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

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

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Introduction

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

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

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

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

The context

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

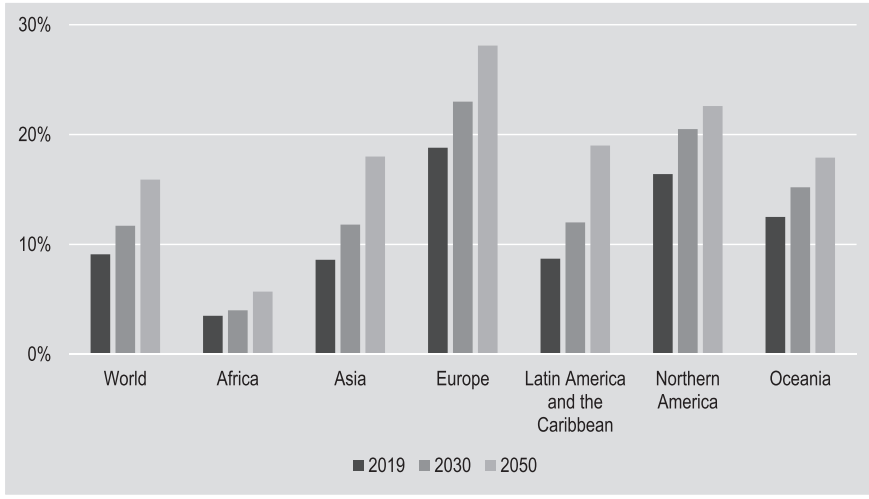
While there is a growing body of literature discussing LTC, definitions of its scope can vary. Some authors include health care and social care services needed across all age groups who require care or support to conduct activities of daily living (Addati, Cattaneo and Pozzan, 2022). While activities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

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

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

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

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



Source: UNDESA (2019).

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

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

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

Box 1. Gender and LTC

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

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

Social protection and healthy ageing

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

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

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

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

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

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

Box 2. Universal social protection throughout the life cycle

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

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

Source: ILO (2021a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage of the population

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

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

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

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

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

Adequacy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Administration

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

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

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

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

19. See the PAERPA website (in French).

Financing

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

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

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

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

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

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

Social protection for decent work in the care economy

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

Securing social protection coverage for unpaid family caregivers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

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

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