older people, regardless of financial and non-financial transactions. The two main cornerstones of the definition are that 1/ informal care relates to a situation whereby care is mainly provided by family, close relatives, friends or neighbours and 2/ carers are non-professionals who did not receive qualifying training to provide care (even though they can benefit from special training). In the definition, carers are not paid although they may obtain financial compensation (cash benefits, leave).

11. For the purpose of this report, informal carers do not refer to paid non-professional carers providing care in private households, such as undeclared carers working in the “grey area”. The use of live-in, and to some extent live-out, migrant undeclared care workers blurs the line between formal and informal caregiving.

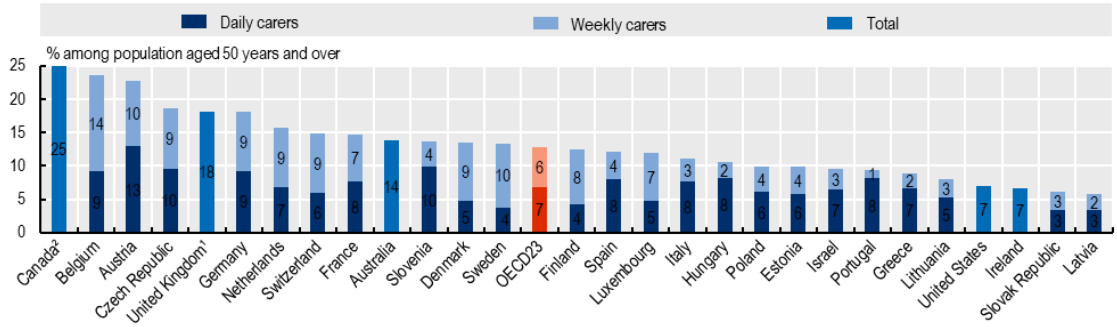
Figure 1.1. About 60% of older people receiving care report receiving only informal care on average



Note: older people refer to those aged 65 years and older. Country-specific sample weights and unweighted OECD average.
Source: OECD calculations based on the Survey of Health and Retirement Survey in Europe, wave 8 (data refer to 2020).

12. Estimating the number of informal caregivers is an important step to understanding the significance of their contribution. Around 13% of people aged 50 and over report providing informal care at least weekly on average across 23 OECD countries (Figure 1.2). In EU countries, it is estimated that between 12 and 18% of the adult population provide informal care on a weekly or daily basis to disabled adults or older people (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021[1]). In Canada, one in four people aged 15 and older provided care to a family member or friend with a disability or problems related to aging in 2018. Almost half of all caregivers reported caring primarily for their parents or parents-in-law and nearly two-thirds of those carers were aged 45 to 64 (Statistics Canada, 2020[2]). It is worth noting that informal carers may not self-identify as such, partly because support can be considered as something that is expected and not particularly out of norms or habits (e.g. cooking for a husband).

Figure 1.2. About 13% of people aged over 50 provide informal care on a daily or weekly basis



Note: The definition of informal carers differs between surveys (see box on comparability). Country-specific sample weights and unweighted OECD average.1. Data refer to England only. 2. Data refer to those aged 15 years and older.
Source: (OECD, 2021[3]), based on SHARE, wave 8 (2019 20); SDC (2018) for Australia; ELSA, wave 8 (2017) for the United Kingdom; HRS, wave 14 (2018 19) for the United States; Census 2016 for Ireland; complemented with (Arriagada, 2020[4]) for Canada.

13. These results are based on the Survey of Health and Retirement in Europe (SHARE) complemented with similar national surveys. These surveys provide a measure of the share of informal carers aged 50 and over who provide any help to older family members, friends and people in their social network, living inside or outside their household, for everyday life activities (see box on data comparability and its limitations).

14. In Europe, there are three main surveys that gather regular data on informal carers (see Annex). The purpose of this report is not to compare them. Overall, each is valuable because they provide specific takes on informal care (Tur-Sinai et al., 2020[5]).

Box 1.1. Data comparability across OECD countries

Informal carers are defined as people providing any help to older family members, friends and people in their social network, living inside or outside their household, who require help with everyday tasks. The data relates only to the population aged 50 and over, and is based on national surveys for Australia (Survey of Disability, Ageing and Carers, SDAC), the United Kingdom (English Longitudinal Study of Ageing, ELSA), the United States (Health and Retirement Survey, HRS) and an international survey for other European countries (Survey of Health, Ageing and Retirement in Europe, SHARE). Data for Ireland was taken from its 2016 census.

Questions about the intensity of care vary between surveys. In SHARE, carers are asked about how often they provided care in the last year; this indicator includes people who provided care at least weekly. It is important to highlight the change of methodology in SHARE wave 7, in which over four fifths of the respondents answered the SHARELIFE part of the questionnaire only instead of the panel interview. In ELSA, people are asked if they have provided care in the last week, which may be broadly comparable with “at least weekly”. Questions in HRS and SDAC are less comparable with SHARE. Carers in HRS are included if they provided more than 200 hours of care in the last year. In SDAC, a carer is defined as someone who has provided ongoing informal assistance for at least six months. People caring for disabled children are excluded for European countries but included in data for Australia, Canada and the United States. For the United States, data only includes those caring for someone outside their household. Australia and Ireland consider all informal carers together. As a result, data for Australia, Canada, Ireland and the United States may not be comparable with other countries’ data.

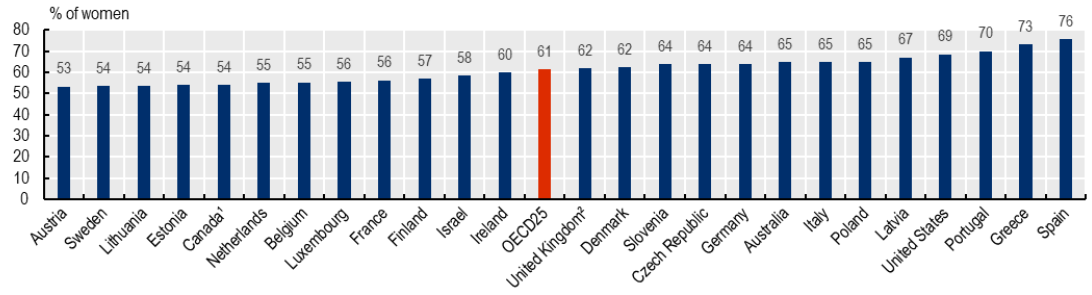
Source: Extracted from (OECD, 2021[3]).

15. The majority of informal care is performed by women, like other forms of unpaid caring and domestic work. Across OECD countries, women perform 4.4 hours of unpaid work per day – including care for older people and children, compared to 2.3 hours per day for men. Women are responsible for two-thirds of unpaid care and domestic work in homes and communities. In the vast majority of OECD countries, women spend more total time on paid and unpaid caring and domestic work than men (OECD, 2017[6]).

16. Women, men, the state and the private sector all have a responsibility for meeting care needs, whether paid or not. However, time trends suggest that, over time and across countries, women have gradually reduced the time they spend on unpaid caring and domestic work, in part due to timesaving technology, while men’s behaviours has changed little. Observing gender stereotyped patterns of behaviour in early age can also affect their aspirations for later life and subsequent labour market opportunities. Children, once adults, tend to mimic their own parents’ behaviours paid and unpaid work behaviours (OECD, 2017[6]). It is very likely that gender inequality will remain stable in care to older people in the near future.

17. Carers are predominantly women caring for a spouse, a parent or a parent-in-law. The gender gap in the provision of care varies by the intensity of care: women represent 61% of daily carers on average across 25 OECD countries (Figure 1.3). Those aged between 50 and 65 are much more likely to be women, caring for a parent on a weekly or monthly basis. Carers aged over 65 are more likely to be caring for a spouse on a daily basis and the gender gap is smaller.

Figure 1.3. Three out of five daily carers are women across OECD countries



Note: The definition of informal carers differs between surveys (see box on methodology). Country-specific sample weights and unweighted OECD average. 1. Data refer to those aged 15 years and older. 2. The United Kingdom refers to England.
Source: (OECD, 2021[3]), based on based on SHARE, wave 8 (2019 20); SDC (2018) for Australia; ELSA, wave 8 (2017) for the United Kingdom; HRS, wave 14 (2018 19) for the United States; Census 2016 for Ireland, complemented with (Arriagada, 2020[4]) for Australia.

18. While the gender gap among carers is smaller at older ages (65+), the type of help provided may still be different. In Canada, older men are as likely as older women to provide care, but women more often perform domestic chores such as meal preparation and house cleaning (56% for women, 47% for men in 2018) and they care more hours (20 hours versus 14 hours). Older men are more likely to provide help with house maintenance and outdoor work (47% compared with 29%) (Statistics Canada, 2020[2]).

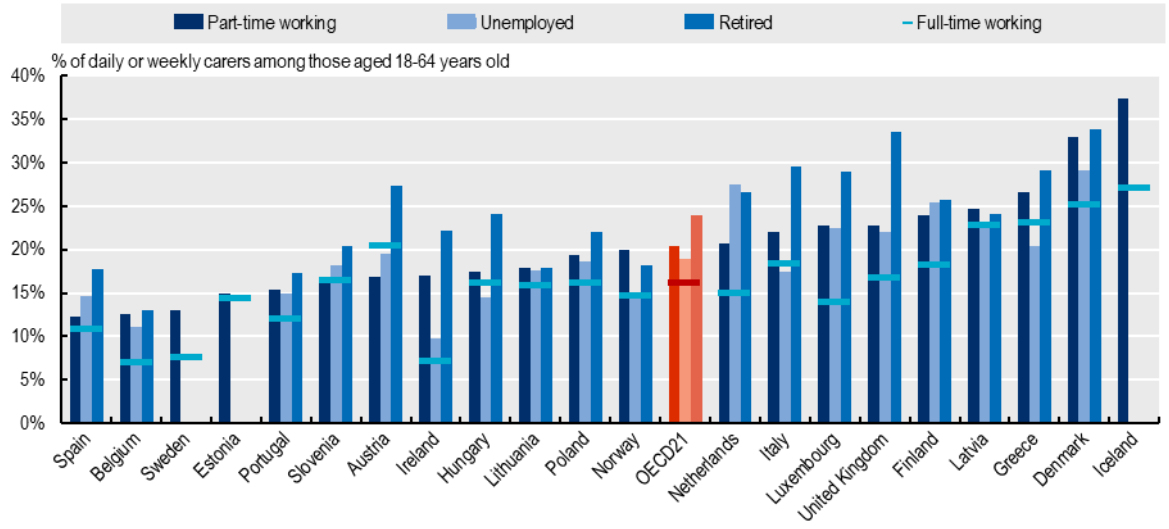
19. In at least some countries, a high proportion of carers feel constrained to care – out of normative and societal pressures or necessity. In the Netherlands, one study found that 36% of surveyed carers decided to care because "it was their [my] duty", 20% because they were "the most suitable", 15% because they were "the only one in the environment who had time available". In comparison, 7% decided to care because they "found it pleasant" and 3% because "the care recipient did not want differently" (Brouwer et al., 2005[7]). A British study found that while 81% of surveyed carers reported caring by choice, 65% 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, 2017[8]). In Canada, two-thirds of older women felt that they had no choice but to take on care responsibilities, and 58% for men in 2018 (Arriagada, 2020[4]).

20. Women's disproportionate share of unpaid work has negative impacts on their ability to participate in the labour market, leading to gender gaps in employment outcomes, wages and pensions (OECD, 2017[6]). For working-age women, daily caregiving has an impact particularly strong on employment status and work hours of people aged over 50 in European countries. However, providing care at a weekly basis (or less than weekly) do not significantly change employment status and the hours worked (Ciccarelli and Van Soest, 2018[9]). Intense care, in terms of number of hours, has an impact on the employment status of carers of disabled adults and older people (starting from about 20 hours of care and much stronger at 40+ hours of care)

(European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021[1]).

21. Based on the latest available microdata of the European Health Interview Survey, the share of daily or weekly carers was higher among those working part-time, those unemployed and those retired than with those working full-time across 21 OECD countries in 2014 (Figure 1.4).

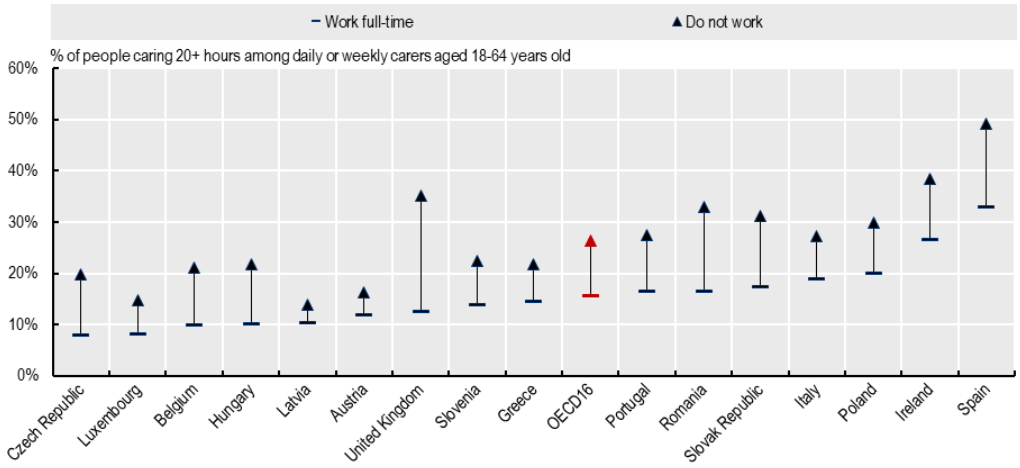
Figure 1.4. Informal carers are less likely to work full-time



Note: Country-specific sample weights and unweighted OECD average. The question to identify carers is "Do you provide care or assistance to one or more persons suffering from some age problem, chronic health condition or infirmity, at least once a week?"
Source: EHIS wave 2 (data refer to 2014).

22. Over one out of four daily or weekly working-age carers out of employment spent at least 20 hours caring every week, compared with one out of six among those working full time (Figure 1.5). This gap is partly explained by the provision of intense care, but not completely. A body of evidence has shown that female carers were already more likely be inactive before starting to care to older people. It may be partly because women care for kids before caring to parents and partners (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021[1]). Overall, informal care to older people reinforces gender inequalities in labour force participation.

Figure 1.5. Over one out of four daily or weekly working-age carers out of employment spend at least 20 hours every week caring an older person



Note: Country-specific sample weights and unweighted OECD average. The question to identify carers is "Do you provide care or assistance to one or more persons suffering from some age problem, chronic health condition or infirmity, at least once a week?"
Source: EHIS wave 2 (data refer to 2014).

23. Informal caregiving also impacts the mental health of informal carers. A body of evidence shows that that mental health is poorer because of informal caregiving (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021[1]). A German study found that the impact on mental health fades out over time (5 years) (Schmitz and Westphal, 2015[10]). While the evidence on the impact of caregiving on physical health is mixed and likely negative only for those providing intense care, a number of studies highlighted the association of informal caregiving and poorer physical health (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021[1]; Schmitz and Westphal, 2015[10]).

24. Unpaid care work by family and community members makes a substantial contribution to societies. While there is no unified and internationally accepted methodology to estimate the value of informal care (Eurocarers, 2019[11]), some studies provide a good overview of the economic contribution of informal carers in a few countries. In France, the contribution of informal carers of older people was estimated between EUR 12 to 21 billion in 2019 (or 0.5% and 0.9% of GDP) (Roy, 2019[12]). In the UK, estimates of the value of informal care (of older people and adults) range from GBP 58.6 billion to nearly GBP 100 billion per year (or 2.1% and 3.5% of GDP) (National Audit Office (NAO), 2018[13]). In Canada, the economic contribution middle-aged and older unpaid caregivers providing care to older people was estimated at CAN 25-26 billion in 2009 (Hollander, Liu and Chappell, 2009[14]). Total out-of-pocket costs[1] paid for by caregivers of people with dementia alone were estimated at CAN 1.4 billion in 2016 and are projected to rise to CAN 2.4 billion in 2031 (Canadian Institute for Health Information, n.d.[15]). In the United-States, the value of informal care to older people was estimated at USD 522 billion annually (based on an opportunity cost approach) in 2011/12 (Chari et al., 2014[16]).

[1] They include home modifications, professional health care or rehabilitation services, hiring people to help with daily activities, transportation, travel or accommodation because of caregiving responsibilities, specialized aids or devices, and prescription or non-prescription medicines.

25. An EC-funded study estimated that the value of the number of hours of informal carers of older people and disabled adults ranged overall from 1.4% of the EU GDP to 5.2% of the EU GDP, depending on the methodology and the assumptions, with the most likely values being between 2.4%-2.7% of EU GDP. In comparison, the cost of public expenditure on LTC is estimated at 1.7% of 2019 EU GDP according to the 2021 Ageing Report (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021[1]).

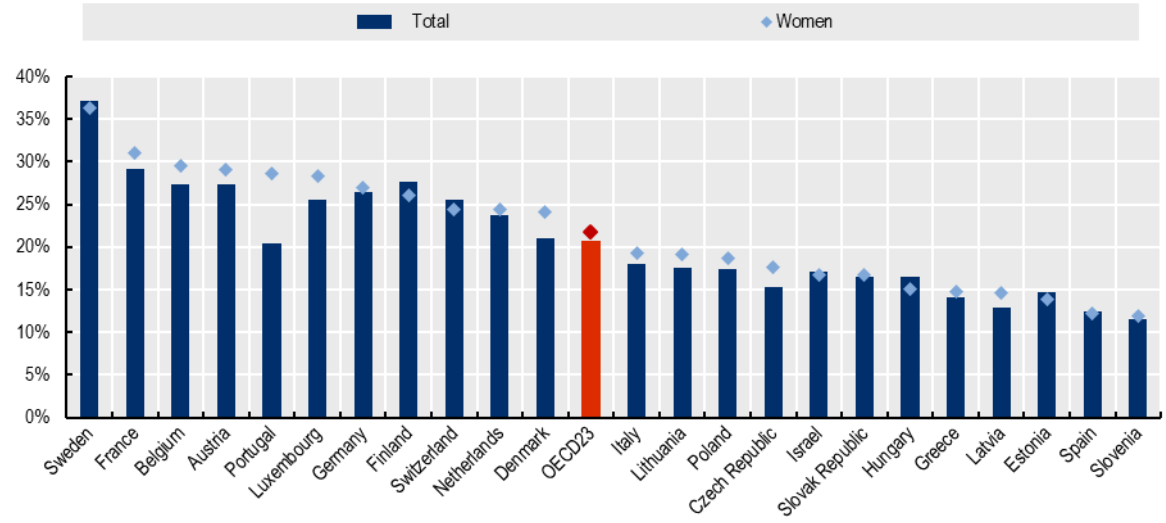
26. Informal care has an "opportunity cost" in terms of lost revenues from social contributions and taxes. In EU countries, estimated lost revenues accounted for 0.76% of the EU GDP in 2019, driven mostly by the lower employment of women aged 45-64 (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021[1]).

2 Since COVID-19, there has been more pressure on informal carers

27. Since the beginning of the pandemic, the decrease in formal care support and sometimes complete closure of LTC services has impacted informal carers, who had had to take over in any way they could. For example, a study showed that informal carers of working age (up to 67 years old) reported a decrease in the availability of formal services in Germany, particularly respite care (-35%), support groups (-31%), home visiting services (-28%) and counselling by mobile care services (-25%) in July-August 2020 (Eurocarers, 2021[17]).

28. Between July and September 2020, one out of five people aged 50 and older helped others[2] carry out domestic chores (e.g. food preparation) or provided personal care out of their household across 26 OECD countries (Figure 2.1). In the overwhelming majority of countries, more women provided informal care. Findings from a survey in Austria undertaken during the initial months of the pandemic suggest a tightening of care networks, with new carers of older people likely to have stepped in to provide low intensity care to relatively autonomous people (Rodrigues et al., 2020[18]).

Figure 2.1. Over one out of five people aged 50 and older helped others out of their household across OECD countries



Note: Informal carers are those aged 50 and older who helped others to obtain necessities (e.g. food, medications or emergency household repairs) or who provided personal care outside their household. Care recipients cover people of all ages, including children.

[2] Anyone, including older people but also adult children.

Source: SHARE-COVID-19 wave 8 (data refer to June and August 2020).

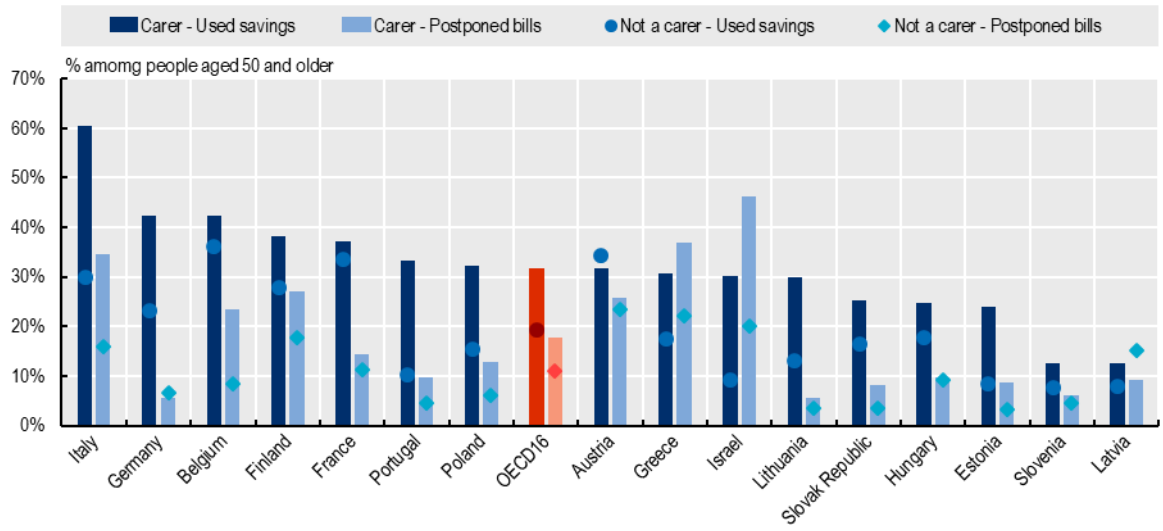
29. About 60% of carers aged 50 and older supporting their parents who live outside their household reported providing more care than before the pandemic on average across the 23 OECD countries by Q3 2020. In the UK, the decrease of formal care provision was combined with an increase of care needs as well. There were up to 9.1 million unpaid carers across the UK before the COVID-19 pandemic. Since then, there has been an estimated 4.5 million additional new carers, 2.8 million of whom are both working and caring. Among those who started caring before the crisis, over 80% of carers have provided more care since the start of the pandemic. About eight carers out of ten reported that the needs of the person they cared for had increased since the pandemic (CarersUK, 2020[19]).

30. For carers of older people with dementia, stopping activities was particularly challenging – activities were anchors for routine and it has been difficult to create new ones according to them. At the same time, some countries are taking steps to address this challenge. For example, in 2021 Italy approved a EUR 15 million fund to finance for the first time Italy's National Dementia Plan over a 3-year period, which includes measures for carers (Alzheimer's Disease International, 2021[20]).

31. Providing more care impacts the work-life balance of carers. In Germany as in other countries, some services temporary decreased or closed in July-August 2020, and over half of working-age family caregivers reported that they spent more time every day providing care and support since the pandemic. Five out of seven (71%) carers who work reported more problems reconciling paid employment and care (Eurocarers, 2021[17]).

32. Due to the challenge of combining care responsibilities with employment, informal carers may reduce their labour market attachment, or leave the job market entirely, and therefore sacrifice their labour income. While there is little data available on the number of informal carers who reduced their labour market attachment or stopped working due to additional caring responsibilities brought on by the pandemic, it is clear that carers situation is compounded by COVID-19-related financial hit and that many carers experienced a financial impact (Lorenz-Dant and Comas-Herrera, 2021[21]). About one third of people who provided care outside their household had dipped into savings to cover necessary day-to-day expenses by Q3 2020 since the start of the pandemic across 16 OECD countries (Figure 2.2). About 20% of carers had postponed regular payments such as rent, mortgage and loan payments and/or utility bills in OECD countries. People who provided care were more likely to dip into savings and postpone payments than those who did not provide any care outside their household. In comparison, the rates were respectively 19% and 11% across OECD countries.

Figure 2.2. About one third of carers have dipped into savings to cover necessary day-to-day expenses since the start of the pandemic across OECD countries



Note: Data on carers to be interpreted with caution because of small sample sizes. Informal carers are those aged 50 and older who helped others to obtain necessities, e.g. food, medications or emergency household repairs or who provided personal care outside their household. Care recipients cover people of all ages, including children.
Source: SHARE-COVID-19 wave 8 (data refer to June and August 2020).

33. Limited care services available during the pandemic, social distancing, increased unemployment and competing care needs within households (e.g. due to school closures) have increased the psychological strain experienced by caregivers. In Germany, while about one third of informal carers could be classified as "feeling lonely" before the pandemic, in July-August 2020, this share reached over 50% (Eurocarers, 2021[17]). In Austria, caregiving to older people during the pandemic was associated with poor mental well-being, especially among those without children. Additionally, the psychological well-being gap between carers and non-carers has increased (Rodrigues et al., 2020[18]). In the UK, nearly three quarters of informal carers reported feeling exhausted and worn out because of caring during the pandemic (CarersUK, 2020[19]). In Ireland, over half of family carers of older people with dementia have felt worried about how they will continue to cope, while 44% reported feeling less able to cope as the time passes. About 28% of these family carers have considered a move to long term care for the person with dementia over the past year and 65% of them reported that this move is sooner than expected due to COVID-19. (The Alzheimer Society of Ireland, 2021[22]).

34. While the COVID-19 pandemic has brought international attention to the importance of ensuring the safety of LTC workers, the crisis has not necessarily put informal carers' vulnerability and risks in the spotlight. Yet, factors of transmission are identical, including prolonged exposure, inadequate hand hygiene and insufficient PPE. At the onset of the pandemic, informal carers could count mostly on themselves and NGOs, in collaboration with countries, to access PPE. Exceptions included the UK where unpaid carers who do not live with their care recipient have benefited from free PPE through a new national scheme since February 2021. At the time of writing, two-thirds of local authorities had signed up to set up distribution systems (UK Government, 2021[23]). Similarly, OECD countries except Australia and Italy did not include informal carers among their priority group in their vaccination rollout strategy while health and LTC workers were included in priority groups.

35. Most countries did not implement specific support for informal carers. However, Canada, Germany, Japan, Korea, Lithuania, Luxembourg, Netherlands, Norway, Scotland and a few states in the United States put in place at least one specific measure. In Germany, informal carers could receive financial support for up to 20 days (instead of 10 days) when there was a reduction in community care from 14 May 2020 to 30 September 2020 (Pflegeunterstützungsgeld). The right to stay away from work due to an acute care situation was also extended from 10 to 20 days (Lorenz-Dant, 2020[24]). In Scotland, a special one-off Coronavirus Carer's Allowance Supplement of GBP 230 was provided to 83 000 eligible carers in June 2020. In Luxembourg, a new leave for carers was introduced for public and private sector employees and self-employed workers who had to stop working because of care facility closure. France implemented in September 2020 a 2019 law that provides financial compensation for family carers taking leave to care for ill older people, subject to specific eligibility conditions.

36. In Lithuania, sickness leaves are given to employed informal caregivers – spouse, children and guardians - who provide care to an older relative who uses day care centres for older people and disabled adults, if the day care centre closed because of the COVID-19 pandemic and its responses (e.g. emergency, quarantine). Sickness leaves are paid until the day care centre re-opens for up to 28 calendar days, but can be extented under specific conditions. The sickness benefit is about 66% of the compensatory wage (which is essentially the labour income of the last 3 months) (SoDra, 2021[25]).

37. Korea extended its unpaid family care leave to 20 days, up from 10 days, in case of national emergency. Five more days were granted for single parents and underprivileged families. Between the start of the pandemic and September 2020, 40% of the 120 000 eligible workers had used at least 10 days. Another 16% had used between 6 and 9 days (The Korea Herald, 2020[26]). Japan has developed a new subsidy scheme for small and medium employers that had already introduced a paid leave program for caregivers. It aims to support workers who need to take care of their family members by taking more than 20 days of paid care leave.

38. In Canada, the Recovery Caregiving Benefit was introduced to employed and self-employed individuals who were unable to work because they provided care for a child under the age of 12 or another family member who needed supervised care as a result of the closure or unavailability of schools, regular program or facilities due to COVID-19, or because they were sick, self-isolating, or at risk of serious health complications due to COVID-19. Eligible individuals could apply to receive the benefit for up to a total of 42 weeks between September 27, 2020 and October 23, 2021 to receive CAN 500 per week. As of August 2021, there were a total of 6 722 720 approved applications for 450 950 unique applicants. The total value stood at CAN 3.36 billion (Government of Canada, 2021[27]). In Australia, additional funding of AUD 3.5 million was allocated to service providers to increase support to carers as part of the Australian National Mental Health and Wellbeing Pandemic Response Plan.

39. In some countries, there may have been a shift in terms of delivery of training during the pandemic, with a move to online or computer-based support. For example, a study showed that in Ireland the need for practical supports almost tripled from July 2020, seeing a rise from 27% to 70% in early 2021 (The Alzheimer Society of Ireland, 2021[22]). In parallel, some organisations for carers have noticed a significant increase in the number of participants using their support services, a large proportion of whom had not engaged with face to face support previously. In the Czech Republic and Chile, social workers who were unable to make home visits were staffed on hotlines providing advice and emotional support to informal carers. The WHO released a version of iSupport – their online training for caregivers of people with dementia - with a series of practical support messages, focussing on reaching out to others to

care, responding to changes in the person with dementia and ensuring that the person with dementia continues to receive care, among others (World Health Organization, 2021[28]).

Informal carers providing emotional and social support for residents of LTC facilities were particularly concerned by the restrictions on visits in nursing homes (Rocard, Sillitti and Llena-Nozal, 2021[29]). Although virtual visits were implemented to try to meet needs of residents, they are not a substitute for on-site visits. More concerning, many residents have died alone without family present to support end-of-life needs. Since the beginning of the pandemic, a number of policy recommendations have been published to strike the right balance between infection prevention and control and people's well-being (Stall et al., 2020[30]).

3 Legal definitions and assessments are uncommon

40. Informal carers do not always self-identify as such, partly because support can be considered as something that is expected of them due to prevailing social norms or existing social and familial arrangements. This lack of self-identification relates to the tasks which they often perform. Informal carers often provide personal care and monitor medication, but they generally devote most of their time to practical care tasks (sometimes referred to as "social care" or "social support"), such as shopping and doing the laundry, and providing company. For example, an older woman may not think of herself as the informal carer of her dependent husband by doing the laundry and cooking if she has performed those domestic chores all her married life. Similarly, an adult child may not consider herself as an informal carer if she does the groceries every weekend for her parents. When informal carers do not recognise themselves as such, they are less likely to seek support for themselves. Whether or not informal carers seek support also depends in large measure on whether or not they are recognised as carers by the public authorities. In other words, the legal and ad-hoc definition of informal carers adopted by countries is a milestone.

Legal and ad-hoc definitions focus on family ties, co-residency and intense care

41. Even though only 20% of EU countries and Australia have a legal definition of informal carers, some countries have taken steps to recognise them. A number of countries have introduced formal or ad-hoc definitions, including Australia, France, Belgium, Finland, Portugal and England. In Estonia, a Task Force will propose a legal definition of informal carers as well as possible rights for informal carers in the near future. Overall, the type of relationship, co-residency, the type of care provided and the number of hours of care are criteria used to target carers to support. When family ties and co-residency do not restrict the pool of carers, countries often target those providing more intense care.

42. Most legal or ad-hoc definitions of informal carers focus on the close bond to the person in need of care (eg. in Belgium, Canada, Finland, France, Italy, Portugal, Spain and the US, but not in Australia, England, Germany). Since 2015, France refers to an informal carer as "any person who is cohabiting or having a close and stable relationship with the person in need of care, and who is helping frequently and regularly, on a non-professional basis, to accomplish all or a part of the activities of daily living" (UNECE, 2019[31]). Since 2016, Finland considers that "a carer is a relative or another person who is close to the care receiver who has signed an informal care agreement with the municipality". In Belgium, the 2019 ad-hoc definition refers to a person who continuously or regularly helps or supports a person with a care need, with a relationship of trust or a close, affective or geographical relationship with the assisted person, and provides assistance on a non-professional basis and free of charge.

43. In Southern European countries, Canada and the US, the definition of informal carers is more restrictive, focusing on family ties or co-residency. In Spain, the Dependency Law defines a carer as a family member up to the third degree co-habiting with the dependent person for at least one year, except if the dependent person lives in an area where there is a lack of public services, or in a rural or remote area. Informal carer status can only be granted when the dependent person has a degree of dependency of at least two out of three on the national need assessment scale, except in rural areas. In Portugal, the 2019 law introduced two types of informal carer: principal and non-principal carers. A principal informal carer is a family member co-habiting with the dependent person, providing care on a permanent basis without remuneration. A non-principal carer is a family member caring on a regular but non-permanent basis, with or without remuneration (Perista, 2019[32]). In Italy, the 2017 law defines the carer as a family member who assists and takes care of a dependent person or a co-resident. In Canada, there is a definition of family caregiver or someone considered as family for the purposes of state caregiver benefits (Government of Canada, 2021[33]). In the US, the law defines an informal carer as an adult family member or another individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or another health condition.

44. In other countries, the legal definition focusses less on the relationship, although support can be tied with more intense care. In Australia, the Carer Recognition Act in 2010 defined informal carers as individuals who provide personal care, support and assistance to another individual who needs it because of a disability, a medical condition, a mental illness, frailness and age. In Germany, carers are legally defined as people who provide non-professional home care to other people in need of long-term care due to a physical, mental or emotional illness or disability. That being said, Germany supports registered carers providing at least 14 hours of weekly care to a care-dependent person. In England, the 2014 Care Act defines a carer as someone who helps another person in their day-to-day life. The entitlement to the cash allowance requires people to provide help or care for at least 35 hours a week. Councils have to carry out an assessment of the carer where it appears that the carer may need for support. In Nordic European countries (except Finland) and the Netherlands, municipalities set the entitlement criteria for informal carer benefits. Informal carers' status generally focuses less on the type of relationship and more on the hours and type of care provided.

45. In Korea, there is no legal, nor ad-hoc definition of informal carers. However, the introduction of a public long-term care insurance in 2008 has contributed to strongly develop formal care, relieving pressure on informal carers to a certain extent (from 0.2% of GDP in 2007 to 1.1% of GDP in 2019 according to OECD Health Statistics Database).

Assessing carers' needs remains very uncommon in OECD countries

46. As many carers do not identify as such, one approach to ensure that carers are identified and supported is to perform a carer's assessment when the dependent person is assessed, and provided with advice about their entitlements, and the support available to them. However, this approach is not widespread in OECD countries. Only in England, the Netherlands, and in some municipalities in Sweden, carers are entitled to a carer assessment. In Australia, an assessment is required to access services through Carer Gateway.

47. As shown in Sweden, carer's assessment enables to take into account carer's views on home care, to create more individualised and flexible forms of support, to work proactively with carers to avoid crisis situations for the carer and/or the care recipient and to increase the recognition of carers (Hanson, Magnusson and Nolan, 2008[34]).

48. Having an assessment of carer may be important for gender equality because even in countries that offer carer-blind support in principal, in practice informal care may be considered (unconsciously or not) during care recipients' care assessment. This means that there may be financial implications because of gender stereotypes about capacity to care. For example, in France, the needs of carers are not assessed and the care assessment of care recipients is carer's blind in principle, but the ability of carers to care is still considered at the assessment of the care recipient. The rules are implemented in gendered ways by individuals. A 2020 paper showed that the amount of care provided was 54 EUR per year lower on average (about 10% of the average total care provision of 550 EUR) for a male care recipient living with his wife, compared with a female care recipient living with her husband, for identical needs - perhaps because wives are expected to carry out more care tasks than husbands on average. In addition, the amount of care provided was 130 EUR per year lower on average (or 24% of the average total amount) for a care recipient living with a spouse than for a care recipient living alone, for identical care needs, in 2017 (DREES, 2020[35]).

49. When assessing the carer, care activities assessed are personal care and domestic chores and to some extent emotional support. In England, care activities include washing, dressing and taking medicines, getting out and about, travelling to doctors' appointments, shopping, cleaning and laundry, paying bills and organising finances. Emotional support includes sitting with someone to keep them company and watching over someone if they cannot be left alone (National Health Service, 2020[36]). In Sweden, five municipalities developed 'The Carers Outcome Agreement Tool' (COAT) in 2003-2005, as a result of the collaboration between Swedish and English carers and practitioners.[3] The COAT focussed on carer-focused outcomes by looking at four domains:

- Helping carers to care, which considers the type of help, information and skills needed.
- Supporting carers' own needs, which explores support that might improve carers' quality of life.
- Making life better for carers' care recipient, which examines what might improve the quality of life of the care recipient.
- Getting good quality support, which looks at what carers want from a care service.

50. In Ireland, discussions on a carer assessment tool have been ongoing since 2013. The carers' assessment would mainly focus on the carer's own health, wellbeing, and self-identified support needs (O'sullivan et al., 2017[37]).

51. In England, carer needs are assessed when the needs of an older person's needs are assessed, although not necessarily at the same time, and regardless of the results of the older person's needs assessment. The carer assessment evaluates how caring affects the physical and mental health, work, free time and relationships of the carer. The assessment is usually face-to-face, but can also be conducted via phone or online. It usually lasts for at least one hour (National Health Service, 2020[36]). In 2017, about 45% of adult care recipients had a registered informal carer. Among them, 45% were aged 65 and over and 8% were aged 85 or over (National Audit Office (NAO), 2018[13]).

52. In Australia, carers requiring immediate emergency respite do not undergo the assessment and the planning process. Emergency respite is available 24 hours a day, seven days a week.

1. [3] The COAT was implemented in the five Swedish municipalities only between 2006-2008.

53. Swedish research suggested that when the assessor had the capacity to directly grant public support, the carer's assessment process was more effective at helping carers (Hanson, Magnusson and Nolan, 2008[34]).

4 Public support to counselling, training and respite care is generally limited

54. Many countries have taken steps to support access to information, counselling, training and respite. Typically, public websites share information to carers and care recipients along with local information centres or social centres. However, many LTC systems remain difficult to navigate for informal carers. While information is usually targeted to the general public, counselling is often more destined for those asking for support. Typically, LTC providers and social services inform and counsel and the health care sector is not very involved in information-sharing activities and counselling. Public support to training is often limited across OECD countries, and in most countries, training relies heavily on the voluntary sector. Countries often work with NGOs who deliver training. While developing skills on diseases, rehabilitation, daily life practicalities and the management of emergencies are fundamental for carers, support to train carers about their own well-being is important. Public support to respite care is fragmented across OECD countries. Countries mostly provide it in kind, with a couple of exceptions. Low take-up of respite care appears to be common, for many reasons related to the availability and perceived quality of LTC services, the carers and the care recipients. In the few countries with available data, the number of beneficiaries of public support to respite has been growing since at least 2014.

Countries mostly provide information to carers online and in the social sector

55. Countries have taken steps to facilitate access to information on carers' support. Typically, websites provide useful information to carers and care recipients. However, LTC systems can still be intricate and difficult to navigate for informal carers. According to a number of surveys in different countries, carers would welcome more user-friendly information on available support (COFACE, 2017[38]; Corcuff, 2019[39]). For example, the French website "For the older people" offers a list of the local information centres in France where information for informal carers is available (CNSA, 2020[40]). In France, public services and NGOs also run various types of local information centres, including the "House for older people and carers". This type of centre provides help for both care recipients and carers in parallel, allowing social workers and NGOs to initiate contact with informal carers (Ministère des Solidarités et de la Santé, 2019[41]). This is important given the important share of older people among carers, many of whom may not know well enough how to use digital tools. The centres help carers get in touch with each other, provide information on resources (in the form of financial, physical, emotional and social resources), as well as assistance for the care recipient (in the form of health, support and care). Similarly, in Paris, the NGO "Autonomie Paris Saint Jacques" offers

a hub for carers offering psychological support, speaking group and therapeutic education provided by a multidisciplinary team (Ministère des Solidarités et de la Santé, 2019[41]).

56. Providing counselling and training to carers can be more difficult in intermediate-size towns or in rural areas partly because of distance, although some initiatives exist. For example, the French NGO 'The Company of Carers' set up a caravan where inside, carers can speak to social workers. The caravan usually sits in a central square of intermediate-size towns (typically a square nearby the main church and the town hall). The caravan also reaches to people in cities, by sitting in the parking area of hospitals or big supermarkets. Between 2018 and 2020, the caravan had visited about 10 towns or cities (Corcuff, 2019[39]).

57. While information is usually provided to the general public, counselling is often more targeted to those asking for help. LTC providers and/or social services generally counsel carers. Counselling can also be tied to LTC services, like in Germany. In Germany, counselling for informal carers is tied to care recipient' services. Informal carers that are registered as such by the LTC insurance fund are legally entitled to take part in a free counselling and training course funded by the long-term care insurance fund. Some of these courses are offered in cooperation with NGOs, which have to be approved by LTC insurance fund or by local communities. Courses offer practical instructions and general information on carers' rights, as well as advice and support on any related topics. These courses are also an opportunity for carers to meet, but they can be done in the household of the care recipient if requested by the informal carer.

58. The health care sector is typically not very involved in information-sharing activities and counselling, although GPs and other primary health professionals can inquire about informal carer's health status and direct them towards better sources of information and counselling. One exception is the Netherlands, where GPs are involved in the identification of informal carers. A recent plan was developed to ensure that GPs can detect, signal and support potentially overburdened informal carers. The strategy includes a toolkit and a monitoring approach.

Training relies heavily on the voluntary sector

59. A body of research show that informal carers often wish to receive more training to enable them to provide better care (COFACE, 2017[38]). For instance, carers are not always knowledgeable about the diseases of the person they care for or have difficulties performing personal care (e.g. lifting someone from a bed to a chair without experiencing pain). According to Eurocarers, carers would mostly benefit from training on specific diseases, skills required to maintain or rehabilitate the health status of the care recipient, skills to deal with the management of symptoms, skills related to daily life activities, and the management of emergencies. Practical nursing skills – mainly managing and administering medication, pain management, and moving and handling techniques without suffering strain – are also often sought. These practical nursing skills are particularly important for carers who take over between nurse visits, which means mostly in the evening of working days and during the weekends.

60. Availability of training services is fragmented across OECD countries. Most training is typically provided through local initiatives and relies heavily on the voluntary sector. In the majority of OECD countries, free training (at least online) is available. For example, in Greece, NGOs collaborated with academic institutions to create free training courses for carers - the "i care program"- and in Spain, secular NGOs and religious charities or organisations (e.g. Caritas) provide the bulk of training.

61. In Canada, France, Ireland and the UK, countries collaborate with NGOs to provide counselling and training. In Ireland, a range of training programmes is delivered either by the Health and Safety Executive, jointly with carer representative organisations like Family Carers Ireland, or directly by carers' representative organisations. Courses are delivered through group work and one-to-one training where appropriate. Accreditation is available for longer training programmes. In the UK, NGOs like Carers Trust and Carers UK are subcontracted to provide training.

62. Similarly, Australia has developed a comprehensive public training programme in collaboration with NGOs. Access to training through Carer Gateway is free. Online training and resources cover carer health and wellbeing, financial information and how to access financial support, understanding inclusion and advocacy and understanding the caring journey. A one-off practical support (up to an amount of AUD 1,500) is available to eligible carers to enable them to purchase items to assist continued education, such as a laptop and/or payment for training courses.

63. Conversely, Korea has a comprehensive public training programme that does no rely on the collaboration with NGOs. It consists of 10 professional individual and collective counselling activities for families of care recipients with dementia or severe LTC needs. Employees with national qualifications in mental health provide these programmes at LTC Insurance management centres.

64. Mexico and Colombia offer more narrowed public training. In Mexico, the Institute of Social Security and Services for State Workers and the Mexican Institute for Social Security finance and organise only online courses. In Colombia, the public National Learning Service and a network of registered institutions provide teaching in regional or local offices or remotely.

65. Training can be tied to a carer allowance, such as in Finland, Germany, Portugal, Luxembourg and Norway, and they include more often in-person training. In Germany, the LTC insurance fund offers professional care counselling consultations in private households twice a year if the care recipient has moderate needs (levels 2 and 3 out of 5) or four times a year if the care recipient has severe needs (levels 4 and 5). The visit also helps to ensure that appropriate, quality care is provided. In addition, carers can also access counselling and training during the free information session offered by the LTC insurance fund when the registered informal carer begins to provide care. In Norway, municipalities are obliged to deliver training to caregivers providing intense care, under specific conditions. In Luxembourg, LTC insurance covers 2 hours per year of training on assistive technology and 6 hours per year of training in assisting dependent persons to perform activities of daily living (ADLs).

66. In the United States, training through the National Family Caregiver Support Program (NFCSP) is provided in-person or online. A study showed that 24% of NFCSP client caregivers received caregiver education/training, individual counselling, or support group services in the past 6 months in 2018. Among them, 52% used support group services, 36% training in groups or online, and 24% received individual counselling. States and territories are required to offer various core services in partnership with local public centres and local service providers, including individual counselling, support groups, and caregiver training, to receive funding. The funding for the NFCSP was about USD 180 million in 2018 (Avison et al., 2018[42]).

67. While skills on diseases, rehabilitation, daily life practicalities and the management of emergencies are fundamental, training on carers' own well-being is also important. For example, providing techniques for coping with demands, relaxation and reducing isolation through peer support are valuable interventions (Brimblecombe et al., 2018[43]; Larkin, Henwood and Milne, 2018[44]).

68. Examples of public interventions to provide psychological support to carers are found in Australia, Denmark, Latvia and Norway. Australia has developed the Carer Coaching service, which is a free psycho-educational service specifically designed to assist carers. Engagement may be in-person, via telephone and/or online. Carers engage with a coach in up to six sessions - or more if required. In addition, in-person free facilitated peer support is available through the Carer Gateway website to enable carers to connect with people in similar circumstances and learn from their peers. In Denmark, the government covers 60% of the cost of psychological consultations if a carer has an ill relative and requires psychological support. In Latvia, informal carers receiving a cash benefit are supported either by social workers (fully financed by municipalities) or by psychologists (partially financed by municipalities). In Norway, the municipal centres offer courses to close family members to help them cope with their everyday lives.

Access to respite care is fragmented across OECD countries

Public support to respite care is overwhelmingly provided in-kind

69. Respite care, which is designed to offer caregivers a break from their regular duties (see Box 5.1), is often perceived as the most important and common form of support to alleviate caregiving burden (COFACE, 2017[38]).

Box 4.1. What is respite care?

Respite care refer to different types of interventions providing temporary ease from the burden of care. The most common types of respite care are:

- day-care services;
- in-home respite;
- institutional care in LTC facilities.

An important element of respite care is its length. Some services offer short stays (such as day-care services) and others consider longer periods of time (vacation breaks for carers). Both duration and frequency of respite breaks (every day or every week) are relevant when assessing the importance for the carer and the care recipient. Formal and informal carers can provide respite breaks.

Source: adapted from (Colombo et al., 2011[45]).

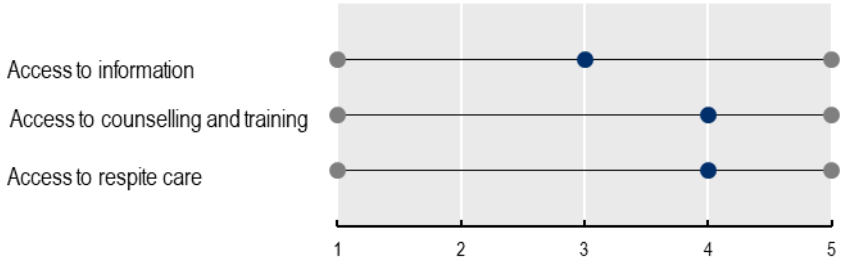
70. Without respite, caregivers may face serious health and social risks due to the stress associated with continuous caregiving, and may feel isolated or enjoy little time to rest. In the US, findings from a 2018 survey showed that more caregivers used National Family Caregiver Support Program respite care than education/training, individual counselling, and support group services combined. Among the 43% of caregivers who used respite in the last six months, 86 % said the service was very helpful and about 40 % deemed respite the most helpful service received from their local public centres, compared with information sharing services, training, individual counselling and other services (e.g. transportation, home modification) (Avison et al., 2018[42]).

71. While evidence of best practices across countries remains scant, providing a range of services is best to give carers the choice, depending on their needs and the care recipient. Many carers prefer planned respite. In France, a survey showed that carers tend to prefer services that can be embedded in a routine, such as for example, placing the care recipient in the same day-care centre on a regular basis. Informal carers perceive that organising irregular or one-off respite care is not always worth the time, energy and money.

72. As some carers and care recipients can spend a considerable amount of time commuting, combining respite care with services for transportation of the care recipient can further alleviate the caregiving burden, especially in rural areas.

73. Across a scale from one (less important) to five (more important), OECD countries ranked access to respite care as particularly important (average of 4) (Figure 4.1). Policies for carers in almost all OECD countries include respite care, although legal entitlement to respite services vary widely (Colombo et al., 2011[45]). Public support to respite care is tied to a cash benefit for informal carers in nine European countries (Austria, Denmark, England, Finland, France, Germany, Iceland (Reykjavik), Luxembourg and Portugal).

Figure 4.1. Access to respite care is perceived as very important in LTC policy discussions



Note: Averages based on answers to the following question "Considering recent reforms/discussions on LTC in your country, please rank the following from 1 (less important) to 5 (more important), for each area of interest". N ranges from 19 to 21 countries for these questions.
Source: 2020 OECD questionnaire on informal carers.

74. Public support to respite care is mostly provided in kind. In eight European countries (Denmark, Finland, France, Iceland (Reykjavik), Ireland, Luxembourg, Lithuania and Portugal), Australia, Korea and the US, respite care is available only in kind. In Canada, all provinces offer a support to respite care, which is mostly in-kind. In Ireland, the National Service Plan 2020 aims to have 28 000 day care places available per week in public and voluntary day care centres for respite care, reablement, rehabilitation and palliative care. In 2018, public and voluntary day care places were estimated to cost around EUR 27 million per year. In these centres, clients paid an average out-of-pocket contribution of EUR 10 per day for day care, including transport costs. In Korea, older people with dementia and those with severe limitations (LTC grades one and two out of five) are allowed up to six days per year of publicly-funded respite care. In France, since 2016 an informal carer can benefit from in-kind respite care up to the limit of 500 EUR per year (with a co-payment based on means and needs), which includes day care or night care, temporary residential care and home care (CNSA, 2020[46]).

75. Lithuania has recently strengthened the regulation on respite care. Since 2021, the temporary respite has been a separate social service in the Catalogue of Social Services. Temporary respite services are provided on an as-needed basis, for up to 720 hours per year

(in exceptional cases, in a crisis situation, temporary respite can be provided continuously for up to 90 days). Lithuania envisages to improve further the legislation on temporary respite by either including respite care in a possible forthcoming Long-Term Care Act or amending the law on Social Services to allow individuals to provide social services to people with disabilities when their informal caregivers use respite care.

76. Germany and the Slovak Republic are the only European countries that provide support to respite care in cash rather than in kind. In Germany, under the 'stand-in' care scheme, the LTC insurance funds cover the cost of replacement of the informal carer for up to six weeks per year for those caring at least 14 hours a week. Informal carers need to have provided care for at least six months to benefit from this scheme. In the Slovak Republic, municipalities provide respite care for a maximum of 30 days to registered informal caregivers[4], but take-up is very low. Only 174 care recipients benefited from respite care in 2014, of which 44% relied on day centres (Gerbery, 2016[47]).

77. Low take-up of respite care appears to be common in OECD countries. Informal carers typically tend to contact first another informal caregiver before reaching out to formal care arrangements. Respite services can be perceived as inadequate to the informal carers and/or the dependent older people's needs or preferences. Some informal carers also report that respite care can be unaffordable (KCE, 2014[48]). The complexity of care management is another reason for low take-ups - it can take time to organise well-functioning routines.

78. Respite care should be available in combination with other types of support. One country example is Australia, where there is a comprehensive support system and respite care is one the important services. Carer Gateway provides access to services for all unpaid carers, regardless of the age of the care recipient. Carer Gateway was developed by the public authorities through a co-design process with carers and the voluntary sector over a four-year period from 2015. The introduction of Carer Gateway is part of the Australian Government's commitment of over AUD 700 million across five years to 2023-24, to recognise and support the important contributions of unpaid carers.

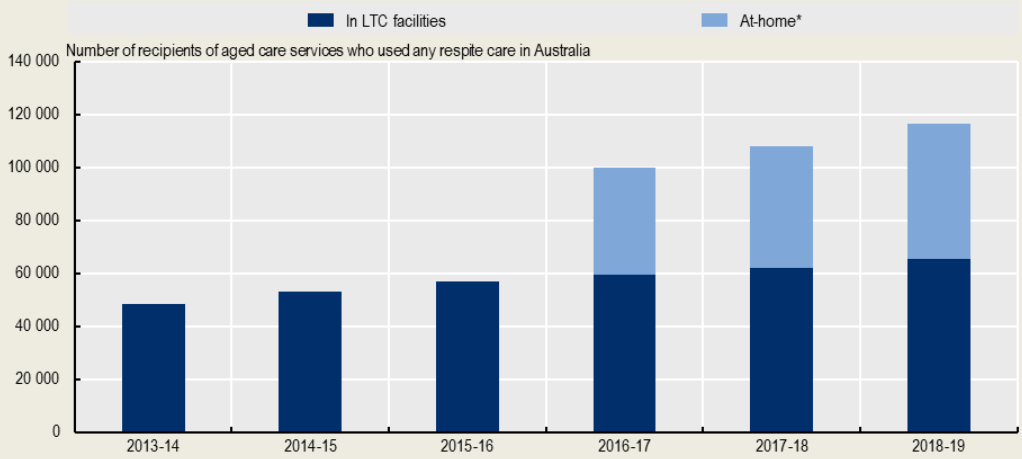
79. Ten not-for-profit organisations commenced as Carer Gateway service providers in April 2020 and are receiving approximately AUD 539 million over five years (November 2019 to June 2024) to deliver the national network of carer support services in 16 regions across Australia. Carer Gateway service providers are required to support the service area/s they have been allocated and have established a regional presence throughout their respective service areas. In 2018-19, nearly 120 000 people had used respite and the number of users has increased (see Box 4.2).

[4] Those entitled to the cash benefit are strictly means-tested and they can combine care with a paid work only if labour income does not exceed twice the guaranteed minimum income for an adult person.

Box 4.2. Respite care is an essential component of the carer support system in Australia

Respite is provided in LTC facilities and at home through the Commonwealth Home Support Programme (CHSP). An increasing number of recipients of aged care services have been benefiting from respite care since 2013-14 (Figure 4.2). Following the start of the COVID-19 pandemic, Australia announced AUD 798.3 million from 2021-2022 to 2026-2027 to provide greater access to respite care services and payments to support carers, as part of the AUD 17.7 billion aged care package.

Figure 4.2. Respite care has been increasing steadily in Australia since 2013-14



Note: The years refer to financial years. * recipients of aged care services who used any respite care services provided through the Commonwealth Home Support Programme (CHSP). It started in 2015-16; complete and comparable data for the year of commencement of this program is not available. Prior to the CHSP, the Home and Community Care (HACC) programme provided respite care at home.
Source: 2020 OECD Questionnaire on informal carers.

Data on respite care beneficiaries and spending are limited

80. Data on the beneficiaries and the cost of respite care services is challenging to collect across OECD countries. Out of 27 OECD countries surveyed, only five countries (Australia, Austria, the Czech Republic, Luxembourg and the United States)[5] were able to provide quantitative information on respite care in 2020. In Austria, the number of beneficiaries of respite care increased gradually from 9 200 beneficiaries in 2014 to 13 328 beneficiaries in 2019. The expenditure amounted to EUR 11.7 million in 2019 - or about EUR 880 per beneficiary per year on average. In comparison, France finances in-kind respite care for a maximum of EUR 500 per year per eligible informal carer. In Luxembourg, in 2018, 62% of care recipients living at home used respite day-care and about 4% of care recipients living at home used respite care at night. This support for respite care at night is only available for care recipients who formally rely on a carer in the daytime and who need supervision during the night.

[5] In Norway, the available data does not target informal carers of older people, even though Norway is a country with easily-accessible and readily-available data on respite care and other care services (see: https://www.ssb.no/en/statbank/table/11642).

81. In the Czech Republic, respite care is a social service that is paid by carers at an hourly rate. It is partially financed by municipalities and the Ministry of Labour and Social Affairs. The number of clients has gradually increased from 10 778 in 2014 to 13 894 in 2019. The share of women among the beneficiaries has remained stable at around 63%. The number of social providers of respite care has slightly increased from 284 providers in 2014 to 310 providers in 2019.

82. In the United States, in 2014, over 604 000 caregivers used respite care services at home or in an adult day care or an institutional setting for a total of nearly 6 million hours through the National Family Caregiver Support Program (NFCSP) (Administration for Community Living, 2021[49]). The NFCSP offers respite care in partnership with local public centres and local service providers (Avison et al., 2018[42]).

5 Cash benefits aim to support carers in two-thirds of OECD countries

Two-thirds of countries provide a cash benefit to informal carers

83. About two-thirds of the 33 OECD countries with available data have at least one cash benefit to carers either paid directly to carers through a carer allowance or paid to those in need of care, part of which may be used to compensate formally carers. Twenty countries have a direct payment towards the carer, while 13 countries have cash benefits for the care recipient that can be used to formally compensate carers (Table 5.1 and see Annex for a detailed table). The Netherlands, the Slovak Republic, Spain, Sweden and the UK (England) provide both types of cash benefits. These cash benefits are not taxed in all countries except in Ireland, Finland and Sweden. Most OECD countries with a cash benefit to informal carers are European countries. Canada, Colombia, Japan and Korea do not have a cash benefit for informal carers. However, they have developed systems of care leave to help workers combine care and work (except Colombia, see next chapter) and Canada further developed a time-limited COVID-19-related caregiving benefit (see Chapter 2).

84. After over 20 years of discussions, Slovenia passed in 2021 a structural reform on LTC that comprises new funding routes, a new needs assessment tool, and a gradation scale of 5 categories. Beneficiaries will choose to receive a cash benefit, formal care at home or formal care in an LTC facility. Those with the highest needs (grades 4 and 5) will also be able to register an informal caregiver as a carer. Eligibility will not be restricted to relatives nor co-residents. The carers will receive 1.2 times the minimum wage and will be able to access respite for 21 days per year (by placing the older person in an LTC facility). The legislation is expected to be implemented in 2024-25.

Table 5.1. Two-thirds of countries have a cash benefit for informal carers, directly or indirectly

Country	Direct cash benefit to carer	"Formal" indirect cash benefit to carers
Australia	Yes (two)	No
Austria	No	Yes
Canada	No	No, except in Newfoundland and Labrador
Belgium (Flanders)	Yes	No
Bulgaria	Yes	n.a.
Croatia	Yes	No
Czech Republic	No	No
Denmark	Yes, with a contract with the municipality and restricted to end-of-life care	No
Estonia	Yes	No
Finland	Yes, with a contract with municipalities	No
France	No	Yes, with an agreement with the care recipient
Germany	No	Yes, with an agreement with the care recipient
Greece	No	No
Hungary	Yes, with a contract with the public authority	No
Iceland (Reykjavik)	Yes (two)	No
Ireland	Yes (three)	No
Italy	No	Yes, without agreement needed
Japan	No	No
Korea	No	No
Lithuania	No	No
Luxembourg	No	Yes, with the care recipient
Netherlands	Yes, with a contract with the care recipient	Yes, with a registration
Norway	Yes, two (one is restricted to end-of-life care)	No
Poland	No	Yes
Portugal	Yes (pilot phase)	No
Romania	Yes	n.a.
Slovak Republic	Yes	Yes, but care recipient has to have been receiving it before age 65
Slovenia	Yes	No
Spain	Yes, available with or without a contract to receive social security benefits	Yes
Sweden	Yes, with a contract with the municipality	Yes, with an agreement with the care recipient, restricted to end-of-life care
Switzerland	Yes (cash benefit is set at the local level)	Yes (cash benefit is set at the local level)
UK (England)	Yes	Yes, but only on exceptional ground
United States	No	Yes, with a contract with Medicaid and other public programmes and care recipient.

Note: indirect cash benefits are considered "formal" here when the LTC system has registered the informal carer. The table excludes the situation where the carer provides cash to informal carers without any registration of the transfer of money in the LTC system. "n.a." for "not available".

Sources: OECD Policy Questionnaire 2020, (Mutual Information System on Social Protection, 2019[50]) , (Colombo et al., 2011[45]), (Zigante, 2018[51]), Eurocarers Country Profiles, for Canada (Government of Canada, 2021[52]) and for Norway (NAV, 2021[53]).

85. All countries have to delineate the pool of beneficiaries of the cash benefits. In most countries, means-testing is the central entitlement condition to limit the pool to people on low-incomes - this condition is commonly found in social assistance programmes. With means-

testing, countries aim to strike the right balance between avoiding to trap carers in a low-paid informal care position and providing sufficient income assistance. In addition, other eligibility criteria include the relationship between the carer and the care recipient (e.g. family members), co-residency, the level of care effort (e.g. number of hours of care per week), the care level of the care recipient (e.g. high LTC need). Countries tend to focus conditions on the relationship with the care recipient or the requirements on the intensity of informal care provision (without restricting informal care to relatives). Targeting carers by their bond with the care recipient is more restrictive. A few countries target co-resident family members, which is particularly restrictive.

86. Indirect carer allowances is less common (42% of countries against 65% for direct cash benefits). Several countries (e.g. France, Germany, and the Netherlands) require that care recipients make a formal contract (or health plan) with their caregiver to receive benefits. All the Nordic European countries except Norway require that care recipients have a formal contract with the relevant public authorities (usually municipalities). These indirect carer allowances have the advantage of being more regulated, and therefore they tend to offer more protection to carers and care recipients. However, they are more complicated to put in place.

In most countries, means-testing is a central entitlement condition

87. Means-testing delineates the potential beneficiaries to those on poor incomes – one of the main goals of social protection is to protect against poverty. Means-testing of benefits is found in 16 countries, either on the carer's and / or the informal carer's household. In general, means-testing is related to the carer's household. When the care recipient has to be a co-resident (e.g. Spain, Portugal), means-testing applies to both the carer and the care recipient. For countries requiring a contract or an agreement with the care recipient (e.g. Austria, France), means-testing applies only on the care recipient's household.

88. Means-tested programs typically establish eligibility against a standard that is related to very low incomes. They are received by people with no other income sources to cover basic needs (like minimum-income programmes), but they can be designed to top up the incomes of low-paid workers and other low-income groups. This is the case for the cash benefits of informal carers in many countries. Countries have designed these cash benefits with means-testing to provide a form of income assistance.

89. However, means-testing might discourage carers' participation in the labour market depending on the level of the thresholds and the "cliff edges" effects. Given the profile of informal carers – lower or medium-educated women with relatively low incomes – means-testing might discourage carers otherwise interested to work additional hours to increase their income. Previous OECD publication showed that means-tested allowances in Australia and the United Kingdom generated incentives to reduce hours of work for carers (Colombo et al., 2011[45]). Countries aim to strike the right balance between avoiding to trap carers in a low-paid informal care position and providing sufficient income assistance.

Other eligibility criteria include the type of relationship, the co-residency, the level of care effort for the carer and the care needs

90. Countries rely on other eligibility criteria to target the pool of carers. The main other eligibility requirements include the relationship between the carer and the care recipient (e.g. family members), co-residency, the level of care effort (e.g. number of hours of care per week), the care level of the care recipient (e.g. high LTC need).

91. In a number of countries (e.g. Australia, Croatia, Denmark, Finland, Sweden, the Slovak Republic), the cash benefit does not specifically target informal carers of older people, even though they are eligible like informal carers of children and adults. The share of informal carers of older people varies by country and the eligibility criteria of the cash benefits. In Denmark and Sweden, the share is important because the cash benefits are targeted to those helping people in palliative care. In Croatia, public support is directed at informal carers of older people and children with disability, and while the take-up for carers of older people has increased markedly since 2016, it remains very low compared with informal carers of children (less than 1 000 informal carers of older people vs over 4 000 informal carers of children in 2019). The cash benefit is limited to spouses/partners aged below 65 years old and the compensation is well below minimum wages.

92. Another example of the importance of these eligibility criteria to target the pool of carers is found in comparing Spain and the Slovak Republic, two countries that offer two relatively similar benefits. There is one direct benefit targeting the family members and one indirect benefit for care recipients to employ non-relatives. However, the take-up of the indirect benefit is well higher in Spain. In the Slovak Republic, the indirect benefit is available only for older people who started receiving it when aged under 65 years old. Therefore, the take-up is small among older people (Gerbery, 2016[47]).

Other eligibility criteria tend to focus either on the bond to the care recipients or the intensity of informal care provision

93. Overall, countries tend to focus conditions on 1/ the relationship with the care recipient or 2/ the requirements on the intensity of informal care provision (without restricting informal care to relatives). Targeting carers by their bond with the care recipient is more restrictive. Countries like Spain and Portugal, which target co-resident family members, are particularly restrictive. France is an uncommon case where all family members are eligible, except spouses, but they are not required to be co-residents. This also reduces the pool of eligible carers. Conversely, other countries like the Nordic European countries, the Netherlands, Germany and the UK (England), have a broader population target, but eligibility criteria on care intensity.

94. Portugal is unique in the way that it balanced the need for a token of recognition to a large share of informal carers and the financial support for those providing most care. The law enacted in 2019 differentiates between two types of informal carer: principal and non-principal. A principal informal carer is a family member living in the same household as the person being cared for who provides care on a permanent basis. They may be eligible for the carer's allowance and is always eligible for other types of support like respite care. A non-principal carer is a family member caring on a regular but non-permanent basis. They are not eligible for a carer's allowance but can benefit from other types of support (Perista, 2019[32]).

95. Several countries (e.g. France, Germany, and the Netherlands) require that care recipients make a formal contract (or health plan) with their caring relatives to formalise the arrangement. In Germany, carers can be affiliated to the LTC fund if the care recipient receives an allowance. Once registered, the LTC fund pays for the social security contributions of the carers and provides free training, but does not establish a contract of care with a formal transfer of money. However, once registered, the carer can formally receive part of the cash benefit of the care recipient to compensate for care. The LTC allowance of the care recipient varies between EUR 125 per month (grade 1 needs) to EUR 901 per month, depending on the needs of older people, if care is provided by an informal carer. The monetary amount is less generous

than if receiving in-kind formal services (which can be up to EUR 1 995 per month)[6] (Federal Ministry of Health, 2017[54])

96. In the Netherlands, the amount of the cash benefit is defined through a care package. Family members can be paid through this personal budget, subject to an employment contract. Employment conditions include holiday right, but exclude social security coverage. Local authorities are responsible for the provision of the care package and the cash benefit (Colombo et al., 2011[45]).

97. Some countries require that care recipients enter into a formal contract with the relevant public authorities. In particular, in all Nordic European countries except Norway, municipalities set eligibility criteria and directly employ informal carers. They are not obliged by law to provide cash benefits, but they are urged to do so. While compensation levels are higher than in many other countries, they still constitute very low wages and are unlikely to compensate the full value of caregiving (Colombo et al., 2011[45]).

98. In the United States, some public programmes (Medicaid, some state-revenue only programs, Veterans-Directed Care) enable older people eligible for home care to hire family members. A compensation is paid to family caregivers as an hourly wage and is subject to the Fair Labor Standards Act minimum wage and overtime pay requirements. Payroll taxes apply and provide for social security pension coverage, Medicare, and unemployment compensation. Most states place some restrictions on family members who may be hired as paid helpers. The most common restriction is a prohibition on hiring spouses. The only other country excluding specifically spouses is France. Evidence in Europe shows that spousal informal care to older people and disabled adults impacts particularly mental health (European Commission, Directorate-General for Employment, Social Affairs and Inclusion, 2021[1]). A few states also place limitations on hiring individuals who reside in the same household.

99. There are two types of benefits that allow Medicaid recipients to hire individual providers (including family members). In one type, the Medicaid program determines the number of aide hours per month that the recipient may receive and the state or state/county determines the hourly wage rate. The second type of benefit provides the Medicaid recipient a monthly monetary allowance (a “budget”) and the recipient may decide how many aide hours to purchase and negotiate how much to pay per hour with individual hired workers (at least the state minimum wage or minimum union-negotiated wage). In the former case, a paid family caregiver will be paid the same hourly rate as a non-relative. In the latter case, hourly wages paid to different workers (family or non-family) may vary.

100. US public authorities are not the employers of independent provider aides hired by individual program participants except for very limited purposes (e.g. contract negotiations with unions over hourly wages and, in some cases where it should determine hourly wage rates). In some US states where “independent provider” home care aides[7] are unionised, health insurance and other benefits such as retirement plans and paid time off, may be available if negotiated in the union.

[6] Germany also provides additional financial support of up to EUR 4 000 per older person to improve living environment, especially to adapt houses (e.g. beds). Multiple care recipients living together can benefit to up to EUR 16 000.

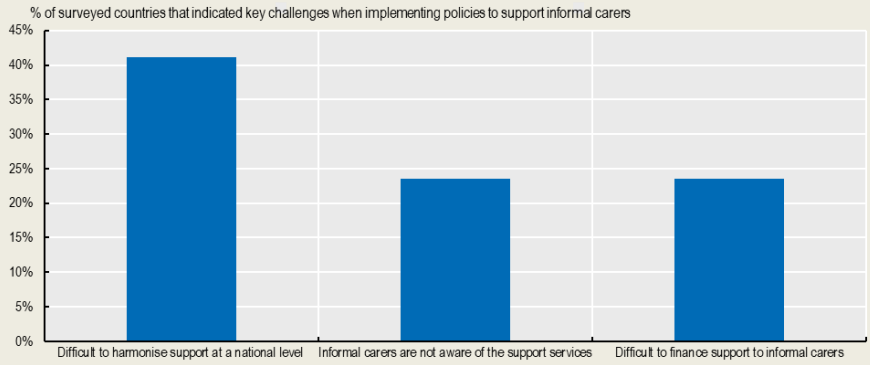
[7] These are family and non-family paid helpers hired and supervised directly by Medicaid recipients, not via professional home care agencies.

101. In the US and in other countries where the competence for health and social welfare lies at the subnational level, national authorities may face challenges in harmonising support to informal carers (see Box 5.1).

Box 5.1. When competences are set at the subnational level, more collaboration and coordination across the authorities could improve support to carers

102. Many countries like Belgium, the Czech Republic, Colombia, Estonia, Finland, Sweden, and the United States reported that harmonising support across their territory was a key challenge when implementing policies for informal carers (cash benefits, respite care, leave) (Figure 5.1).

Figure 5.1. Key challenges faced by countries when implementing support policies



Note: N=17. The question was "What, if any, key challenges does your country face in implementing these policies?" Multiple answers were accepted.
Source: 2020 OECD Questionnaire on informal carers.

103. Another challenge reported by nearly 25% of countries is financing support for informal carers, although some are taking steps. In Italy, the 2017 law established that the Ministry of Labour and Social Policies had a fund of about EUR 20 million per year, from 2018 to 2020. The fund of nearly EUR 24 million in 2020 is distributed to the regions until 2023. The regions have to finance policies for caregivers of people with severe disability, caregivers of people who were denied access to residential care services due to emergency restrictions, if they are able to show proof of the rejection; and programs to support the deinstitutionalisation of care. Regions can transfer the funds to local authorities and can involve not-for-profit organisations.

More regulated cash benefits offer more protection to carers and care recipients

104. Cash benefits to informal carers and care recipients that are more regulated offer more protection for vulnerable users (Zigante, 2018[51]), but also for undeclared workers working in the grey labour market. It can be difficult for countries to control what care recipients or carers effectively do with cash benefits, in particular when it is provided without monitoring. It has been argued that a lack of control of cash benefits has fuelled a grey market, such as in Spain and in Italy (OECD, 2020[55]).Typically, the care recipient's family uses the cash benefit to employ informally an undeclared worker, often migrant, to take care of older dependent people. This worker may live in the care recipient's household, but as they work informally, they receive

virtually no social security protection. This means that they have been exposed to COVID-19 without the social protection put in place for formal workers. Austria also has a cash benefit to support stand-in care and it has developed a legal framework to protect registered carers. Many carers are migrants, but they are more included in the formal labour market, although with contracts that are usually not very protective.

105. To ensure that carers provide high-quality care, countries mostly rely on planned or unplanned visits of health and social care professionals to witness neglect or abuse - even though neglect may be unintentional. Sometimes carers are left with so much to do that they can neglect some care activities. In Germany, older people benefiting from a care allowance receive professional counselling at home (twice a year for those with moderate needs and four times a year for those with severe needs). During these visits, health professionals also ensure that care is adequate. If not, health professionals either offer training sessions to the carer or take appropriate action against the carer, depending on how inadequate the care is. In addition, care recipients claiming only cash benefits or at-home LTC services are periodically audited. In Portugal, any health or social care professional can file a Social Security form to report carers to the Social Security in the event that they suspect an abuse. The 2019 law states that carers can be fined between EUR 100 to EUR 700 depending on their income in case of neglect or abuse. In Belgium, the renewal of the carers' allowance provides the opportunity to monitor care quality.

In the few countries with available data, over 70% of beneficiaries are women and men are not getting more involved

106. More information on spending beneficiaries is not straightforward to collect. Out of 27 surveyed OECD countries in 2020, only Nordic European countries, Estonia and Luxembourg provided data about the number and profile of informal carers of older people receiving a cash benefit. The overwhelming majority of beneficiaries are women in countries where data are available. In Estonia, Finland, Norway, Luxembourg, Sweden, about 70% of beneficiaries are women. In Ireland, the share of women ranges from 77% to 89%, across the three cash benefits. The gender breakdown has remained stable in all these countries in the last five years. In the Slovak Republic, women represented about 80% of the recipients in 2014.

107. In all countries with available data, the number of beneficiaries has been stable or increased in the last five years. The number of beneficiaries varied a lot across countries in 2019: 16 347 carers in Sweden, around 7 000 in Estonia, at least 6 276 carers in Luxembourg (in 2018), 2 770 carers in Denmark, 1 167 beneficiaries in Norway for the benefit related to end-of-life care, less than 1 000 in Croatia, 120 carers for the Iceland capital Reykjavik.

108. Total spending per beneficiary also varied widely across countries. In 2019, in Estonia, total spending amounted to EUR 547 per beneficiary, in Norway about EUR 2 570-2 810 per beneficiary, in Denmark about EUR 9 620 per beneficiary, in Sweden about EUR 10 440, in Reykjavik (Iceland) about EUR 10 800 per beneficiary. In 2017, Luxembourg spent EUR 50.2 million on the LTC package of care recipients who rely on registered informal carers, for an average of EUR 8 190 per year per care recipient with an informal carer. Note that the benefits are taxed in Finland and Sweden. More quantitative information on the benefits is contained in Annex.

109. In Finland, about 50 000 carers were compensated in 2020 while it is estimated that there are about 350 000 principal carers, based on 2014 data (Ministry of Social Affaires and Health, 2014[56]; Sotkanet, 2020[57]). Among the compensated carers, 70% are women and 58% are aged 65 and over. Over a third take care of people primarily because they have memory disorders. While they have the right to have 2-3 days off per month, half do not take them, for

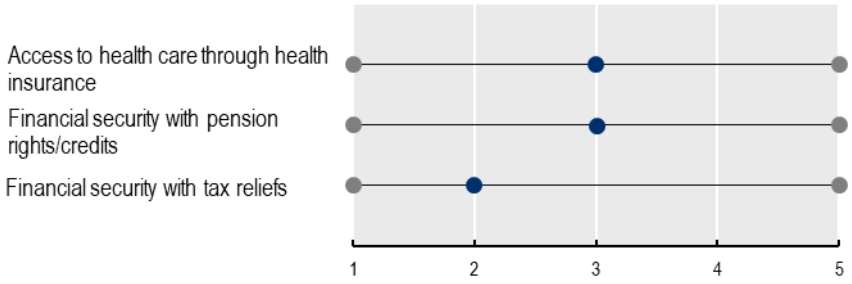
multiple reasons. In comparison in Finland, there are about 50 000 formal LTC workers, of which 15 000 provide care at home. (Kalliomaa-Puha and Kangas, 2018[58])

In about a third of surveyed OECD countries, cash benefits are not tied to social security coverage

110. In the few countries with available data, at least 40% of registered informal carers – the beneficiaries - are aged between 40 and 59 years old. This underlines the importance of social security coverage, including pension rights. Social security coverage tied to cash benefits are essential to help informal carers have a decent income when they retire, to ensure that they can afford health care, and to ensure that they can claim unemployment benefits.

111. However, social security coverage is not perceived as very important on average across OECD countries based on the 2020 OECD questionnaire on informal carers (Figure 5.2). Access to counselling and training as well as respite care were perceived as more important across OECD countries (an average of 4). Still, access to health care and pension rights/credits are perceived as more important than tax reliefs on average.

Figure 5.2. Social security coverage for carers is not perceived as very important in LTC policy discussions



Note: Averages based on answers to the following question "Considering recent reforms/discussions on LTC in your country, please rank the following from 1 (less important) to 5 (more important), for each area of interest". N ranges from 19 to 21 countries for these questions.
Source: 2020 OECD questionnaire on informal carers.

112. Among surveyed OECD countries with available data, about 70% of countries offered some kind of social security coverage tied to a cash benefit, although they are tied to specific conditions (see Annexes B and D for country-specific details).

113. The social protection may not be tied to a cash benefit. Lithuania has recently improved the social protection of caregivers - under specific income and age conditions among other conditions, but without introducing a cash benefit for informal caregivers. Since 2020, Lithuania has covered the pension and the unemployment social insurance of caregivers of people with a special need for permanent care (or assistance) under specific conditions (see Annex D) (Ministry of Social Security and Labor of the Republic of Lithuania, 2021[59]).

114. Some OECD countries have created "carer credits" for those with interrupted workforce histories, which take the form of an amount of time credited to the carer's working record (for pension purposes). To avoid those with fewer years of contributions receiving a lower pension, the government provides a credit to their contribution record or reduces the required balance for a full contribution record. Carer credits can also be in the form of a financial credit to the

pension account (OECD, 2020[55]). In Finland, France and the United Kingdom, carer credits have become easier to access (Hamilton and Thomson, 2016[60]). However, credits are usually available for childcare only. The United Kingdom is the only European country where employers continue to contribute to the occupational pension on behalf on an employee during periods of care. In Sweden, employers are encouraged to do so and most comply, even though this is not mandatory (OECD, 2020[55]).

A range of tax reliefs - another form of financial assistance - covers various types of carers support

115. Tax relief is an indirect form of financial assistance to caregivers that aims to recognise care provided by informal carers. However, they are perceived as of little importance on average across OECD countries (see above Figure 5.2). In many OECD countries, they are not tied to being an informal carer receiving a cash benefit, but usually concern households or family members with a dependend person.

116. For most tax reliefs, the central entitlement condition is the degree of dependency of the older people, combined with other criteria like the age of the dependent person and the type of relationship (e.g. Belgium, Canada, Finland, France, Ireland, Spain, United-States). In Belgium, there are tax deductions for households with a co-resident who is disabled and aged below 65 years old (Colombo et al., 2011[45]). In Ireland, the Home Carer's Tax Credit is paid to married couples or civil partners (who are jointly assessed for tax) where one partner cares for a dependent person. This person can be a child, an adult over 66 years or a person with a disability who requires care. The conditions regarding the need for care are much less stringent compared with those for the cash benefits. In 2020, the value of the tax allowance for the household was EUR 1 600 (Eurocarers, 2021[61]).

117. A few tax reliefs recognise the financial support of families who contribute to nursing homes' bills (Japan, France). Tax relief can also recognise the financial support for medical expenses (Japan, Korea). In France, tax incentives are provided when contributing to the payment of parents' stay in nursing homes. In Japan, taxpayers with dependents are entitled to deductions, including on medical expenses, nursing homes and transportation. In Korea, a tax exemption is available for dependents of the taxpayer. Dependents must be aged under 20 years old or over 60 years old, live in the same household and be on low incomes. Additional deductions are available for dependents aged over 70 years old. In addition, the cap of 7 million won per year is removed for the 15% deduction on medical expenses available to all salaried employees (under specific conditions) with a dependent person in the household.

118. Spain has developed a tax deduction for people combining paid employment and care responsibilities. There is a specific tax deduction for taxpayers who are employed or self-employed and who have made social security contributions. The deduction is up to EUR 1 200 per year per disabled person. The basic tax credit per child or dependent family member amounts to EUR 9 000 per person with a disability of 65% or more, or EUR 12 000 if also requiring third party help (Eurocarers, 2021[62]).

119. Tax credit can also apply to service vouchers, in part to incentivise formal domestic work (Belgium, France, Ireland, Luxembourg). In Belgium and France there are tax credits through service vouchers to employ home workers for domestic chores. In Ireland, the Tax Relief on the Cost of Employing a Home Carer is available to offset the costs of employing a professional home carer and is paid at the highest tax rate up to a maximum deduction of EUR 75 000 per year (Eurocarers, 2021[61]). In Luxembourg, there are tax deductions for LTC

services to hire a carer up to EUR 3 600 per year. The carer hired must be below 65 years old (Colombo et al., 2011[45]).

120. In Finland, a tax credit supports informal domestic work and related expenses. The tax credit for domestic help or household expenses (‘kotitalousvähennys’) reduces taxes directly for expenses of family members. Up to 40% of the costs of domestic help or household expenses (including VAT) can be deducted. This tax credit was capped at EUR 2 250 in 2020. The deduction rate is at 15% of the labour income and related expenditure when an individual is employed (Eurocarers, 2021[63]).

6 Leave for carers has increased and the COVID-19 responses led to a telework uptake

121. Decisions within families as to who will be an informal carer or whether to use formal care instead are influenced by a range of personal, professional and societal factors, such social and individual expectations about who provides care, labour market opportunities and labour income as well as the cost, availability, accessibility and quality of formal care services. Carers are overwhelmingly women and they are often older and with lower education, and are more likely to have a relatively low labour income. Previous OECD publications showed that carers are less likely to be in paid employment, even after taking into account the employment situation in the period before caregivers begin to provide care. The greater the hours of care provided, the more carers are likely to withdraw from the formal labour market entirely. The impact of care on labour force participation is significant only when individuals provide a high intensity of care (a previous OECD publication had found a threshold of about 20 hours per week) (Colombo et al., 2011[45]). Policies which enable both men and women to more readily combine work and care responsibilities reduce the risk of dropping out of the labour market altogether, and may help address the gender inequality in caregiving.

Nearly two-thirds of countries provide leave to care for an older person

122. Across OECD countries, there is a growing commitment to support informal carers combining paid employment and caring. Among EU countries, this is well exemplified by the Work-life Balance Directive, which entered into force in 2019 and must be adopted by member states within three years. The directive includes a carers' leave: workers providing personal care or support to a relative are entitled to five days of leave per year.

123. Currently, nearly two-thirds of countries (22 countries) provide paid or unpaid leave to care for a family member (Table 6.1) and the Annex for a detailed table). Half of countries offer paid leave for carers of older people. Three introduced paid care leave in the past decade: Austria, the Czech Republic and Germany. Still, in comparison, parental leave to care for children is more widely available in EU countries (Colombo et al., 2011[45]). Care leave is found mostly in European countries. In non-European OECD countries, only Japan and Canada have paid leave, and only Canada, Japan and Korea provide unpaid leave. In the United States, five states legislated paid care leave under specific and various conditions. Australia is currently reviewing unpaid carers leave and is considering possible reforms to the National Employment Standards.

Table 6.1. Half of countries provide paid leave to care for an older dependent

Country	Paid leave (at least one)	Unpaid leave (at least one)	Paid or unpaid leave
Australia	No	No	No
Austria	Yes	Yes	Yes
Belgium	Yes	Yes	Yes
Bulgaria	No	No	No
Canada	Yes	Yes	Yes
Croatia	No	No	No
Cyprus	No	No	No
Czech Republic	Yes	No	Yes
Denmark	Yes	No	Yes
Estonia	Yes	No	Yes
Finland	Yes	No	Yes
France	Yes	No	Yes
Germany	Yes	Yes	Yes
Greece	No	No	No
Hungary	No	Yes	Yes
Ireland	Yes	No	Yes
Italy	No	No	No
Japan	Yes	Yes	Yes
Korea	No	Yes	Yes
Latvia	No	No	No
Lithuania	No	No	No
Luxembourg	Yes	Yes	Yes
Malta	No	No	No
Netherlands	Yes	Yes	Yes
Norway	Yes	No	Yes
Poland	Yes	No	Yes
Portugal	No	No	No
Romania	No	No	No
Slovenia	Yes	No	Yes
Slovak Republic	No	No	No
Spain	Yes	Yes	Yes
Sweden	Yes	No	Yes
Switzerland	Yes	Yes	Yes
United Kingdom	No	Yes	Yes
United States	No (but 5 states)	No	No
Number of countries	19/35 (54%)	11/35 (31%)	22/35 (63%)

Source: (Colombo et al., 2011[45]), 2020 OECD Policy Questionnaire on informal carers and for Australia (Australian Government, 2021[64]).

124. Paid leave entitlements vary starkly across countries in terms of duration, eligibility criteria and generosity of compensation (see Table 6.1 and the Annex for a detailed table). The duration varies from 2 days in Spain to three months, renewable once, in France, to unlimited time in Denmark. In five countries (Estonia, Germany, Netherlands, Norway and Spain), paid care leave for non-terminally-ill care recipients is limited to less than one month. In all countries with paid leave, aside from Nordic countries, Belgium and Ireland, the care recipient has to be a member of the family and/or be a co-resident. In five countries (Belgium, Denmark, France, Luxembourg and Sweden), paid leave targets specifically carers with a relative at the end of their life.

125. Some countries provide a generous leave. Nordic European countries, Poland and Slovenia generally provide the most generous compensation. In Denmark, the minimum compensation is equal to 82% of the sick pay ceiling. In Norway, the paid leave is equal to the full wage. In Poland, paid leave is equivalent to 80% of the wage, for a duration up to 60 days per year. Belgium has one of the most well developed systems of paid leave for care recipients across OECD countries. It provides the longest publicly paid leave for non-terminally-ill care

recipients, for a maximum of 12 months, which employers may refuse only on serious business grounds.

126. France and the Czech Republic stand out in the design of the leave entitlement. In France, leave for carers looking after terminally ill relatives is paid for 21 days, but can be taken up to 3 months renewable once. Unemployed carers are also entitled to the leave. In the Czech Republic, since 2018, paid care leave is available for carers of a family member discharged after at least a 7-day hospitalisation and requiring at least 30 days of care at home. The carer can benefit from paid care leave of 30 to 90 days. In 2019, one year into its implementation, 4 255 people benefited from this new leave, of whom 90% were women, for a state expenditure of about EUR 4.285 million. Employers may refuse the leave.

127. About one-third of countries developed unpaid care leave for workers (Table 6.1 and the Annex for a detailed table). Conditions of unpaid leave vary to a lesser extent than for paid leave. Unpaid leave entitlements tend to be longer than paid ones. The care recipient has to be a member of the family and/or be a co-resident. Duration varies between 3 months to about 6 months to 2 years in Hungary and Spain, with the exception of the UK (2 days). Eligibility criteria may be strict, can depend on employers' agreement, and the sector in which workers are employed (whether public or private). In Austria, Canada and the Netherlands, unpaid leave is targeted only to those caring for terminally ill relatives. Spain provides long leave of up to two years, but they may be refused by employers on business grounds. In Belgium, unpaid leave in the private sector can go up to ten days, compared with two months in the public sector.

128. Little information is known on the take-up of such leave. In countries with available time series, the number of beneficiaries has increased in last years. In Austria, 3 267 people used the paid care leave ("Pflegekarenz") in 2019, for an expenditure of EUR 11 million. In comparison, 2 321 people had used it, for a federal budget of EUR 4,9 million, in 2014. In Japan, the number of beneficiaries more than doubled in the period between 2014 and 2019, to about 21 500 people in FY 2019, compared with 9 600 in FY 2014. Over the same period, the related spending increased from about EUR 14.398 million to about EUR 49.111 million. Since 2014, the share of women slightly decreased from 77% to 73%. Note that in Japan, paid carers' leave covers those caring for any dependent relative, including children and adults. In Belgium, the use of medical assistance leave has increased gradually over the past two decades, from 1 335 in 2000 to 19 348 users in 2019.

129. In Estonia, paid leave was used by 564 people in 2019, of whom 83% were women, for a total cost of over 61 700 EUR. On average, they took 4.7 vacations days, although the maximum is 7 days. Leave may not be taken up for several reasons such as unawareness and stigma. Caregivers might prefer to use holidays or sick leave, especially if workers fear that a request for care leave might endanger career opportunities or if they wish to receive their full salary.

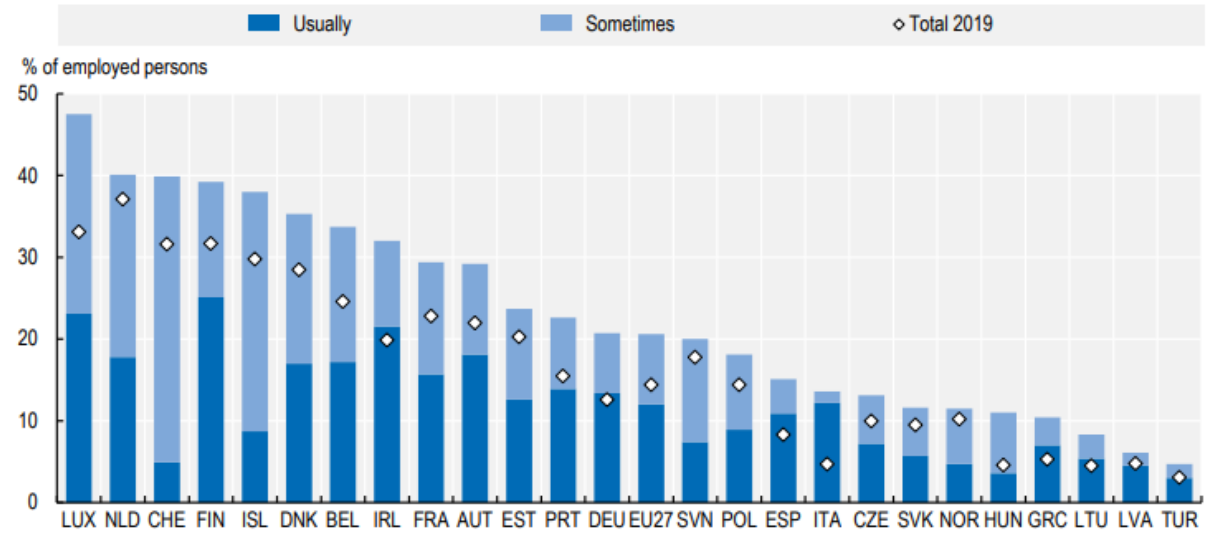
130. It is to be expected that the lower the level of compensation, the lower the level of take up (Colombo et al., 2011[45]). This makes access to flexible working hours important to help carers remain in the labour force.

Telework has progressed due to COVID-19 responses, but other flexible work arrangements are uncommon for carers

131. In addition to leave from work, flexible work arrangements may help carers to remain in the labour force and accommodate care needs if they are low. Flexible working can attenuate the risk of a reduction in working hours associated with caring. A study from the United States showed that women with caring responsibilities who worked in companies with flexible hours had 50% greater odds of still being employed two years later than those who did not (Pavalko and Henderson, 2006[65]). Flexible work schemes may offer good solutions to balance care obligations and work by providing carers sufficient income and a social network. While flexible work arrangements tend to benefit more women (because they need them more given the distribution of unpaid work), it remains key for gender equality to aim to change the underlying distribution of carers by including more men in the care provision.

132. Because of COVID-19 containment and mitigation responses, telework has become more common since 2020. It increased markedly – by around one-third or six percentage points on average - between 2019 and 2020 in the OECD countries shown (Figure 6.1). In almost all countries, the greatest increase was in people "usually" working from home. This means that people also increased the frequency of telework. In a majority of countries, the greatest increases in telework occurred among women.

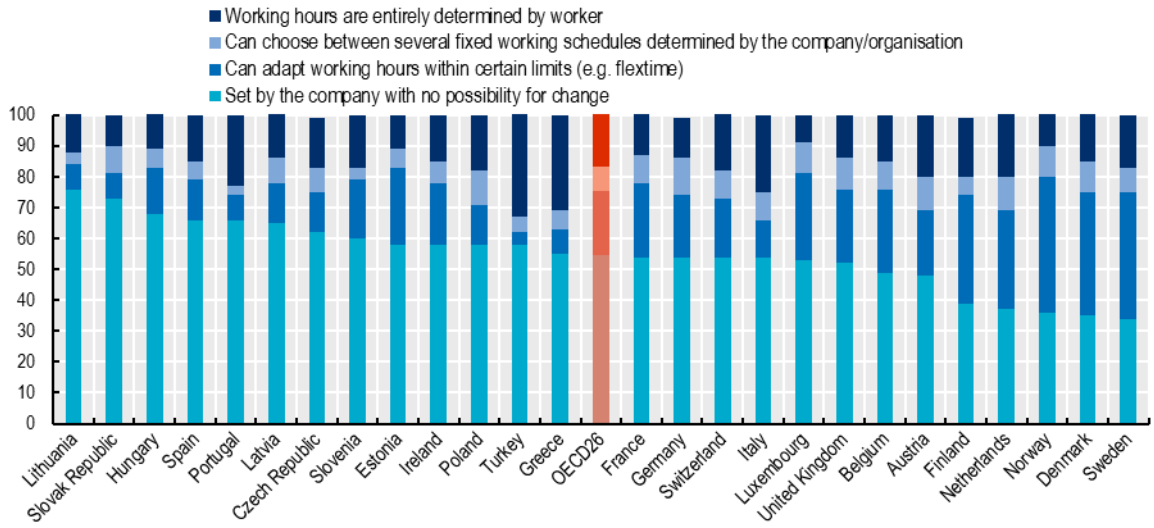
Figure 6.1. Telework has increased in all OECD countries since the start of the COVID-19 pandemic



Note: Employed people reporting about working from home.
Source: (OECD, 2021[66]), based on EU Labour Force Survey.

133. However, over half of employees have their working hours strictly set by their company across OECD countries (Figure 6.2). For carers, it is nearly impossible to keep working while providing care during working hours, even on a punctual basis if employers do not offer flexible work arrangements. On top of that, their other domestic responsibilities may also be time-consuming, leaving them without any other option that to stop working if they can afford to.

Figure 6.2. Over half of employees have their working hours strictly set by their company



Note: Working-time arrangements for employees in EU countries, 2015.
Source: (ILO, 2018[67]), based on Eurofound.

134. Other flexible work arrangements, such as reduced working hours, remain uncommon. Some countries have flexible work arrangements designed for carers of older people (e.g. Austria, Belgium, France, Germany and Japan) tied to a care leave. In many countries with paid leaves, the leaves can be taken part-time or full-time. In Austria, family members can take the care leave benefit (Pflegekarenz) full-time or part-time. In France, workers with a carer's status ("Proche aidant") can turn the leave into reduced working hours. They also have the legal right to refuse night shifts.

135. Substantial variation is found in the length of part-time work, which may be requested for care reasons and the possibility to revert to full-time hours. For example, the "Time Credit" leave in Belgium can be taken as a full or partial reduction in working time up to a maximum of 51 months (about 4 years). In Germany, an employee can take unpaid leave to care for a family member for up to six months, or claim it for part-time work for up to 24 months.

136. At the EU level, the 2019 Work-life Balance Directive also gives the right to request flexible working conditions (reduced working hours, flexible working hours and flexibility in place of work) to all carers. In Japan, companies have to take one of the following measures in addition to carer leaves: adjusting time to start and finish work, restricting overtime work and adjusting working hours. In Australia, The Fair Work Act 2009 includes provision for an employee requesting a change in their working arrangements if they require flexibility because they are a carer (within the meaning of the Carer Recognition Act 2010).

137. Flexible work arrangements, like telework, reduced or flexible working hours, may offer good solutions to balance care obligations and work for people providing low intensity care. However, they are often not sufficient for those providing moderate to intense care, and care leaves can be more appropriate. To target those informal carers, entitlements are defined in terms of the relationship to the dependent person and the care needs of the dependent person. Difficulties arise when setting the eligibility criteria that are neither too restrictive nor too loose. In addition, care leaves are temporary by nature, which makes them better designed for temporary care situations (although one criterion of dependency is its long duration), and may be particularly adequate for people caring a terminally ill relative or for people caring a relative

who has just been discharged from a hospital and requires substantial home care for rehabilitation.

138. In addition, policies on flexible work arrangements and care leaves should also consider the gender aspect, by aiming to change the underlying distribution of carers so both women and men are better able to care by choice. OECD Gender recommendations provide guidance on how to advance gender equalities on leaves, and especially parental leaves. They may be a good start to consider policies that aim to include more men in care provision. For example, it is recommended that leaves replace well previous labour earnings, otherwise, in a household, it makes economic sense that the person with lower income takes the leaves (OECD, 2017[6]).

Annex A. Data sources on informal carers in European countries

139. In Europe, there are three surveys that provide regular data on informal carers of older people across many EU countries: the European Quality of Life Survey (EQLS), the European Health Interview Survey (EHIS), and the Survey of Health, Aging and Retirement in Europe (SHARE). The 2016 EU-SILC ad-hoc module covered access to social services and included a question on informal care provided, but it was not specific to informal care for older people.

140. EQLS is a survey that covers the 27 EU countries and aims to capture the quality of life in its multiple dimensions (living conditions and social situation, with subjective and objective indicators). It was initiated in 2003 and was iterated in 2007, 2011 and 2016. It covers the population aged 18 and over.

141. EHIS is a survey that covers the 27 EU countries and aims to collect information on health status, health determinants, healthcare activities and the demographic and socio-economic status. It was initiated in 2006 and reiterated between 2013 and 2015 and between 2018 and 2019 in the twenty-eight EU countries, as well as in Iceland. It covers the population aged 15 and over, living in private households.

142. SHARE[8] is a survey that aims to compare the health, economic situation, and welfare of older people in different European countries over time (longitudinal data). It was initiated in 2004 and reiterated every other year. In 2020, the questionnaire was modified to focus on COVID-19.

[8] This report uses data from SHARE Wave 7 (DOI: 10.6103/SHARE.w7.700), see Börsch-Supan et al. (2013[1]) for methodological details. The SHARE data collection has been funded by the European Commission through FP5 (QLK6-CT-2001-00360), FP6 (SHARE-I3: RII-CT-2006-062193, COMPARE: CIT5-CT-2005-028857, SHARELIFE: CIT4-CT-2006-028812), FP7 (SHARE-PREP: GA N°211909, SHARE-LEAP: GA N°227822, SHARE M4: GA N°261982) and Horizon 2020 (SHARE-DEV3: GA N°676536, SERISS: GA N°654221) and by DG Employment, Social Affairs & Inclusion. Additional funding from the German Ministry of Education and Research, the Max Planck Society for the Advancement of Science, the U.S. National Institute on Aging (U01_AG09740-13S2, P01_AG005842, P01_AG08291, P30_AG12815, R21_AG025169, Y1-AG-4553-01, IAG_BSR06-11, OGHA_04-064, HHSN271201300071C) and from various national funding sources is gratefully acknowledged (see www.share-project.org).

Annex B. Direct and indirect cash benefit to carers

Table B.1. Direct and indirect cash benefit to carers

Country	Direct cash benefit to carer	"Formal" indirect cash benefit to carers	Income-tested	Social security coverage (health, pension, ...)	Additional information
Australia	Yes (two)	No	Yes	No	They are not specific to older people. Carer Payment: AUD 952.70 per fortnight (maximum rate). The base rate of Carer Payment is indexed twice a year based on the Consumer Price Index (CPI) and the Pensioner and Beneficiary Living Cost Index (PBLCI). Carer Allowance: AUD 131.90 per fortnight, Carer Allowance is indexed annually based on the CPI. There are also annual supplements for those eligible to Carer Payment and/or Carer Allowance
Austria	No	Yes	Yes, the caree has to earn less than EUR 2 500/month	Yes (pension, health)	24-hour care at home: other criteria include for care recipients being in need of 24-hour care and qualifying for LTC cash benefits over level 3 (or level 1 with dementia). There are two types of contracts: 1/ employment and 2/ self-employment (less social coverage). Migrants are common. Usually 2 or 3 self-employed migrants work by shift of 2 weeks/1 month.
Canada	No	No, except in Newfoundland and Labrador			
Belgium (Flanders)	Yes	No	Eligibility criteria are set at the local level	No	
Bulgaria	Yes	n.a.	n.a.	n.a.	n.a.
Croatia	Yes	No	Yes	Yes (pension, health, unemployment)	A spouse or a partner under age 65 can be formally recognised by the state as a caregiver if the care recipient needs permanent support to maintain life. The cash benefit amounted to HRK 4 000 (or EUR 530)

					in 2021 and carers can take four weeks of leave per year.
Czech Republic	No	No			
Denmark	Yes, with a contract with the municipality and restricted to end-of-life care	No	No	Yes (unemployment, pension)	Care recipients are in palliative care and are expected to die in 3-6 months. The cash benefit lasts 6 months and can be extended of 3 months. If the care recipients dies before the end of the contract, the benefit ends 14 days after the death of the care recipient. Hourly rate is EU 24 per hour or 1.5 times the sickness benefit per month.
Estonia	Yes	No	Eligibility criteria are set at the local level		
Finland	Yes, with a contract with municipalities	No	No	Yes (pension, health)	Minimum of about EUR 400 per month across Finland in case of less intensive care and otherwise about EUR 825 per month. The benefit is taxed. Carers have at least 24 days of statutory paid leave per year.
France	No	Yes, with an agreement with the care recipient	Yes (in the form of co-payment for the caree)	No	The LTC package value ranges between EUR 666 to EUR 714 per month, but there is co-payment, which depends on the severity of LTC needs and the income of the person (or the couple). Below EUR 800, the budget is fully covered, between this threshold and below EUR 2 948, the co-payment increases with income up to 90%. Above, the copyament is 90% of the care budget. On average, the consumed LTC package was EUR 550 in 2017. The cash benefit lasts two years, but is renewable without limit. Spouses are not eligible.
Germany	No	Yes, with an agreement with the care recipient	No	Yes, if has an agreement and cares for over 10 hours per week spread over at least 2 days (pension, health unemployment)	The care recipient has to have a care need grade between 2 and 5. The amount for the carer is linked to the cash benefit of the care recipient, which values depends on the grade of need: EUR 316/ 545/ 728/ 901 per month.
Greece	No	No			
Hungary	Yes, with a contract with the public authority	No	Only very specific public support is considered (so not labour income for example)	Yes (pension (10% contribution), health, unemployment)	It is not specific to older care recipient. In 2020, the monthly amount of the cash benefit ("nursing fee") varied from HUF 39 365 to HUF 70 860 (about EUR 110 to 200), depending on the LTC needs.

					Carers of people with very high LTC needs who received the benefit for more than 10 years are allowed to receive the nursing fee and the old age pension after retirement age.
Iceland (Reykjavik)	Yes (two)	No	Yes, total income when counting the cash benefit must be under ISK 595 642 per month.	Yes (health)	The care recipient has to have been medically assessed. The cash benefit is ISK 161 732 per month (EUR 1 039 per month). It lasts one year and is renewable without limit.
Ireland	Yes (three)	No	Yes (and asset tested, but not on primary residence). An income disregard of EUR 665 per week for a couple and about EUR 332 for a single person applies.	No	The cash benefits are not specific to older people. The carer cannot be employed or self-employed outside the home for more than 18.5 hours per week and must be caring for the person on a full-time basis. The cash benefit is about EUR 220/week for those aged under 66 and EUR 239/week for those aged over 66. If caring for more than one person, she receives 50% in addition. The cash benefit is taxed.
Italy	No	Yes, without agreement needed	n.a.	n.a.	The cash benefit is considered as a carer cash benefit, although it is unclear whether it is an allowance for the care recipient or the carer. The value of the cash benefit is around EUR 500 per month.
Japan	No	No			
Korea	No	No			
Lithuania	No	No			
Luxembourg	No	Yes, with the care recipient	No	Yes (pension)	Eligible if the care recipient requires at least 3.5 hours per week for ADL and if his/her dependency condition is likely to last longer than 6 months or to be irreversible. The cash benefit can be counted as a tax credit and has no time limit. Weekly flate rate (EUR) 1. 12.5 < 61 mins. 2. 37.5 between 61 and 120 mins. 3. 62.5 between 121 and 180 mins. 4. 87.5 between 181 and 240 mins. 5. 112.5 between 241 and 300 mins.

					6. 137.5 between 301 and 360 mins. 7. 162.5 between 361 and 420 mins. 8. 187.5 between 421 and 480 mins. 9. 212.5 between 481 and 540 mins. 10. 262.5 if over 541 mins.
Netherlands	Yes, with a contract with the care recipient	Yes, with a registration	No	No, but care period can be taken into account when calculating career length requirement for pension and unemployment	
Norway	Yes, two (one is restricted to end-of-life care)	No	For both benefits: the carer must have been at work for at least 4 weeks immediately before the care allowance period starts. The income corresponds to at least half of the basic amount in the National Insurance Scheme.	Yes (pension, health, unemployment)	They are not specific for carers of older people. Unlike the other Nordic EU countries, there is no contract with public authorities. The care allowance depends on the former labour income and is capped to about EUR 870 per month. As for the amount for carers providing end-of-life care, it ranged from EUR 117 to EUR 701 per month in 2020. The duration is 60 days maximum.
Poland	No	Yes	n.a.	Yes (pension)	
Portugal	Yes (pilot phase)	No	Yes (pilot phase)	No	The maximum amount is about EUR 527 per month. The benefit is the difference between this maximum amount and the equivalised income of the household (care recipient & carer). The carer has to provide permanent care.
Romania	Yes	n.a.	n.a.	n.a.	
Slovak Republic	Yes	Yes, but care recipient has to have been receiving it before age 65	Yes	n.a.	They are not specific to older people. Care recipients have to be aged over 6 years old. Relatives or co-residents are entitled to receive the direct allowance, under specific conditions. These include the number of care recipients, their age (e.g. children), the use of day care, as well as income. Those working for a low wage can keep their job: the condition is that labour income must not exceed twice the allowance. The allowance cannot be combined with more than 8 hours of formal home care per month, nor with weekly or yearly residential care. An additional allowance is available for the carers who pursue their education. In 2016, the

					basis amount was EUR 199.
Slovenia	Yes	No	n.a.	n.a.	
Spain	Yes, available with or without a contract to receive social security benefits	Yes	Yes	Yes, if has contract (pension, health, unemployment). Carers are exempted of social contributions since 2019.	The amount of the benefits depends on both the LTC needs of the care recipient and the means. The carer receives between EUR 290- EUR 388 per month to take care of older people with the most severe LTC needs (grade 3), and EUR 153 if older people have low needs. The benefit lasts two years and it is renewable without limit.
Sweden	Yes, with a contract with the municipality	Yes, with an agreement with the care recipient, restricted to end-of-life care	Eligibility criteria are set at the municipal level Yes for the end-of-life care cash benefit	Yes for the end-of-life care cash benefit (pension, health, unemployment)	The end-of-life care benefit lasts 100 days and is not renewable. The maximum amount was limited to about EUR 79 per day in 2020.
Switzerland	Yes (cash benefit is set at the local level)	Yes (cash benefit is set at the local level)	Eligibility criteria are set at the local level		
UK (England)	Yes	Yes, on exceptional ground	Yes	Yes, (pension if receives the carer allowance)	The carer's allowance flat rate is around GBP 60 per week (around EUR 280 per month).
United States	No	Yes, with a contract with Medicaid and other public programmes and care recipient.	Yes	Yes	In all state Medicaid programmes there is at least one benefit for Medicaid recipients eligible for home care that permits them to hire family members as paid helpers. Other support include some state-revenue only programmes and Veterans-Directed Care.
Number of countries	**20/33 (67%)**	**13/33 (39%)**			

Note: indirect cash benefits are considered "formal" here when the LTC system has registered the informal carer. The table excludes the situation where the carer provides cash to informal carers without any registration of the transfer of money in the LTC system. "n.a." for "not available".

Sources: OECD Policy Questionnaire 2020, (Mutual Information System on Social Protection, 2019[50]) , (Colombo et al., 2011[45]), (Zigante, 2018[51]), for Canada (Gouvernement du Canada, 2019[68]), for Norway (NAV, 2021[53]) and Eurocarers Country Profiles.

Annex C. Quantitative information on the cash benefits

143. Information on beneficiaries is also not straightforward to collect. Out of 27 surveyed OECD countries in 2020, only the Nordic European countries, Estonia and Luxembourg provided data specific to informal carers of older people. Australia and Ireland provided data on beneficiaries caring for and older people and others. Detailed information is outlined below.

Table C.1. Quantitative information on cash benefits

Country	Information
Australia	In Australia, the benefits are for informal carers of all ages, including older people. Carer Payment - There were 294 272 beneficiaries in 2020, a 15% increase since 2015. Australia spent AUD$ 6.14 billion in 2020, up from AUD$ 4.6 billion in 2015 (nominal terms). Carer Allowance – There were 619 038 beneficiaries in 2020, a 3% increase since 2015. Australia spent AUD$ 2.41 billion in 2020, up from AUD$ 2.05 billion in 2015 (nominal terms).
Denmark	In Denmark, the number of beneficiaries has increased from 2 574 carers in 2014 to 2 770 carers in 2019. Spending reached DKK 199 021 000 in 2019. This translates in about EUR 9 620 per beneficiary per year.
Estonia	In Estonia, the number of informal carers has been stable around 7 000 informal carers (of carees aged over 65) since 2014. In 2019, spending reached EUR 3 850 804, or EUR 547 per informal carer. Almost 70% of beneficiaries were women and almost 40% were aged between 40 and 59 years old.
Ireland	In Ireland, the benefits are for informal carers of carees aged over 16, including older people. Note that the benefits are taxed. *Carer allowance* – There were 87 601 beneficiaries in 2019, up from 66 017 beneficiaries in 2014. Ireland spent EUR 265.392 million in 2019 (about EUR 3 000 per beneficiary), compared with about EUR 105.102 million in 2014 (nominal terms). Women represented 77% of beneficiaries and almost half of beneficiaries were aged between 40 and 59 years old. *Carer Benefit* – There were 5 620 beneficiaries in 2019, up from 2 964 beneficiaries in 2014. Ireland spent about EUR 20.715 million in 2019 (about EUR 3 700 per beneficiary), compared with about 7 million in 2014 (nominal terms). Women represented 86% of beneficiaries and almost two-thirds of beneficiaries were aged between 40 and 59 years old. *Carers Support Grant* - There were 120 509 beneficiaries in 2019, up from 82 974 beneficiaries in 2014. Ireland spent about EUR 216.129 million in 2019 (about EUR 1 800 per beneficiary), compared with about 114.801 million in 2014 (nominal terms). Women represented 79% of beneficiaries and half of beneficiaries were aged between 40 and 59 years old.
Iceland (Reykjavik)	The number of registered informal carers has been stable since 2019 at around 120 carers, for a total expenditure of ISK 155 905 427 in 2019, compared with ISK 136 987 620 in 2014. This translates in about EUR 10 800 per carer per year.
Luxembourg	In 2017, Luxembourg spent EUR 50.2 million on the benefit to support carees who rely on registered informal carers, for an average of EUR 8 190 per year per caree with a registered informal carer. In 2018, 6 276 carees relied on registered informal carers, and among informal carers, over 40% were aged between 40 and 59 years old and 72% were women.
Sweden	The number of beneficiaries has increased from 15 620 carers to 16 347 carers between 2014 and 2019. Spending reached SKR 163 097 133 in 2019, compared with SKR 170 248 325 in 2014 (nominal terms). This translates in about EUR 10 440 per beneficiary. Note that the benefit is taxed.
Norway	The following data relate to the benefit for informal carers of carees of all ages, including older people. The number of beneficiaries decreased from 76 822 to 61 423 beneficiaries between 2014 and 2019. Spending reached NOK 1 555 000 000 in 2019, compared with NOK 1 680 000 000 in 2014 (nominal terms). This translates in about EUR 2 570 per beneficiary. The following data relate to the benefit for informal carers of carees receiving end-of-life care. The number of beneficiaries increased slightly from 1 054 to 1 167 beneficiaries between 2014 and 2019. Spending reached NOK 32.3 million in 2019, compared with 26.2 million in 2014 (nominal terms). This translates in about EUR

	2 810 per beneficiary.

Note: Eurostat Database for annual exchange rates.
Source: 2020 OECD questionnaire on informal carers.

Annex D. Information on social security coverage

144. Among surveyed OECD countries with available data, about 70% of countries offered some kind of social security coverage tied to a cash benefit (see Anex B). Social security coverage is tied to specific conditions (see below table for examples).

Table D.1. Access conditions to social security coverage varies widely across countries

Country	Description
Austria	If the carer is employed, they are entitled to a pension scheme, health insurance and public unemployment insurance. There are two types of contract for stand-in informal carers (employed and self-employed). Self-employment is more common.
Finland	An earning-related pension accrues from the care allowance. Carers are also entitled to public unemployment insurance.
Hungary	10 % pension contribution. In addition, the period during which the cash benefit is paid is included in the insured person's service time in the PAYG pension scheme. Private or supplementary pension schemes do not provide it. Carers are also entitled to public unemployment insurance and health insurance.
Italy	No social security coverage. However, the 2017 law on informal carers recognises the possibility of earlier retirement for carers in paid employment (63 years of age and 30 years of contributions), only if cohabiting with the care recipient.
Poland	Special attendance allowance (Specjalny zasiłek opiekuńczy): The Polish Social Insurance Institution contributes to pension insurance. Carers are entitled to health insurance and public unemployment insurance. Care benefit (Świadczenie pielęgnacyjne): municipalities, districts or social assistance institutions pay contributions for pension insurance, unless carers are entitled to other pension insurance, under specific conditions.
Lithuania	Lithuania has recently improved the social protection of caregivers, under specific conditions. Since 2020, Lithuania has covered the pension and the unemployment social insurance of caregivers of people with a special need for permanent care (or assistance). Parents or guardians caring for disabled relatives are covered by the state for pension and unemployment social insurance if they have no insured income or if their income is below the minimum monthly salary, have not reached retirement age and do not receive their own social insurance pensions, excluding social security widows' pensions, state pensions, social assistance pensions, social pensions or home care pensions for the disabled.
Luxembourg	The LTC insurance covers the pension contributions of informal carers.
Spain	Since April 2019, Spain has allowed carers to register to the social security with exemptions of contributions (pension, health and unemployment). These exemptions have boosted the registered number of carers, of which 89% are women.
Germany	Carers receive social security benefits if they care for at least ten hours a week, spread over at least two days a week. The LTC fund contributes to the pension and provides health insurance. The overall value of the pension credit depends on care provision. Those who worked before the care period can continue to pay contributions for unemployment.
Sweden	The Swedish social insurance gives carers a compensation in the public pension scheme. The right to access public health care and unemployment benefits in Sweden is not affected by the registration as an informal carer.
United States	Payroll taxes apply and provide for Social Security pension coverage, Medicare, and unemployment compensation.

Note: Social security coverage is tied to a cash benefit in all these countries.
Source: 2020 OECD Questionnaire on informal carers and for Lithuania (Ministry of Social Security and Labor of the Republic of Lithuania, 2021[59]).

Annex E. Paid and unpaid leaves for informal carers

Table 6.2. Paid leave for informal carers

Country	For terminally-ill relative	Paid leave	Eligibility criteria	Payment conditions
Australia	No	No (an employee can take paid carer leave to care for or support a member of their immediate family or household who is sick, injured or has an unexpected emergency. But sick and carer leave comes under the same leave entitlement (10 days per year for full-time employees))		
Austria	No	Paid leave for **one week** per year	Care for sick children or dependent family members	100% of previous labour earnings
	No	Care leave benefit (Pflegekarenz) can be paid for up to **six months** per family member in need of care (if at least two close family members take care leave or part-time leave for caregivers). If the care grade is increased, a new care leave or part-time care leave agreement can be made one time only for the same relative for up to a maximum of 12 months. Wages are reduced at the prorated payment if the carer keeps working (a minimum of 10 hours per week). The employer has no legal obligation to grant the leaves in general. However, there is an entitlement to care leave in companies with more than five employees.	Care for family member. Entitlement in companies with more than five employees. Income-tested. Cannot be combined with unemployment benefit or unemployment assistance.	Paid at the same level as unemployment benefit (55% of the daily net income). Beneficiaries receive the full coverage of health and old-age insurance.
Belgium	Yes	Palliative care leave to take care of a parent in terminal illness up **to two months** (one month extendable). May be granted full-time of part-time.	For anyone who needs help (can be friends or neighbours). A doctor should provide evidence that the care needs will be provided by the employee and that the person is in terminal illness.	State compensation (Office National de l'Emploi): EUR 741 per month (proportional amount in case of part-time leave)
	No	Medical assistance leave: Up to **12 months** which can be taken in several periods, from one month up to three months per disabled. May be granted full-time of part-time	Family member (2nd degree) or co-residential relative needing assistance. Doctors should provide evidence on the need of constant care. If the company has fewer than 10 employees, the employer can deny leave on business and organisational grounds. The employee is protected from being fired during the whole period and up to three months after the end of the leave.	State compensation: EUR 741 per month
	Both	Time credit (part-time or full-time career break) for employees in the private sector. **One year to up to five years leave** full or part-time during the whole career. Can be taken in periods from three months to one year at a time.	Palliative care of care for a sick family member	The state compensation (gross) for full-time Time Credit is EUR 520/month when having less than 5 years seniority and EUR 607 /month with 5 years or more seniority.
Bulgaria	No	No		

Canada[9]	Yes	Employment Insurance (EI) caregiving benefits provide financial assistance to care for or support a critically ill or injured person **up to 15 weeks** or someone needing end-of-life care **up to 26 weeks**.	A family member (or someone considered as a family member by the caree) can receive the benefits during the 52 weeks following the date the care recipient is certified by a medical doctor or nurse practitioner to be critically ill or injured or in need of end-of-life care. Weeks of benefits can be taken either all at once or in separate periods.	The carer receives 55% of earnings, up to a maximum of EUR 595 a week.
Croatia	No	No		
Cyprus	No	No		
Czech Republic	No	Yes, since June 2018, the carer, whether employed or self-employed, is compensated for up to **90 days**.	Family member or household member discharged from the hospital after at least a 7-day hospitalisation and requiring at least 30 days of further care (maximum 90 days). The entitlement is subject to the approval of a physician. The employee providing care must have been insured at least 90 days in the 4 months immediately preceding the need for care. Self-employed persons must have at least 3 months of coverage immediately preceding the need for care to be eligible for the benefit. The care recipient has to sign a written consent.	An insured carer family or household member receives 60% of the assessment base.
Denmark	Yes	Employees have the statutory right to leave for the care of someone terminally ill, according to the Act on Leave from work due to Special Family reasons (2006). There is **no fixed time limit** for the leave. Municipalities can also pay maintenance fees when expenses are very high	The dependent can be a spouse, cohabitant or parents terminally ill. Proof that the care recipient has two to six months to live is required.	The minimum amount is 82% of sick pay ceiling (and up to 1.5 times the sick pay if there is more than one dependent).
Estonia	No	The Care benefit (hooldushüvitis) is paid to an insured person if caring for a family member who is sick at home. The duration of the benefit **is up to 7 days per relative**.	The dependant must be a family member. The care benefit cannot be cumulated with labour earnings during the care period.	The benefit is paid by the Estonian Health Insurance Fund from the first day of exemption from work, and is 80% of the previous labour income.
Finland	No	Legislated right: job alternation leave is available for **100 days, up to 180 days** (6 months) but company-specific – or collective agreements may differ. This leave is not tied to acting as an informal carer.	The person should have been working for at least 12 months prior to the claim (and have at least ten years of experience).	Compensation of 70% of the daily unemployment allowance (80% if more than 25 years work history) paid by the state through the unemployment funds and the Social Insurance Institution
France	Yes	Since 2 March 2010 Law, family members and co-residents are eligible to paid leave of **three months** (renewable once)	Care of a first-degree family member or co-residential member terminally ill. The employee should make a claim two weeks prior to the leave and the employer cannot deny the leave	A daily compensation will be paid to the carer up to 66 days.
	No	Family support leave (Congé de soutien familial) for **three months, renewable once**, with job guarantee, to take care of a dependent family member	Care of a dependent relative – the employee must have at least two years' experience and the person needs to have a permanent disability of 80% on the disability scale or a GIR 1 to 3.	With agreement from the employer, the Family solidarity leave can turn into reduced working hours. Daily compensation rate varies from 43.83 € for someone living with a partner to

[9] Caregiving benefits provide financial assistance and can be used in combination with unpaid leaves (compassionate care leave, leave related to critical illness).

				52.08€ for someone living alone. An employee can be compensated for up to 22 days per month.
Germany	No	Employed people who provide LTC support to a relative and who need time to organise an acute care emergency of a close relative can take **up to ten days** per person in need of care.		In 2017, The LTCI provided EUR 400 per carer on average.
Greece	No	No		
Hungary	No	No		
Ireland	No	Leave is for a maximum of **104 weeks** and can be taken in one period or several (with 13 weeks minimum each time). The employee is protected by the Carer's Leave Act of 2001. Employer may refuse "on reasonable grounds".	Carer must: • be living with the person being cared for care for or be in a position to provide full-time care and attention if not living with the person • be caring for the person on a full-time basis • not be employed or self-employed outside the home for more than 18.5 hours per week • The maximum net labour income a person is EUR 332.50 per week. Person being cared for must: • be so incapacitated as to require full-time care and attention, which should likely last 12 months. • If under age 16, must be a person in respect of whom a Domiciliary Care Allowance is paid.	EUR 220.50/week for those aged under 66 and EUR 239/week for those aged over 66. If caring for more than one person, the carer receives an additional 50%.
Italy	No	No		
Japan	No	If certain conditions are met, such as being insured by employment insurance, the Family care leave ("Kaigo Kyugyou Kyufukin") is paid **up to 93 days**. The leave can be taken separately up to three times for one care recipient and it is not renewable.	Family members include spouses and partners, parents, parents of the spouse and children, grandparents, siblings and grandchildren. The employee must have worked 12 months in the last two years.	If the employer pays 80% or more of the wage, Japan does not provide financial support. Otherwise, Japan adjusts to cover 80% of the wage.
Korea	No	No		
Latvia	No	No		
Lithuania	No	No		
Luxembourg	Yes	End-of a life leave for **five working days** at time and per year (can be taken in several periods or as reduced working hours)	When a first or second degree family member (spouse, parent or children) is terminally ill	The leave days are paid by the sickness fund (Caisse Nationale de Santé) in charge of the employee
Malta	No	No		
Netherlands	No	Paid leave **up to ten days**. Employers can refuse to grant leave on serious business ground.	Care of a sick relative	Paid at 70% of the earning by the employer
Norway	No	Nursing care leave for periods **up to 20 days**, plus Care leave paid **up to ten days.**	n.a.	Both schemes are paid at full wage

Poland	No	Paid leave set at national level. Duration – **max. 60 days** per year	n.a.	80% of the wage
Portugal	No	No		
Romania	No	No		
Slovak Republic	No	No		
Slovenia	No	Leave for a sick co-resident family member: **Up to seven days**. For severe illness can be extended to 30 days (**up to six months** in extreme cases).	Co-resident family member should be a child or a spouse. Need to be a subscriber to have compensation.	Paid at 80% of the average wage of the preceding 12 months.
Spain	No	Care for a sick child or other serious family reason: **Two days** for the private sector (extended to three if involves traveling) and three for the central state public sector (five if traveling)		Paid by the employer.
Sweden	Yes	Leave for terminal care for **100 days.** Paid leave set at national level.	A relative in terminal care; refers only to working age people - up to 67 years. Have to prove terminal illness with e.g. a doctor's certification.	On average, paid at 80% of the wage.
Switzerland	No	Care available for up to 3 days by case and it cannot be over 10 days per year. 2019 law enforced in 2021.		
United Kingdom	No	No		
United States	No	No, not at the national level. But 5 states have paid family leave (CA, NJ, RI, NY, and D.C). These programs are state-specific and differ in various ways.		

Source: (Colombo et al., 2011[45]), OECD Policy Questionnaire 2020, (Australian Government, 2021[64]), for Korea (Replicon, 2021[69]).

Table 6.3. Unpaid leave for informal carers

Country	Unpaid leave	Eligibility criteria	Additional benefits
Australia	No		
Austria	Federal Act Governing Family Hospice Leave in 2002 provides flexible work arrangements or unpaid leave to care for terminally ill relatives **up to six months.**	For terminally ill relatives (up to six months) and for seriously ill children (up to nine months). Spouses, partners, parents, children, grandparents, grandchildren, adopted and foster relatives and brothers and sisters and children of the spouse/partner.	Beneficiaries receive the full coverage of health and old-age insurance. Wages are reduced at the prorated payment if the carer keeps working.
Belgium	Emergency leave of **ten days** per year (private sector) or **45 working days** per year (public sector)	All unforeseen circumstances that require the urgent intervention of the worker. This includes illness, accident or hospitalisation of a person residing in the same house or a first degree family member.	There is no social security coverage associated.
Bulgaria	No		
Canada	**Compassionate** care leave up to **28 weeks within a 52-week period** to look after a family member who has a serious medical condition with a significant risk of death. The leave can be shared between family members. Provinces and territories may also have provisions for unpaid caregiver leave (e.g. Ontario).	A health care practitioner must sign a medical certificate. Unpaid leave is for employees working in federally regulated industries and workplaces. Restricted to family members.	n.a.

Croatia	No		
Cyprus	No		
Czech Republic	No		
Denmark	Relies on collective agreements		
Estonia	No		
Finland	Relies on collective agreements		
France	No		
Germany	Leave is possible up to **six months**	Restricted to family members (until the second degree). The employer can refuse on business grounds if employs less than 15 employees	The care leave can also be claimed for part-time work for up to 24 months.
	Emergency leave for medical reasons is also possible **up to ten days**	Restricted to family members (until the second degree). Emergencies include severe illness, accident or terminal illness. The employer cannot deny the right to the employee	n.a.
Greece	No		
Hungary	Unpaid leave for a **maximum of two years**	Upon the employee's request for care of a dependent relative	n.a.
Ireland	No		
Italy	No		
Japan	Yes	Days off for caregiving: a worker may take up to five days per year, or up to ten days per year when there are two or more care recipients, in order to take care of his/her family member in a condition that requires caregiving. Eligible families are: i) carer's spouse (including those in de facto marital relationship), parents, children, and parents of the spouse. ii) carer's grandparents, siblings and grandchildren	n.a.
Korea	The period of family care leave is **90 days a year**. Employees can use up to 10 days each year on a single-day basis. An employer can only refuse an employee's request to go on family-care leave or request a change in the leave period on a restricted basis (in other words, if asking more than 10 days of leave).	Leave for employees working in companies with at least 30 employees. In case of national emergency, employees can take up to 20 days on a single-day basis. Five more days are granted for single parents and underprivileged families.	n.a.
Latvia	No		
Lithuania	No		
Luxembourg	Unpaid leave for family care of **six months, up to 2 years**. Relies only on collective agreements.	Should be documented by the employee (proof with a doctor's certificate). The dependent care recipient should be a first degree family (parents or spouse).	Pension contributions guaranteed by insurance
Malta	No		
Netherlands	Legislation at the national level: minimum standard set in the long-term care leave: An employee may take a maximum of half the number of hours that she works as care leave for a period of **twelve weeks**, in one or several periods	Care of a sick first-degree relative, whose life is threatened in the short term. The employer can deny the leave on serious business grounds.	n.a.

Norway	No		
Poland	No		
Portugal	No		
Romania	No		
Slovak Republic	No	No	
Slovenia	No		
Spain	Long-term leave for a dependent: **Up to two years** (extreme cases: **three years**)		Pension credits granted by the state
Sweden	No		
Switzerland	Depending on the sector/company. Set at national levels, by employers or through collective agreements	n.a.	n.a.
United Kingdom	Emergency leave. The length of the leave should be "reasonable" – i.e. **two days**	Only for family members.	n.a.
United States	No		

Source: (Colombo et al., 2011[45]), OECD Policy Questionnaire 2020, (Gouvernement du Canada, 2021[70]), for Korea (Replicon, 2021[69]).

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