Help Wanted?
Providing and Paying for Long-Term Care
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Chapter 4

Policies to Support Family Carers

In most countries, family carers and friends supply the bulk of caring, and the estimated economic value exceeds by far expenditure on formal care. A continuation of caring roles will be essential given future demographic and cost pressures facing long-term care (LTC) systems across the OECD. This is also what care recipients themselves prefer. Continuing to seek ways to support and maintain the supply of family care appears therefore a potentially win-win-win approach: For the care recipient; for the carers; and for public systems. This chapter provides an overview and an assessment of the current set of policies targeted to family carers, in relation to three main aspects: Caring and the labour market, carers' wellbeing, and financial recognition to carers. The effectiveness of policies in helping carers combine care with paid work, in reducing burnout and stress of carers, and in recognising the additional costs associated with caring will then be discussed.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

4.1. Improving carers' role and wellbeing

Countries have implemented a number of policies that directly or indirectly target family carers.[1] Yet, some carers still struggle to combine their caring role with work and often suffer from mental health problems, suggesting that policies to support carers could be improved. OECD countries differ in the extent to which they do so, and in the set of measures targeted to carers, for example in terms of cash and in-kind services (*e.g.* respite care), as well as initiatives to reconcile work and care (*e.g.* flexible work arrangements).

4.2. Helping carers combine caring responsibilities with paid work

Caregiving is associated with a significant reduction in employment and hours of work, especially for individuals providing a high intensity of care (Chapter 3). Other studies have confirmed that, in addition to lower labour force participation, informal caring leads to absenteeism, irregular attendance (coming late and having to leave work) and lack of concentration at work (Gautun and Hagen, 2007). Policies which reduce the dual pressure from work and care for employed caregivers might improve their employability, making caring a viable option for more potential carers. The following section discusses current policies to facilitate the employment of carers and how they could be improved.

Leave from work

While many OECD countries recognise the important role of family carers and incorporate the principles of helping them balance work and caring, this is not always translated into services in practice. Two-thirds of the OECD countries for which information is available have leave for carers, although conditions for leave tend to be limited and paid leave is restricted to slightly less than half of the countries (see Annex 4.A1 and Annex 4.A2 for a detailed description of care leave for each country). In contrast, parental leave to care for children – albeit different in nature and content – is widely available and is paid in three-quarters of OECD countries, although often at low rates (OECD, 2007). Studies on the use of parental leave found positive effects on working hours and the labour force participation of women for short-term leave (Spiess and Wrohlich, 2006). While the literature on care leave is less extensive, some longitudinal studies have found that family leave and access to flexible hours has a positive effect on the likelihood of employment retention for women, although the overall effect on employment is uncertain as it might reduce job possibilities for those caring but not at work (Pavalko and Henderson, 2006).

In three-quarters of the countries where it is available, paid care leave is limited to less than one month or to terminal illness. Belgium provides the longest publicly paid leave, for a maximum of 12 months, which employers may refuse only on serious business grounds. In Japan, paid leave is also fairly long, since carers can take leaves up to 93 days with 40% of wage paid through the employment insurance if the company does not compensate during the leave. In terms of remuneration, Scandinavian countries tend to pay the most. For instance, in Norway and Sweden paid leave is equivalent to 100% and 80% of the wage

respectively. In Denmark, in exchange for employers continuing to pay full wages during care leave, municipalities reimburse a minimum equivalent to 82% of the sick benefit ceiling.

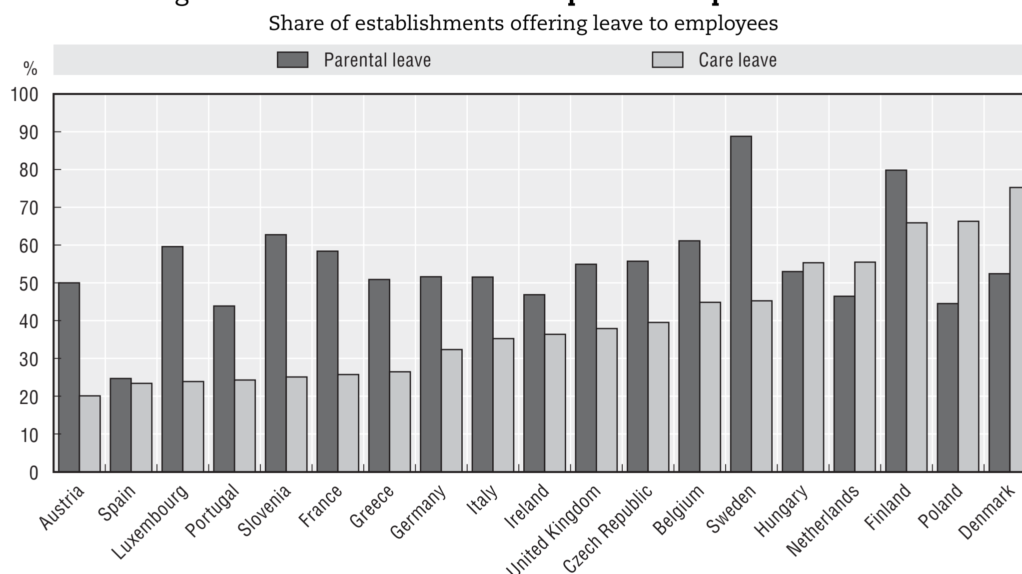
In the case of unpaid leave, there is a geographical divide. A group of countries provides long leave of one or more years (*e.g.* Belgium, France, Spain and Ireland). While being relatively long, unpaid leave is not a statutory right for workers in Ireland and Spain and may be refused by employers on business grounds. In the case of France, while employers may not oppose the leave, eligibility criteria remain strict: leave is only available to care for a relative with an 80% autonomy loss. A second group provides relatively short leave of up to three months[2] (*e.g.* English-speaking countries and the Netherlands), with a couple of countries providing medium-term leave of six months (Austria, Germany). In Austria the availability of unpaid leave is limited to care for terminally ill relatives.

The use of leave for long-term care might be even more limited in practice because employees fear that it will have an impact on career and household income. In this respect, the use of statutory rights to care leave might be influenced by the intensity of caring obligations and the generosity of leave compensation. Caregivers with less intensive obligations might prefer to use holidays or sick leave, particularly if workers fear that a request for care leave might endanger career opportunities. It is to be expected that the lower the compensation rate, the lower the take up for such care leave will be. Loss of income during care leave is often cited as a reason for preferring to use annual paid leave or sick leave since workers receive full salary during holidays and many countries have generous replacement rates during sickness (Ikeda *et al.*, 2006). On the other hand, for those caring for their partner, providing more hours of care might be more prone to ask for statutory care leave, even if it is unpaid.

Data on leave use are difficult to obtain but a representative survey of companies in European countries contains information on companies providing leave for long-term care purposes (Establishment Survey on Working Time and Work-Life Balance) (Figure 4.1). Roughly 37% of European companies declare that long-term leave is available for employees to care for an ill family member, whereas nearly all establishments offer

Figure 4.1. **Care leave is less frequent than parental leave**

Share of establishments offering leave to employees



Source: European Establishment Survey on Working Time and Work-Life Balance, 2004.

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parental leave and in 51% of the establishments employees have taken parental leave in the previous three years. A greater portion of companies offer care leave to their employees in Scandinavian countries and in Poland (60% on average) and a much smaller fraction is found in Southern Europe (around 25%). Similar data from Canada (from the Federal Jurisdiction Workplace Survey 2008) show that approximately 20% of all companies under federal jurisdiction provide annual paid family-related and/or personal leave. This is comparable to data from Japan (Tokyo prefecture only) showing that 10.7% of the companies have one or more persons who took long-term care leave while in contrasts 90.9% of women who gave birth took parental leave (Tokyo Metropolitan Government Bureau of Industrial and Labour Affairs, 2008).

Use of care leave depends heavily on the sector of work and disparities among workers are likely in the absence of statutory rights. Long-term leave to care for an elder or sick relative is most often found in the public sector and/or in larger companies.[3] In terms of firm characteristics, more establishments grant care leave in companies with a higher proportion of female employees, where there are more skilled workers, and care leave is more likely in the service sector than in manufacture. All of these categories of workplaces are most likely to provide child-related provisions, too (OECD, 2007).

Flexible work schedule

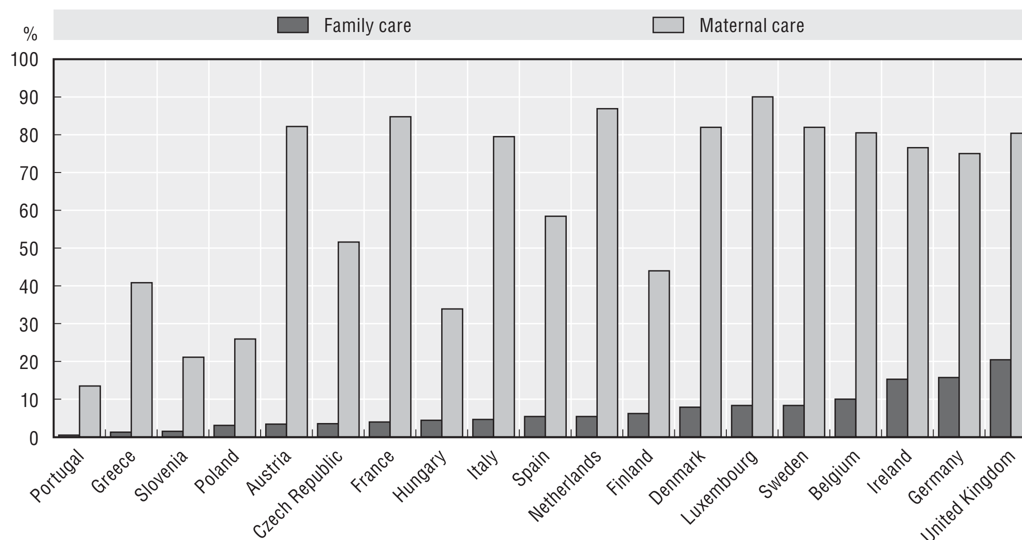
In addition to leave from work, flexible working hours may help carers to remain in the labour force and accommodate care needs. Chapter 3 confirmed that flexible working hours lowered the chances of reduced hours of work for carers in Australia and the United Kingdom. A similar study from the United 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). Flexible work schemes may offer good solutions to balance care obligations and work by providing carers sufficient income and a social network through work.

While almost two-thirds of firms report some use of part-time work,[4] its use to facilitate care for the elderly or sick remains limited. As it was the case with leave provisions, part-time is less often used for long-term care than for taking care of children. About two thirds of the sample of European establishments has female employees using part-time work for children (Figure 4.2). While the use of part-time work by fathers is more limited (21%), it is still more than double the proportion of employees caring for elderly or sick people (9%). The incidence of part-time work for care reasons varies greatly across European countries and is not always related to the overall use of part-time work. On the one hand, some countries show a relation: only 1% of companies report having part-time employees for care reasons in Greece and only 16% of firms have part-timers, while the respective proportions are as high as 18 and 76% in the United Kingdom. On the other hand, the Netherlands has one of the greatest proportion of companies reporting some part-time work (89%) but only a modest use for care of elderly/disabled (less than 5%). There are also differences across sectors (Figure 4.3).

More widespread provisions for full-time parents to request part-time work than for carers of frail elderly help to explain the limited use of part-time for care reasons relative to childcare. While in eight out of ten OECD countries for which information is available, parents are entitled to part-time work, statutory rights to work part-time for non-parents exist in half of the these countries (two-thirds if collective or sectoral agreements are taken

Figure 4.2. **More mothers than family carers among part-time workers**

Share of establishments reporting mothers and family cares among part-timers



Source: European Establishment Survey on Working Time and Work-Life Balance, 2004.

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into account). In addition, conditions for employers to refuse the request are often stricter for parental leave than for care leave. These provisions need to be interpreted in light of evidence that part-time work promotes higher labour force participation (OECD, 2010).

Significant variation is also found in the length of part-time work which may be requested for care reasons and the possibility to revert to full-time hours. Slightly less than half of the 14 countries where the right to part-time work for care reasons exists have also an automatic right to revert to full-time hours. In practice, according to the European Working Time Survey, there is virtually no chance for a part-timer to move to a comparable full-time job in the same establishment in eastern European countries and Portugal. In many countries, no limit is mentioned on the duration of the part-time, while in Japan the total of reduced working hours and days of family care leave is 93 days or over, and in the United States it is set at 12 weeks. Germany provides a slightly longer duration (six months) and New Zealand limits the amount of the reduction in hours per week.

Which care leave for the future?

As in the case of parental leave, it is difficult to define the appropriate duration for care leave since a long leave may damage labour market position while a short leave might not be enough and force workers to resign from their job. However, unlike the care of young children which requires more intensive care at a younger age, care for ill or disabled relatives is unpredictable in duration and intensity over time. Workers might benefit from flexibility in the possibility of fractioning leave over several occurrences. Ideally, care leave should take into account the episodic nature of illnesses, deterioration or improvement in health condition or changes in the availability of formal care. Using leave on a part-time basis or returning to work part-time might also be helpful to accommodate the changing needs of carers and frail or disabled people. Other forms of flexible work might be more suitable for carers who need to vary their hours week-by-week or who do not want to cut down on their working hours but want to work flexibly.

Figure 4.3. **Care leave and part-time work is more likely in certain sectors**

Share of establishments reporting offering care leave or part-time work for care

Panel A. **By proportion of women in the company**

Panel B. **By proportion of skilled workers**

Low (< 20) Medium (20-80) High (> 80)

Panel C. **By type of sector**

Public sector Private sector

Panel D. **By type of activity**

Manufacture Services

Panel E. **By size of company (number of employees)**

Small (< 20) Medium (20-99) Large (> 100)

Source: European Establishment Survey on Working Time and Work-Life Balance, 2004.

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At the same time, care leave, particularly paid leave, could become a pre-retirement option. While parents take parental leave at the beginning or through mid-career, most carers tend to be older than 45 or 50 years. Long paid care leaves, particularly if they offer high replacement rates and if workers are guaranteed pension and unemployment contributions, create a risk of early retirement. This has occurred with the "*Crédit temps*" or

"Time Credit" in Belgium, which can be taken as a full or partial reduction in working time up to a maximum of one to five years.

Care leave is sometimes limited to caring for those with a terminal illness. Obviously, much care is needed also for people with non-terminal diseases. A wider definition of care leave may be desirable but moral hazard could emerge. First, while a parent-child relation and the needs for child care are relatively clear-cut, it remains difficult for policy makers to identify who are the long-term carers and which level of caring commitment should trigger an entitlement to care leave. To prevent such problems, entitlements are defined in terms of the relationship to the dependent person, but since a person might have several carers, the problem of how many carers per person should benefit from leave arrangements emerge. Such provisions are already present in the case of care allowances *(e.g.,* in Ireland). Belgium is considering the introduction of a tax and social statute for carers as a way to identify carers and to provide them with legal rights (Box 4.1). Second, additional difficulties arise with respect to decisions about what care needs justify a care leave and the setting of eligibility conditions that are neither too restrictive (*e.g.* terminal illness, 80% dependency as in France) nor too loose so that any relative may claim to be a full-time carer. Given the fact that most carers are involved in low-intensity caregiving (Chapter 3), this raises the issue of what care efforts justify entitlements to a care leave. The use of care assessment systems already in place to determine eligibility to publicly funded LTC benefits may need to be extended also to dependent people that rely on care by family and friends.

Box 4.1. **A statute for informal family carer: The case of Belgium?**

Since 2008, Belgium has been researching the possibility of a legal recognition of informal carers. Such legal recognition implies a legal definition of carers, as well as a certificate for a limited duration together with rights and obligations for carers. Goals of the legal recognition include measures to maintain the social entitlement of carers, the creation of mechanisms in labour law for increased flexibility, the granting of tax advantages and to solve problems of civil and criminal liability. Through the statute, time spend in caring for family members will be considered as time at work and carers will be entitled to social security rights and their acquired skills will be more easily recognised. The identification of carers will help in targeting support measures towards them. On the other hand, the legal recognition stumbles upon the difficulty of identifying what should be in the procedure. In particular, criteria need to be set in terms of the dependency level of the care-recipient and on the identification of carers in terms of the charge of care and its duration.

4.3. Improving carers' physical and mental wellbeing

Chapter 3 has shown that caregivers are more likely to experience worse mental health because of their strenuous duties. Policies relieving stress from carers are thus of prime importance, particularly in the context of carers themselves becoming older and possibly frailer. This section discusses the advantages and challenges of three types of policies supporting carers' well-being: Respite care, counselling services and co-ordination of help.

Respite care

Respite care is often perceived as the most important and common form of support to alleviate caregiving burden and stress. Respite care can provide carers a break from normal caring duties for a short period or a longer time (see Box 4.2). Without respite, caregivers

Box 4.2. **What is meant by respite care?**

Respite care may refer to very different types of interventions providing temporary ease from the burden of care. Often, the objective of such breaks is to increase or restore the caregiver's ability to bear this load (Van Exel *et al.*, 2006). The most common forms of respite care include:

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

An important element of respite care definition is the length of respite. Some of the services offer short stays (such as day-care services) and others consider longer periods of time (vacation breaks for carers, emergency care etc.). Both duration and frequency of respite breaks (everyday or every week) are relevant when assessing the importance for the carer and the care recipient. Some countries offer more diversified "packages" of support (combining both short and long-term breaks) in order to better meet the needs of the caregiver. The provision of respite breaks can be provided in various settings, such as community care or institutions, and by various actors, such as family and friends, and nurses.

may face serious health and social risks due to the stress associated with continuous caregiving, and may also enjoy little time for leisure or feel isolated. Carers are often reluctant to take such breaks because of uncertainties about the quality of respite care and financial difficulties. Policies ensuring ease of access to respite, for example via financial support to pay for such breaks, geographical proximity and sufficient availability of respite services, are thus important.

Policies for carers in almost all OECD countries include respite care, although legal entitlement to respite services varies widely. In Ireland, an annual grant for respite care can be used throughout the year, while in Austria a specific allowance is available to pay for respite care for up to four weeks. In Germany, the insurance system includes provisions for financing respite care of up to four weeks. In Luxembourg, the long-term care insurance includes additional funding for a three-week respite care. The new Act on Family Caregiving 2006 in Finland grants at least three days respite a month for carers who care on a continuous basis. (The Finnish Ministry of Health and Social Affairs is currently preparing a National Development Plan on Informal Care Support). In many other countries, respite care is seen as a service but there is no specific right to carers to receive such services, or no direct reference to the number of days carers are entitled to.

Direct public provision and financing of respite care is uneven across countries and respite care remains scarce. In most OECD countries, short-term respite care is financed directly by families, although some subsidies exist for those with limited resources. In Austria, Finland and Hungary, in-home respite care is not publicly financed and users need to pay full costs. In certain countries such as Canada, for instance, financial incentives in the form of tax credits for families paying for respite care services are available.[5] On the other hand, in Denmark the municipal council is obliged to offer substitute or respite care services to those caring for a relative and respite services are fully publicly funded. There is also an under-supply of respite services in some OECD countries. For instance, residential respite care services in France and Switzerland have waiting lists as respite is offered only when LTC beds are unoccupied. In addition, charges for respite care in France

often exceed the value of the universal cash benefit allowance. In many countries, such as Japan, northern European countries, Spain or the United Kingdom, municipalities are in charge of organising respite care particularly in the case of day-care and in-home respite, which leads to large local disparities in access and availability.

Respite care results in satisfactory outcomes for carers but it is not cost-effective for all forms of service provision. Assessment of the effectiveness of respite is complex because of the multiple dimensions of impact on informal caregiving (mental and physical health, satisfaction or admission in institutions), but recent evaluations show that carers highly value such services (Pickard, 2004; Zank and Schacke, 2002; Van Exel, 2007). Unfortunately, this does not systematically translate into better mental health outcomes for carers. In particular, the evidence on the effectiveness of *day care* in improving the psychological health of carers is mixed, and there is little evidence to draw a conclusion on the effectiveness of in-home respite care. The impact may be higher for high-intensity carers and day care appears to be more effective for carers in paid-employment and where the person cared for has cognitive problems (Davies and Fernandez, 2000). Overnight respite care has proven to be effective at reducing the subjectively reported burden of carers, but it might hasten the institutionalisation of the dependent person (Pickard, 2004). Mixed forms of respite care, including a combination of the above-mentioned types of respite, also showed contradictory results in the United States but these might be driven by low take-up of services.

Well-planned, flexible respite care services may improve carer's outcomes and alleviate barriers to accessing respite services. Yet evidence on the positive effect of respite care on carers remains scant, limiting possible recommendations on the most appropriate form of delivery of respite. In that respect, a range of services is probably most appropriate, to provide flexibility of respite provision and responsiveness to carer and care recipient characteristics and needs, and also changes in those needs over time. More tailoring of respite to the needs of carers instead of fixed hours and days is cited as a suitable option (Pickard, 2004). Mixed forms which include in-home care on demand and drop-in services combined with more traditional forms of respite also appear to be useful for carers (see Box 4.3). As some users of adult day services spend a considerable amount of time in travelling and preparations, combining respite care with services for planning and transportation of the dependents is likely to alleviate the burden of carers.

Counselling and training services

According to surveys, carers would welcome more psychological counselling and information from health professionals (Van Exel *et al.*, 2002). For instance, carers are not always knowledgeable about the disease of the person they care for or have difficulties dealing with disabilities. Counselling has been found to be effective at relieving carer's stress (Pickard, 2004).

Most social support and training is typically provided through local initiatives and relies heavily on the voluntary sector. Many local community organisations and NGOs offer social support and counselling programmes, making them often more widely available to carers than respite services but are often provided in informal settings or as a crisis response. Informal counselling is often provided through support groups which have developed at the local level to provide a listening ear and a forum to exchange experiences. However, evidence on their effectiveness in terms of mental health outcomes of carers is inconclusive.

Box 4.3. **An integrated respite and support system to carers in Sweden**

Sweden has supported family carers through mixed projects involving public entities (such as medical staff in institutions), private actors, local communities, NGOs and families and friends. These projects encompass counseling, training and also respite care.

Respite care, especially in-home respite care, has become very popular in recent years. Municipalities offer family carers in-home respite care during the day free of charge. Almost all 290 municipalities offer such services across the country. Other forms of respite care are also available, such as "24h instant-relief" (or drop-in services) or weekend breaks. Municipalities offer stays at spa-hotels and arrange for care of the care recipient for one or two days. Mixed strategies combining different forms of respite are complementary to relieve carer's stress.

In addition to respite services, public authorities have encouraged communication between socio-medical staff and carers. Collaboration with carers is prone to create more "carer-friendly institutions". Counseling programmes are also seen as a supportive service offered in the core package for family carers. These programmes are both run by voluntary organisations as well as public services, such as help-line services, and are moving towards further integration.

Source: Johansson (2004).

Some country initiatives are promoting a more comprehensive and integrated counselling system. Sweden has promoted a better space for dialogue between the socio-medical sector and the families and friends of disabled. "Caring for Carers" in Ireland developed a comprehensive network of support institutions for carers, which offer 13 skills training courses called "Caring in the Home". The Netherlands uses a preventive counselling and support approach (the POM-method or *Preventieve Ondersteuning Matelzorgers*). Once enrolled in national care plans, individuals are contacted by trained social workers who carry out house visits. These workers provide carers with information and follow-up phone interviews on a three-month basis to prevent the occurrence of mental health problems among carers, especially at the early stages of caregiving. In the United States, the National Family Caregiver Support Programme includes support groups and individual counselling, workshops and group work.

Information and co-ordination services

Carers may not be fully aware of services available to them and may find it difficult to get help from fragmented services. Eligibility criteria for allowance or tax benefits and credits can be confusing and carers may require help from other family carers or social workers. Internet websites and other discussion boards provide useful information to the carer, though they are often left alone to tackle administrative issues. Daily planning of different tasks and duties may be difficult for carers and can cause burnout. Doctor's appointments, organisation of respite care breaks or social workers appointments may be difficult to co-ordinate, especially when combined with personal or familial duties and employment.

One-stop shops for carers and their families can better inform and help carers. Such information centres help carers be in touch with others having similar experiences and acquire information on sources of help (financial, physical, emotional and social), and on the care recipient's illness or disability. For instance, in France, the Local Centres of Information and Co-ordination (CLIC) provide information and help on all topics related to

ageing and elderly needs. Help is provided individually and social workers meet with carers on a regular basis. These centres also link carers with medical staff to address questions related to the disability of the care recipient.

Linking the efforts of private, voluntary organisations and community associations with public authorities can also be important to reduce fragmentation and improve co-ordination of services. In Bremen (Germany), Social Services Centres inform and support carers throughout the caregiving spells and also help co-ordinate medical and social sectors. These centres are partly funded by NGOs and communities but also receive grants from the city of Bremen.

Case (or care) managers can help alleviate the administrative burden of carers and help them co-ordinate their needs and those of the person cared for. A case manager playing the role of a co-ordinator between the different health and social services can simplify significantly the follow-up procedures of carers. An example of such case management can be seen in Austria, where local centres evaluate carers' needs and help them find appropriate services. Support services are available in different social service centres – such as the Vienna Health and Social Care Centres and the Tyrolean Integrated Social and Health Care Districts. They provide help with different dimension of planning, organisation and information. Carers who enrol in local support centres are put in contact with a district nurse who assesses the carer's needs and directs the carer towards appropriate entities and services. Administrative and co-operative tasks are the primary focus of these institutions, but the services also act as brokers and contacts between clients and formal service. The aim is to avoid gaps between health and social care provision and empower carers with knowledge and skills to face the difficulties of caring duties.

Carers assessment is a first step to define which services are needed for carers but does not necessarily mean that all carers are identified and receive support services. Several countries including Australia, Sweden and the United Kingdom have developed protocols for appropriate assessment of carers' needs, helping professionals to define caregivers daily tasks and identify stressors. There is often no mandate for caregiver assessment except in the United Kingdom, resulting often in lack of resources to perform systematic assessment. Even where the assessment is mandated, an estimated half of carers are not known to service agencies (Audit Commission, 2004). The reasons, besides lack of awareness and self-identification as carers, include lack of knowledge of entitlement and difficulty asking for help.

Identifying carers through actors that carers see regularly is key because many carers are not forthcoming in asking for help. General Practitioners, nurses, pharmacists and other health professionals are well placed to recognise and advice carers because of their frequent interaction with the care recipient or simply through normal consultations. In Scotland, GPs have been given incentives to identify carers, set up carer registers and refer carers to appropriate local support. A resource pack is distributed in each GP practices and GPs (and other primary health professionals) are connected to carers' centres. While it is unrealistic to expect that GPs and other primary health professionals will be able to provide all necessary information and counselling to carers, they can be well placed to refer carers to more specialised sources of information and advice.

4.4. Compensating and recognising carers

A large number of OECD countries provide financial support to carers through cash benefits 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 family carers. Slightly less than half of OECD countries have a direct payment towards the carer and slightly over a half of the countries have cash benefits for the care recipient (Annex 4.A1 and Annex 4.A3). A few countries provide both types of cash benefits (*e.g.* Norway, New Zealand, Slovak Republic, Sweden and the United Kingdom) and one-fifth does not have either type of benefit. This section will discuss the effects of both types of cash benefits on carers and the relative advantages and disadvantages of both. Other financial incentives not in the form of allowances include tax incentives, discussed in Box 4.4.

Box 4.4. **Tax incentives benefiting carers**

Tax relief is an indirect form of financial assistance to the caregiver, aiming to encourage family caregivers. Most countries have no specific tax incentives for carers with the exception of tax exemptions for carer's allowances in a variety of countries (Czech Republic, Ireland, for example). Canada and the United States have tax credit programmes.

In Canada, caregivers may be eligible to financial support through the federal tax system. Non-refundable tax measures that offer assistance to unpaid caregivers include the Caregiver Tax Credit, the Eligible Dependent Tax Credit, the Infirm Dependent Tax Credit, the Spousal or Common-Law Partner Tax Credit, the transfer of the unused amount of the Disability Tax Credit, and the Medical Expenses Tax Credit (METC). Under the METC, caregivers can claim, on behalf of a dependent relative, up to USD 10 000 in medical and disability expenses. The Infirm Dependent Tax Credit provides approximately USD 630/year in tax reduction to those who care for disabled family members with severe impairments. Alternatively, the Caregiver Tax Credit provides co-resident carers with a similar amount of money, if the care receiver's income is low. In addition to the federal tax credits, comparable caregiver tax credits are available in each of Canada's 13 provinces and territories. The provinces of Québec and Manitoba also offer refundable tax credits to eligible caregivers

The United States has a tax credit for working caregivers: The Dependent Care Tax credit. It is a non-refundable credit available to lower income working tax payers who co-reside with the care recipient and provide at least 50% of a dependent's support. Since it is only for tax payers who are employed, those unemployed or out of the labour force, who comprise a large section of caregivers, are not eligible. Tax credits often represent a small fraction of household's income and it can be complex for those most in need to claim tax refunds. Limited evidence shows that the eligibility criteria have resulted in such credits not reaching a large percentage of the carer's population (Keefe and Fancey, 1999).

Carer's allowance

A carers' allowance recognises that providing care involves costs for carers. It may help carers to juggle their responsibilities by having some income to compensate for reduced working hours or for additional expenses incurred as a result of caring. In addition, it also provides a strong signal that carers' play an important social role and should be acknowledged by providing a financial reward for their efforts.

Countries with direct payments to carers have very different compensation and eligibility conditions. Two main approaches, discussed below, emerge: *i)* countries providing remuneration to family carers who are formally employed; and *ii)* countries with means-tested allowances. In addition, some countries provide other types of allowances to carers, such flat-rate allowances in the Slovak Republic and in Belgium (three-fourths of the Flemish Municipalities and three Flemish Provinces), and allowances at provincial level in Canada (Nova Scotia's Caregiver Benefit). The amount and the eligibility conditions vary.

In Nordic European countries (Denmark, Finland, Norway, and Sweden), the payment to carers is considered as remuneration. Municipalities, which are responsible for long-term care services, employ family caregivers directly. Salaries vary across municipalities but they include a minimum regulated amount in Finland (EUR 336 per month in 2009), while in the other countries they vary with care needs and are equivalent to the hourly pay received by regular home helpers. Compensation levels are thus fairly generous and offer a fair compensation for carers' efforts, while not providing sufficient disincentives for family members to work because the compensation constitutes a relatively low wage (see Chapter 5 on working conditions in LTC) and is unlikely to compensate the full value of caregiving.

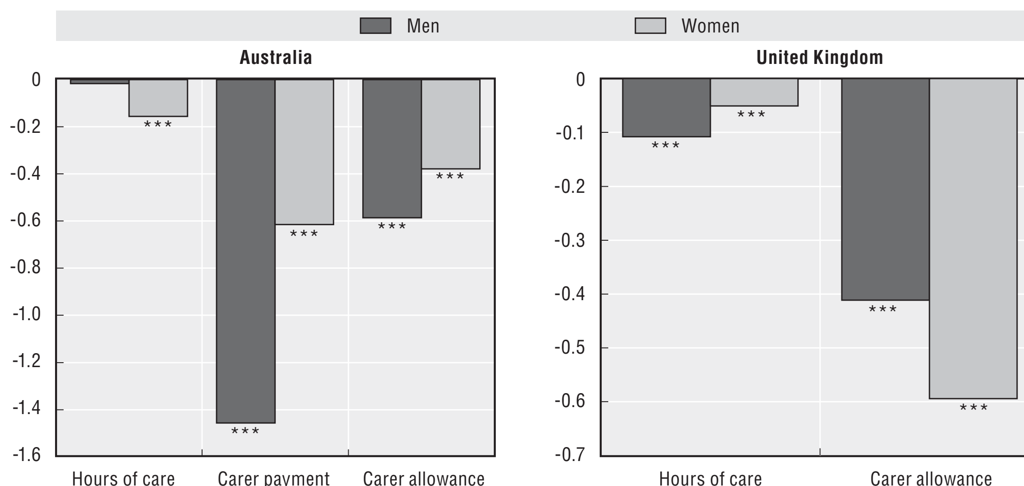
Nordic countries target more intensive care but the entitlement depends on assessments made by local authorities. Municipalities are very restrictive in granting such allowances and they are not obliged by law to provide them, possibly to limit their attractiveness to low-wage earners. Carers' allowances tend to be granted particularly to keep the care recipient at home instead of moving to an institution, and when the care performed is extraordinarily heavy or burdensome. In comparison, many more family carers benefit from payments via the care recipient. Such form of compensation requires appropriate definitions of care intensity, and standardised assessments may be useful to limit local variations in entitlement. While care wages seem a promising avenue to improve targeting and compensate the effort of carers, they remain a relatively costly option and there is a legitimate question as to whether the use of more qualified or experience formal carers should not be used instead.

Means-tested benefits paid directly to carers are found mostly in English-speaking countries (Australia, Ireland, New Zealand, and United Kingdom).[6] Allowances are limited to those most in need, with heavy and regular caring duties that result in forgone earnings. In all cases the definition of carers is linked to a threshold on weekly earnings from work and/or a minimum amount of hours of care per week. In addition, the care recipient must be in receipt of a disability benefit. Such means-tested allowances presuppose that individuals are involved in full-time care. Their stringent eligibility is also linked to low recipiency rates. Just under 1% of the total UK population (or less than one-tenth of carers) received a Carer's Allowance in 2008, while in Australia and Ireland the equivalent figure is around 0.5% – or roughly one-fifth of carers – and there is only a handful of carers receiving Domestic Purposes Benefits in New Zealand (5 246 in 2008).

Means-testing and eligibility conditions may result in disincentives to work. For example, they might discourage carers from working additional hours per week outside the house, particularly those having most difficulties to enter the labour market, such as those with low skills. Indeed, means-tested allowances in Australia and the United Kingdom generate incentives to reduce hours of work for carers (Figure 4.4). The impact depends on the skill level, especially for women, and the availability of formal care. Low-skilled women are more often in receipt of cash transfers and tend to have lower caring responsibilities

Figure 4.4. **Carer's allowances generate incentives to reduce work hours**

Coefficient estimates on hours of work from a random effects tobit



Note: Samples include persons below age 65. The following years are considered for each country: 2005-07 for Australia; 1991-2007 for the United Kingdom. The sample includes individuals present in at least three consecutive waves. All regressions include the same controls as in Figure 3.6. See Chapter 3 for more details on the data and the estimation method.

Source: OECD estimates based on HILDA for Australia and BHPS for the United Kingdom. Negative coefficients indicate a reduction of hours of work.

StatLink http://dx.doi.org/10.1787/888932401444

when in-kind benefits are provided instead of cash transfers (Sarasa, 2007). Such allowances seem thus to provide some form of income assistance, while maintaining caring as a low-paid and low-status work.

Targeting cash allowances to carers is a difficult task, involving a number of trade-offs. Typically, such cash allowances involve a number of eligibility requirements with a view to define an eligible carer (*e.g.* primary carer), the level of care effort (*e.g.* number of hours of care per week), the relationship between the carer and the care recipient (*e.g.* certain relatives, co-residency) as well as the care level of an eligible care recipient (*e.g.* high care need). In practice, some of these requirements can be difficult to verify administratively and may be subject to abuse. They may also be viewed as unfair or simply arbitrary. For example, in the United Kingdom only one carer per LTC recipient is entitled to receive the allowance and carers cannot receive more than one allowance even if they are caring for more than one person. In Ireland, "part-time caring" or sharing caring duties among two carers is permitted as long as each carer is providing care from Monday to Sunday but on alternate weeks. Leaving aside issues pertaining to setting legitimate eligibility requirements, the trade-off in designing a carer allowance is generally between providing a token recognition to a broader group of carers, including some involved in low care intensity, and providing more meaningful support to a narrowly targeted subset of carers. Most countries have opted for the latter.

Cash benefits for the care recipient

Cash benefits for dependants are often advocated as a good approach to maximise the independence of the disabled person and have become more prominent in recent years. In more than three-quarters of OECD countries, such cash schemes allow the use of the allowance to support family carers or even to hire family members formally (see Annex 4.A3 for detail on cash benefits which may be used to compensate family carers,

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and Chapter 1 for an overview of all cash benefits for LTC). Often, the dependent person prefers to hire relatives if they have the choice, as they tend to rate them as more reliable, trustworthy and knowledgeable about their needs (Simon-Rusinowitz *et al.*, 2005). While the primary aim of cash for care schemes is often to expand choice and flexibility for the care recipient, compensating or encouraging family carers can be a secondary aim. In certain countries (Germany, the Netherlands), the cash benefit is set at a lower value than equivalent services in kind.

In all OECD countries with cash benefits, the amount of the benefit for the care recipient depends on care needs. Following an assessment of their care needs, individuals with ADL restrictions are classified according to their degree of autonomy loss into three to four levels and up to seven levels in certain countries. In some countries, the care recipient can chose to receive care services in-kind or through a cash benefit, except in Austria, France and some eastern European countries, where only cash allowances are available. Most countries do not target allowances depending on income, apart from Belgium and Spain, where the allowances are income-tested, and France and the Netherlands, where above a certain level of income the benefit amount is income-tested.

This type of support may present several advantages for carers and policy makers. First, eligibility requirements for carers might be simpler since policy makers avoid the difficulties of defining who are primary carers and interfering with family relations in that way. Many carers do not identify themselves as carers and do not necessarily apply for a specific allowance while carers may be reached via a cash benefit targeting the user. In addition, such cash benefits can be used by elderly carers since they do not constitute wages as in the case of carer's allowances in northern Europe. They can also provide more generous benefits than the means-tested allowances given to carers in English-speaking countries. Finally, a fairer allocation of cash resources is likely to be achieved if allocated to the care recipient since the amount of the allowance depends on needs.

On the other hand, cash benefits given to the dependent person might not always be used to pay family carers and may generate financial dependence of the carer. The allowance might compensate for the additional care expenses and may be used to supplement family income if there is no specific provision to pay for family carer. This leaves carers dependent on the care recipient in terms of the compensation for their efforts or to buy formal care services for breaks. Certain countries (France for relatives other than spouses, the Netherlands) have gone around this problem by having relatives employed through a formal contract if they provide care above a certain number of hours per week. Holidays rights are also included in the conditions of employment. Germany also guarantees holidays and time off during sickness through in-built funding for substitute services (see below). This still leaves carers financially vulnerable if the person needs to receive long-term care in an institution or dies.

Another risk of providing cash benefits to the dependent person is the risk of monetising family relations. Altruism and a sense of duty are often cited as the primary motivations for relatives to provide informal care. Hope of monetary transfers and bequests in particular are another intrinsic motivation. Introducing cash allowances whereby the dependent person may chose among relatives on how to allocate additional resources may increase competition among family members.

The extent to which cash benefits are used by family carers is partly related to restrictions in the use of the allowance and to the degree of monitoring. In Germany, cash benefits are predominantly chosen over home care agency services, in spite of such benefits being 50% lower than direct home care. Cash benefits do not require compliance with a certain use of services and there is no monitoring on the way benefits are spent, nor care management requirements; cash benefits appear thus to have generated incentives for informal care, resulting in an increase in the number of caregivers per care dependent (Glendinning, 2003). Piloting of personal budgets in certain German counties, which were financially more attractive but included closer monitoring by care managers, showed that this resulted in a shift of cash recipients to personal budgets and a substitution of informal care for formal care. Unregulated benefits in Austria were similarly used for family carers but have progressively been used to hire migrant carers. In contrast, in France and the Netherlands, cash benefits or personal budgets come with the definition of a care package, especially in France where service needs are defined by health professionals and not by the dependent person, and are thus rarely used to pay family carers.

Flexibility of the cash benefit, in terms for example of relatives that can be included or not as family carers, also influences the use of such benefits. In France, hiring a relative is permitted with the exception of spouses who are by law providing assistance to their partners. While it is true that partners should care for each other, given the forecasted increase in the number of elderly spouses providing informal care, the question of how best to support the work of frail spouses without providing incentives for inappropriate use of benefits remains open.

Both types of cash benefits could help to expand the supply of workers in the long-term care sector and stimulate home care by tapping on otherwise unpaid carers, but their critics point to important trade-offs for both carers and care recipients. First, cash benefits may discourage the emergence of private providers, as households will continue to rely on family carers. In certain countries, cash benefits have stimulated a grey market, where families use allowances to hire untrained non-family members, often migrants, at the detriment of formal care services. Italy is an example of such developments. A related issue is whether promoting a substitution of formal for informal care has an impact on the quality of care. Second, cash benefits may trap family carers into a low-paid unwanted role. Japan, for instance, decided not to have explicit policies targeting family carers because of a strong tradition of family responsibility and policy focused on decreasing the burden of family carers, although some municipalities do have cash benefits under strict conditions.

The impact of public financial support on the supply of informal care is likely to be influenced by a complex set of factors, including the link between formal and informal care. Several studies have found that formal and informal care may be substitutes or complements depending on the type of care and care needs. Informal care has been found to be a substitute for formal home care (Bolin *et al.*, 2008; Van Houtven and Norton, 2004) but this is only the case for domestic help, while it is a complement to nursing/personal care (Bonsang, 2009). In addition, when the care recipient has a higher degree of disability, the substitution effect for paid domestic help disappears (Bonsang, 2009). Providing financial incentives for carers might be a helpful strategy especially for low-intensity or low-skilled care, but it might be more problematic as care needs increase or require a relatively high allowance to provide sufficient financial incentives. In addition, relying on family carers without adequate support for them and their needs is likely to have detrimental consequences for their health and employment (Chapter 3).

4.5. Conclusions

OECD countries are increasingly concerned about the burden on carers of frail and dependent people and the need to support them. With demographic changes leading to a greater need for care and higher cost for public systems, it is important to recognise the role of carers, whether formal or informal. Carers are more likely to continue caring if they feel valued. Knowledge about good-practice policies remains still fairly limited in this field, however, and especially on the effectiveness of alternative interventions to mitigate the negative impacts of caring on work and mental health.

Cash benefits to carers provide compensation and recognition but they are not the only policy option to support carers. Cash support is a simple way of recognise the important role of carers but can also raise difficult eligibility decisions and policy trade-offs. Cash benefits should therefore be seen in the context of a proper care plan, including basic training for the family member concerned, work reconciliation measures – including flexible work arrangements – and other forms of support to carers, including respite care.

Notes

1. Informal care in the context of this chapter refers to care by family and friends. While disabled groups include both young people with handicaps and frail elderly, this chapter does not provide en encompassing overview of the range of services, labour market and social integration policies directed to young disabled people.
2. In Australia and the United Kingdom, no unpaid leave for care reasons exists; leave consists of a few days only for very short emergency reasons
3. Care vouchers could be used to stimulate the use of leave for the caring of adults. The main idea of care vouchers is that employers provide workers with vouchers, which may be used to buy formal care in lieu of a part of the employee's income. The voucher would be exempt from both national insurance contributions for the employer and from income tax for the employee. While vouchers may provide an alternative half-way to leave for care, their financial implications need to be weighed against other forms of financing long-term care.
4. Flexible work schedule include other forms aside part-time work but no sufficient statistical information was available on flexible hours, and this section focuses therefore mostly on part-time work.
5. In addition, the Veterans Independence Programme provides personal care and housekeeping support for primary caregivers to veterans.
6. Means-tested allowances might be subject to a labour earnings/income limit or to a wealth limit, depending on the country.

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ANNEX 4.A1

Summary Table: Services for Carers

Table 4.A1.1. **Summary Table: Services for carers**

	Carers allowance	Allowance for the person being care for	Tax credit	Additional benefits	Paid leave	Unpaid leave	Flexible work arrangements	Training/ education	Respite care	Counselling
Australia	Y	N	N	N	Y	N*	N	Y	Y	Y
Austria	N	Y	N	Y	N	Y	Y	Y	Y	Y
Belgium	Y**	Y	N	N	Y	Y	Y	Y	Y	Y
Canada	Y**	N	Y	Y	Y	Y	N**	Y	Y	Y
Czech Republic	N	Y	N	Y	N	N	Y	Y	Y	Y
Denmark	Y	N	N	N	Y	N	N**	Y	Y	
Finland	Y	N	N	N	Y	N	Y			Y
France	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Germany	N	Y	Y	Y	N	Y	Y	N	Y	
Hungary	Y	N	N	Y	N	Y	Y	N	N	Y
Ireland	Y	N	Y	Y	N	Y	N		Y	Y
Italy	N	Y	N							
Japan	N	N	N	N	Y	N	Y	Y	N	N
Korea	N	N	N	N	N	N	N**	Y	N	N
Luxembourg	N	Y	Y	Y	N	Y	N**	Y	N	Y
Mexico	N	N	N	N	N	N	N	Y	N	N
Netherlands	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
New Zealand	Y	Y	Y	N	N	N	Y	Y	Y	Y
Norway	Y	Y	N	Y	Y	N	Y	N	N	N
Poland	N	Y	N	N	Y	N	N	N	N	N
Slovak Republic	Y	Y	N					Y	Y	Y
Slovenia	N	N	N	N	Y	N	N**	Y	Y	Y
Spain	N	Y	N	Y	Y	Y	N	Y	Y	Y
Sweden	Y	Y	N	Y	Y	N	N	Y	Y	Y
Switzerland	N	N	Y	N	N	N	N**	Y	Y	Y
United Kingdom	Y	Y	N	Y	N	N*	Y	Y	Y	Y
United States	N	Y**	Y	N	N	Y	Y	Y**	Y**	Y**

N*: Leave for only a couple of days for emergency reasons is available.
N**: No nationwide policy is available but collective agreements exist.
Y**: Not at the national/federal level but available in provinces/states/counties.
Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

ANNEX 4.A2

Leave and Other Work Arrangements for Carers

Table 4.A2.1. **Leave and other work arrangements for carers**

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
Australia	New National Employment Standards (2010): Ten days of personal/care leave	An immediate family member or household resident requires care because of injury. Provide proof of caring needs and reasonable notice	Paid at an hourly rate no less than the employee's basic period rate of pay	New National Employment Standards (2010): two days for each occasion where immediate family requires care or support because of illness, injury or unexpected emergency	The carer should provide relevant document (such as a medical certificate)	May request if have been working for 12 months but employer may refuse on reasonable business ground (only for a sick child)	No
Austria	Paid leave for two weeks per year for sick children and one week per year for other dependents/family members needing care	Care for sick children or dependent relatives	100% of previous earnings	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) and for seriously ill children (up to nine months)	Spouses, registered partners, partners in life, persons directly related to the employee (parents, children, grandparents, grandchildren), adopted and foster children, adoptive or foster parents, parents and children in law, brothers and sisters and children of the spouse, of the registered partner or the partner in life	Employees have a qualified legal claim to a reduction of the ordinary working hours, to a change in the schedule of their ordinary working hours and to leave from work (the so-called "Karenz") for the purpose of caring for a dying person or for a seriously ill child. Family leave can be taken as 24 months of part-time work to care for a seriously ill family member. Employers in companies with <50 employees can refuse on business grounds	Employees acquire compulsory pension insurance contribution periods and they are covered by health insurance during their absence

Table 4.A2.1. **Leave and other work arrangements for carers** *(cont.)*

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
Belgium	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 neighbors): 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) allocation: EUR 741.40 per month (proportional amount in case of part-time leave)	Emergency leave (*Congé pour raison impérieuse*) of ten days per year (private sector) or two months/ 45 working days per year (public)	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	Time credit	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 enterprise has fewer than ten employees, the employer can deny leave on business and organisational grounds. The employee is protected from being fired during the whole period and extended to three months after the end of the leave	State compensation: EUR 741.40 per month				
	Time credit (part-time or full-time career break	One year to up to five years leave full or part-time. Can be taken in periods from three months to one year at a time	State compensation: According to sector and length of service. Public sector: EUR 379.37/month. Private sector: EUR 453.28 or EUR 604.38 per month (Flemish Community: Additional care allowance EUR 110.41				

Table 4.A2.1. **Leave and other work arrangements for carers** *(cont.)*

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
Canada	Compassionate Care benefit: Up to six weeks of income support. Collective agreements complementary: 15% of companies provide annual paid family-related or personal leave	Care for family member who is gravely ill and at the risk of dying. The caregiver must have accumulated 600 insured hours in the 52 weeks prior to the claim	Income support provided up to maximum CAD 447/week (55% of the average insured earnings) through the Employment Insurance Compassionate Care Benefit for those whose income has been reduced by more than 40%	All territory and province legislation on unpaid leave (exception Alberta) provide up to eight weeks of leave per occurrence	Occurrence to care for family members who are seriously ill and have a significant risk of death within 26 weeks	Flexible work arrangements exist in various collective agreements and are set up by companies and sector ($1/3$ contain family leave provisions, $1/20$ eldercare provisions, $7/10$ personal leave)	Canada Pension Plan general drop-out provision allows contributors to preserve benefit levels by excluding 15% of the months or years of lowest earnings from the calculation of pension benefits (maximum seven years) for a variety of reasons (including but not limited to caregiving)
Czech Republic				No		Since 2001, employees who care for a bedridden person can request part-time work. The employer can deny the right on serious operational reasons and there is no right to revert to full-time work after the caring period ended	Yes
Denmark	Employees have the statutory right to leave for the care of a someone close dying, according to the Act on Leave from work due to Special Family reasons (March 2006). There is no fixed time limit for the leave	The dependent can be a spouse, cohabitant or parents in terminal illness but no requirements for close/familial relationships. Evidence should be provided to prove that the dependent has two to six months to live	The minimum amount during the care leave is equal to 82% of sick pay ceiling (and up to 1.5 times the sick pay if there is more than one dependent). The municipality can also pay maintenance fees when expenses are very high	Relies on collective agreements		Flexible work arrangements exist through collective agreements	No

Table 4.A2.1. **Leave and other work arrangements for carers** *(cont.)*

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
Finland	Legislated right: job alternation leave is available for 90 up to 359 days but company-specific – or collective agreements may differ. The leave is to be taken as successive 90 days minimum	The carer 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	Relies on collective agreements		Flexible working arrangements have been possible as part of the job alternation leave since 2010. Those who decide to work part-time for caring reasons are eligible to a part-time allowance from the Employment and Economic Development Office (need to be agreed with the employer). The compensation is proportional to the reduction of working hours. Any employee can request part-time work for social or health reasons for 26 weeks maximum at a time. The employer must consider the claim but is not required by law to agree on the arrangement	No
France	Since 2 March 2010 Law, family solidarity leave is eligible to compensation – for 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 21 days	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 (until fourth degree family member but co-resident) – the employee must have at least two years experience and the person needs to have a permanent disability of 80%	With agreement from the employer, the Family solidarity leave can turn into reduced working hours	Yes

Table 4.A2.1. **Leave and other work arrangements for carers** *(cont.)*

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
Germany				Leave is possible up to six months	A family member (until second degree) needs care for a long period. The employer can refuse on business grounds if employs less than 15 employees	Since 2008, employees in firms with more than 50 employees can request part-time work to care for a disabled co-residential family member – up to six months (renewable once). The employer can deny the leave only on urgent operational reasons. There is a right to revert to full-time hours	Yes
				Emergency leave for medical reasons is also possible up to ten days	Second degree family needs assistance because of severe illness, accident or terminal illness. The employer cannot deny the right to the employee		
Hungary	No			Unpaid leave for a maximum of two years, for the duration of care	Upon the employee's request for care of a dependent relative	Any employee can request part-time work but may be refused on a business case	Yes, nursing fee. As for pension rights, the period of nursing fee payment is counted towards service time. Beneficiaries are entitled to health care service
Ireland	No			Unpaid carer's leave available since 2001. Leave is for a maximum of 104 weeks, can be taken in one period (with 13 weeks minimum each time) or several – employee protected by the Carer's Leave Act of 2001. Employer may refuse "on reasonable grounds"	For employees with at least 12 months of continuous service – proof of full-time care required (only 24 hour care basis). Assessment done by a general medical practitioner and the Department's medical advisor	No	Pension rights/credits: Home-maker's scheme allows for up to 20 years spent caring for children or incapacitated adults be disregarded for pension purposes but still requires a person to contribute 260 contributions and enter insurance ten years before pension rights

Table 4.A2.1. **Leave and other work arrangements for carers** *(cont.)*

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
Japan	Family care leave benefit: leave of up to 93 days is permitted for each family member The LTC leave system itself does not set any provision for compensation paid by employers, but when a subscriber of Employment Insurance takes a LTC leave, s/he can receive a LTC leave benefit	Need to be a subscriber to Employment Insurance. A worker (excl. a day worker) that provides LTC to a spouse, parent and child (or grandparent, brother/sister, or grandson/ daughter living with the worker), or parent of the spouse. The care recipients must require regular care for two weeks and over. In addition, in order to receive a LTC leave benefit from the Employment Insurance, a minimum insured period of 12 months in the two years before the start of leave is required	If the insured of the Employment Insurance meets the requirement in the left column, he/she can receive a LTC leave benefit equivalent to 40% of his/her wage before the leave (if the total of his/her wage and benefit exceeds 80% of his/her wage before the leave, the exceeded amount is reduced) for maximum three months	Nursing leave is also possible for five days a year or ten days a year if more than one dependent	A worker that provides long-term care to a person in need of care (excl. a day worker). The person in need of care and the required condition is the same with Family care leave	The employer must provide either of the following for at least 93 days, on request of his/her employee providing care to the qualifying family in need of care: 1) Shortened working hours 2) Flexible working time 3) Staggered working hours 4) Subsidies or other measures to aid the employee's with LTC spending	No
Korea	No			No		Flexible working arrangements are available depending on the sector/company defined by collective agreements	No
Luxembourg	End-of a life leave (*Congé d'accompagnement de fin de vie*) 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 d'Assurance Maladie*) in charge of the employee	Unpaid leave for family care for six months at a time. Relies on collective agreements	Should be documented by the employee (proof of need for care with a doctor's certificate). The dependent should be a first degree family (parents or spouse)	Flexible working arrangements based on collective agreements	Pension contributions guaranteed by dependency insurance
Mexico	No			No		No	No

Table 4.A2.1. **Leave and other work arrangements for carers** *(cont.)*

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
Netherlands	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	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 he 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	Flexible work hours are possible, depending on collective agreements but an insured minimum is set in legislation	Yes
New Zealand	No			No		Since 2008, employees with six months tenure who work at least ten hours per week and have care responsibilities for children or adults can request part-time work. Employer can deny the claim on operational and business grounds	No
Norway	Nursing care leave for periods up to 20 days, plus Care leave paid up to ten days		Both schemes are paid at full wage			Employees who for health, social or other weighty welfare reasons need to have their normal working hours reduced can request part-time work. Employers may refuse only for serious operational or business reasons	Automatic pension credits for carers who provide more than 22 hours of care per week and during at least six months in a year (three credits a year: Below an average wage)
Poland	Paid leave set at national level. Duration – max. 60 days per year		Paid 80% of salary	No		No	No
Slovenia	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 case)	Co-resident family member should be a child or a spouse. Need to be a subscriber to have compensation	Paid at 80% of average earnings of the preceding 12 months			Flexible working arrangements set at national levels are available, depending on the sector/company	No

Table 4.A2.1. **Leave and other work arrangements for carers** *(cont.)*

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
Spain	Care for a sick child or other serious family reason: Two days for private sector (extended to three if involves traveling) and three for central state public sector (five if traveling)		Paid by the employer	Long-term leave for a dependent: Up to two years (extreme cases: Three years)			Pension credits granted by the state
Sweden	Paid leave set at national levels. Leave for terminal care for 100 days	A relative in terminal care; refers only to persons in working age (up to 67 years). Need to provide evidence such as doctor's certification	On average, paid at 80% of the wage	No		No	Yes
Switzerland	Depending on the sector/company. Set at national levels, by employers or through collective agreements			Depending on the sector/company. Set at national levels, by employers or through collective agreements		Depending on the sector/company. Set at national levels, by employers or through collective agreements	No
United Kingdom	No			Emergency leave can be taken for caring of a family member. The length of the leave should be "reasonable" – *i.e.* two days		Work and Families Act (2006) gives carers the right to request flexible working, can only be refused for clear business reasons. Eligibility: Must have worked for over 26 weeks prior to the claim, must not have requested flexible work the 12 months prior to the claim, dependent must be first-degree family. There is no time limitation as for the flexible work arrangements and should be arranged with the employer	Yes

Table 4.A2.1. **Leave and other work arrangements for carers** *(cont.)*

	Paid leave			Unpaid leave			
	Paid leave	Eligibility criteria	Payment conditions	Unpaid leave	Eligibility criteria	Flexible work arrangements	Additional benefits
United States				All private companies with 50 or more employees grant them up to 12 weeks' unpaid leave per year. Leave may be taken on an intermittent basis or reduced work schedule	Serious illness of a spouse or a child	Employees with 12 months of service working for employers with more than 50 employees can take 12 weeks of Family and Medical Leave (per year) as a period of part-time work (reduced leave schedule) for the birth or adoption of a child, to care for a spouse, child or parent with a serious health condition or if the employee him/herself has a serious health condition. The employer cannot deny this right. Right to revert to full-time	No

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

ANNEX 4.A3

Financial Support for Carers

Table 4.A3.1. Financial support for carers

	Allowance to the carer			Allowance to the disabled dependent (only allowances that can be used to pay the family carer)			Tax benefits
	Name	Eligibility criteria	Payment conditions	Name	Eligibility criteria	Payment conditions	
Australia	Carer payment system	Must be Australian resident and personally provide constant care in the home income and assets test	Paid at pension rates AUD 671.90/fortnight for single and AUD 506.5 for each eligible member of a couple; possibility of carer supplement				No
	Carer allowance	Not income or assets tested – for only co-residential dependents	A fixed amount of AUD 105/fortnight				
Austria	No, but there is a special allowance in case of dementia	Caring for their relatives who have dementia	Contribution to covering the costs of organising professional or private substitute care if the main caregiver is incapacitated (EUR 1 200 to EUR 2 200)	Austrian long-term care allowance system	Need-tested but not means-tested. Eligible people must require care on a full-time basis (included mental disability/dementia)	The allowance should cover between 26 and 70% of monthly expenses (about 36% of nursing homes): Up to EUR 1 655 a month for more than 180 hours a month	No
Belgium	Carer allowance in Flanders (*mantelzorgpremie*)	Variable	Variable according to municipalities or provinces (average EUR 32/month)	Integration allowance for those with serious ADL restrictions	Income-tested (should not exceed EUR 2 630.82 for the household) and need-tested (should have a doctor visit and ongoing control). The claim should be made before 65 years old	Ranges from EUR 1 061.26 to EUR 9 550.33 per annum depending on the number of restrictions	Tax deductions for households with a co-residential disabled and aged below 65 years old.
				Income replacement allowance	For those aged 21-65 whose handicap prevents them from making enough money to live. Income-tested and depends on familial status	The allocation can reach up to EUR 11 618.44 per annum	

Table 4.A3.1. **Financial support for carers** *(cont.)*

	Allowance to the carer			Allowance to the disabled dependent (only allowances that can be used to pay the family carer)			Tax benefits
	Name	Eligibility criteria	Payment conditions	Name	Eligibility criteria	Payment conditions	
Canada	Not at the federal level but relying on provincial systems. The Nova Scotia Caregiver Benefit (July 2009) provides caregivers assisting severely impaired low-income care recipients aged over 19 years with a financial benefit of CAD 400 per month in taxable income. Caregivers must provide a minimum of 20 hours of care per week for more than 90 days. From September 2010, the new Legacy of Care Programme, including the Forces Attendant Care Benefit, provides up to CAD 100/day for family and friends who leave their jobs to care for an injured soldier						Federal: Caregiver Tax Credit (provides co-resident carers with CAD 630/year, if the care receiver is low income); Eligible Dependent Tax Credit; Infirm Dependent Tax Credit (CAD 630/year in tax reduction to carers of disabled family members with severe impairments); Spousal or Common-Law Partner Tax Credit; transfer of the unused amount of the Disability Tax Credit; Medical Expenses Tax Credit (METC, claim can be up to CAD 10 000). The Infirm Dependent Tax Credit Provincial/Territorial: Comparable tax credits for caregivers. Quebec and Manitoba also provide refundable tax credits for eligible caregivers
Czech Republic				Care allowance	Dependent on care: > one year of disability and need assessed by a doctor or a social worker. Not income-tested and amount depending on degree of disability. No age limitation	Amount: CZK 2 000 per year for mild disability, to CZK 12 000 for heavy disability	No

Table 4.A3.1. **Financial support for carers** *(cont.)*

	Allowance to the carer			Allowance to the disabled dependent (only allowances that can be used to pay the family carer)			Tax benefits
	Name	Eligibility criteria	Payment conditions	Name	Eligibility criteria	Payment conditions	
Denmark	Consolidation Act on Social Services (CASS): The carer shall be employed by the municipality for six months (possible extension for three months)	An employment contract shall be made between the carer and the municipal council, setting the employment terms and conditions, including the identity of carer, the duration of the employment, the duties and responsibilities, notice periods, etc.	The salary will amount to DKK 16 556 per month. 12% will be paid into a pension scheme, 4% of which is withheld from the salary, and 8% of the salary will be contributed by the employer				No
Finland	Carer allowance	No income test. Support paid to the carer is considered as income when other social allowances are allowed	EUR 336/month minimum				No
France				Allocation Personnalisée d'Autonomie (APA) is paid to the care recipient for arranging help with ADL restrictions (can be paid to the carer but not his spouse or partner)	Must be aged over 60 years and have residency in France; amount depending on disability and on income	Ranges from EUR 529.56 to EUR 1 235.65 per month (but regional disparities), but a co-payment is required for the care recipient, depending on income	Planned support for carers through tax reductions (hiring of formal labour can lead to tax reductions under certain requirements)
				Compensatory Allocation For Third Person Benefits (ACTP): is directed towards the payment of the family carer	High levels of disability and income-tested. Must be aged below 60 years old	Ranges from EUR 415.34 to EUR 830.69 for high levels of needs and low levels of income	
Germany	Carer allowance under the pension insurance scheme	Directed towards the payment of a carer providing care for at least 14 hours a week – levels of needs assessed by a medical staff determine the payment. The carer will have a contract with the insurance company and salary will be based on the number of hours worked. No specified relationship between carer and care recipient	From EUR 225 to EUR 665 in 2010 for home care and from EUR 1 023 to EUR 1 918 per month for institutional care (depending on partial/full institutional care)				Income tax allowance of EUR 924/year if they do not get payments for care; can declare total costs of care and claim a tax allowance if the person cared for is eligible for nursing care level III

Table 4.A3.1. **Financial support for carers** *(cont.)*

	Allowance to the carer			Allowance to the disabled dependent (only allowances that can be used to pay the family carer)			Tax benefits
	Name	Eligibility criteria	Payment conditions	Name	Eligibility criteria	Payment conditions	
Hungary	Nursing fee	Monthly financial support to persons who nurse at home a close family member requiring long-term care due to serious disability and long-term illness	From January 2011, the nursing fee will be HUF 29 500, irrespective of the minimum old-age pension in case of severe dependency of family members requiring permanent care. Cannot be cumulated with other benefits except of old age pension (in case of ten years care before retirement)				The nursing fee is not subject of taxation. The period of nursing fee payment is counted as service time
Ireland	Carer allowance	Income and assets tested but means test has eased significantly over the years. An income disregard of EUR 665 per week for a couple and EUR 332.50 for a single person applies. The person receiving care requires full-time or continual supervision and frequent ADL assistance and is likely to require care for at least 12 months	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, receive the 50% in addition				Home carer tax allowance of EUR 900/year if carers' income does not exceed EUR 5 080. Carers' allowance/benefit not taken into account for the determination of income. Incapacitated child tax credit and dependent relative tax credit when maintaining a relative
	Carer's benefit. Introduced in 2000 for insured persons who leave the workforce to care for someone		Payable for 104 weeks at a rate of EUR 221.20/week				
Italy				Attendance allowance (*Indemnitá di accompagnamento*)	For high levels of disability and incapacity to work. Need tested but not means tested, no age limits and within a broad national scheme	Cover max of 65 hours of care per week	No
Japan	No				No		No
Korea	No						No

Table 4.A3.1. **Financial support for carers** *(cont.)*

	Allowance to the carer			Allowance to the disabled dependent (only allowances that can be used to pay the family carer)			Tax benefits
	Name	Eligibility criteria	Payment conditions	Name	Eligibility criteria	Payment conditions	
Luxembourg				Cash allowance for care (*prestations en espèces*). Under the LTC insurance, recipients can choose between care in-kind and this allowance		Payment levels ranges from EUR 267 to EUR 1 100	Tax deductions for LTC services to hire someone up to EUR 3 600/year; the carer hired should be below 65 years old and cannot have own pension allowance contributions for carers
Mexico	No						No
Netherlands	Additional allowance for carers providing care to those eligible for long-term care services	Relative or friend living with the carer	EUR 250 (2009) per month for carers providing support to a recipient needing at least 371 days of care	Personal budget: Following reform in 2003, all home care users can choose in-kind services or cash to pay a relative, including spouses and parents, to provide care. Roughly 40% of budget holders hire family members and neighbors	No age limits or income-test to claim. The maximum hourly rate is EUR 4.70 (EUR 129 a month for a single aged over 65 earning more than EUR 40 718 a year)	Average amount per year: EUR 15 350	No
New Zealand	Domestic purposes benefit	Must provide more than four hours of care to a disabled person who would otherwise require rest home care, residential disability care, extended care provided for severely disabled children and young people, hospital care, or care of a similar kind. Income and asset tested	Can reach up to NZD 202.20 per month if married or in couple	Disability allowance: Received in cash with no restrictions on the use	The disability must last at least six months or in case of terminal illness. Income tested (for married couple, income should be below NZD 807.04 a week)	The maximum disability allowance is of NZD 56.98 per week	No tax incentives but may qualify for tax credit for housekeeping (NZD 310/year)
Norway	Care wage for carer: Only for high levels of caregiving (when home care is considered more suitable than residential care)	Pays relatives or others for caring when this is considered better than agency care. Typically 3-10 hrs/week. Not income tested	The carer is paid for a given number of hours, typically using the hourly wage of a care assistant in the public agency. Usually this amounts to about NOK 4 600 a month	Cash payment to the care recipient. Assistance pension is paid by the National social security board, typically on a long-term basis		Depend on care load, Average NOK 4 600 per month	No

Table 4.A3.1. **Financial support for carers** *(cont.)*

	Allowance to the carer			Allowance to the disabled dependent (only allowances that can be used to pay the family carer)			Tax benefits
	Name	Eligibility criteria	Payment conditions	Name	Eligibility criteria	Payment conditions	
Poland				Nursing allowance	For those with a disability who do not receive disability benefits	PLN 153 monthly	No
Slovak Republic	Care allowance	For those taking care of relatives or neighbors with severe disabilities. Income-tested EUR 200-260/month (EUR 83-110 if retired). Cannot be cumulated with other benefits but may be with earnings from employment (with a maximum)		General social benefit-payment in the framework of pensions (paid from state budget) for recipients of pension (invalidity or retirement) who have ADL dependency, benefit is not means tested			No
Slovenia							No
Spain				Carer allowance	If LTC services are not available, the dependent person may receive allowance in order to provide themselves for home care. The allowance is means tested. Requirement: The disabled person should be a third degree relative or a spouse. Do not need to justify the spending	Ranges from EUR 300 to EUR 519.13 depending on the level of need	No
Sweden	Paid kin caregiver	The caregiver needs to be employed by the municipality through a proper contract Directed towards the care of elderly in constant need of care and attention	Based on the number of hours provided by the carer. Paid as a salary equal to one on the formal market and offering the same social security benefits	Attendance allowance Assistance allowance	Minimum level of needs of 17 hours per week. Needs tested but allowance varies across municipalities 20 hours a week, several ADL measured (payment of estimated hours needed), only for the disabled aged over 65 years	According to flat rate: USD 515 (SEK 5 000) per month	No

Table 4.A3.1. **Financial support for carers** *(cont.)*

	Allowance to the carer			Allowance to the disabled dependent (only allowances that can be used to pay the family carer)			Tax benefits
	Name	Eligibility criteria	Payment conditions	Name	Eligibility criteria	Payment conditions	
Switzerland	Bonuses for caregiving	For those caring for disabled family members (*e.g.*, parents, parents-in-law, children, brothers or sisters and spouses). Need to be a caregiver for at least 180 days/year	Bonus for those receiving old-age pension				Tax deductions for fees as a result of illness/disability
United Kingdom	Carer's allowance	For those spending at least 35 hours/week caring. Not eligible if the carer is in full-time education (21 or more hours/week) or earning more than GBP 100/week after deductions	Flat rate: GBP 55.55 per week	Attendance allowance	For those aged over 65 and who need assistance for more than six months	Two rates: GBP 49.30 or GBP 73.60 a week depending on level of disability Non-means tested and tax free	No
				Disability allowance	For children and adults aged under 65 who need help with personal care or have walking difficulties because they are physically or mentally disabled	Care component – Three rates depending on level of care needed: GBP 19.55, GBP 49.30 or GBP 73.60 a week Mobility component: Two rates depending on level of mobility needs: GBP 19.55 or GBP 51.40 a week Non-means tested and tax free	No
				Independent Living Fund	Allowance aimed at encouraging home care instead of institutional care. The Fund is now closed to new applications	Amount based on the cost of care required. Maximum available payment to existing claimants is GBP 475 per week Non-means tested and tax free	No
United States				Consumer directed home care: Medicaid insures specific services provided by agencies to assist in living with disability: provides a cash-like benefit within the constraints of Medicaid's service delivery model			Medical Expenses Tax Deduction. If the tax payer – either the caregiver or the care- receiver – has medical expenses that exceed 7.5% of their adjusted gross income, medical expenses are deductible
				Cash and Counseling: Evaluation programmes in Arkansas, Florida and New Jersey		Amount of money varies across states: From a low of USD 350 per month in Arkansas to a high of USD 1 400 in New Jersey for elders and adults with disabilities	

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

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