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The EU Monitoring Framework on the Council Recommendation on access to affordable high-quality long-term care

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The EU Monitoring Framework on the Council Recommendation on access to affordable high-quality long-term care

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1 Introduction

On 8 December 2022 the Employment, Social Policy, Health and Consumer Affairs Council (EPSCO) adopted the **Council Recommendation on access to affordable high-quality long-term care (LTC Recommendation)**. This is one of the deliverables of the European Pillar of Social Rights action plan adopted on 4 March 2021, contributing to the implementation of its Principle 18 on LTC and several other principles. It is also a key element of the European Care Strategy adopted on 7 September 2022. The European Care Strategy entails several EU-level measures that can support the work of the Indicators' Sub-Group (ISG) of the Social Protection Committee (SPC), in particular those related to strengthening the evidence base for LTC policies.

The LTC Recommendation calls on Member States to improve access to affordable, high-quality LTC for all people who need it. It concerns all people in need of LTC and all formal and informal carers, and applies to LTC provided across all care settings. Achieving this objective entails: ensuring the adequacy of social protection for LTC; continuously aligning the offer of LTC services with the respective needs; ensuring that high-quality criteria and standards are established for all care settings and applied to all providers; supporting high-quality employment and fair working conditions in the sector; improving the professionalisation of care work; addressing skills needs and worker shortages; and supporting informal carers in their care-giving activities. Further, the LTC Recommendation calls on Member States to ensure a national framework for data-collection and evaluation, underpinned by relevant indicators (where relevant and possible disaggregated by sex and age group) and the collection of evidence, including on gaps in LTC provision.

This version 0 of the EU monitoring framework for the LTC Recommendation was developed by the SPC ISG and the European Commission (EC). An agreement was reached at the ISG meeting of February 2024 on the adequacy and availability dimensions, in May 2024 on quality, in June 2024 on workforce and informal carers, and finally at the December 2024 meeting the ISG endorsed the overall framework. The document is structured as follows:

1. a presentation of the conceptual framework (Section 2);
2. a detailed presentation of the five dimensions of the framework, including relevant indicators and data (Section 3), notably adequacy (Section 3.1), availability (Section 3.2), quality (Section 3.3), workforce (Section 3.4), and informal carers (Section 3.5); and
3. annexes:

    - Annex 1: Key data sources;
    - Annex 2: Indicator description tables;
    - Annex 3: Data tables; and
    - Annex 4: Country tables.

The monitoring framework translates the different dimensions of the 2022 LTC Recommendation into measurable and actionable indicators and policy levers, which will be updated on a regular basis.

The monitoring framework on LTC will be used as reference for all policy processes, including the social Open Method of Coordination, the European Semester, future joint EC-SPC reports on pensions adequacy and LTC, and the EC report to the Council on the implementation of the 2022 LTC Recommendation in 2027.

2 Conceptual framework

The monitoring framework is based on three types of indicators/information for monitoring the LTC Recommendation: performance indicators, policy levers, and context information.

Firstly, the **performance indicators** should reflect progress towards the key objectives of the LTC Recommendation. They are **quantitative** and can be based on comparable EU-level indicators or, if these are not available, on easy-to-interpret national-level indicators (with work to be undertaken by delegates to develop a common understanding, to ensure comparability and clear interpretation).

Secondly, the **policy levers** are indicators of Member States' policies and provide **qualitative information** as to whether the specific provisions of the LTC Recommendation are reflected in national legislative or policy frameworks. In that sense, the existence of appropriate policy levers would have a positive impact on quantitative performance indicators for the Member States. Both performance indicators and policy levers show Member States' progress towards implementing the LTC Recommendation.

Thirdly, **context information** recalls the demographic, socio-economic and fiscal context in which the dimensions of the LTC Recommendation are situated, and this context does not directly reflect progress on implementing the LTC Recommendation. Context information can be quantitative and/or qualitative. The different dimensions are monitored through a mix of performance indicators, policy levers and context information.

The main data sources consist of administrative and survey data collected by Eurostat, complemented by other data collections where needed. Eurostat administrative data are from non-expenditure healthcare statistics, the system of health accounts (SHA), and the European statistics on accidents at work (ESAW); further data stem from the EC – Economic Policy Committee (EPC) Ageing Report and the OECD analytical work comparing social protection for LTC[1]. Survey data were provided by Eurostat for the European health interview survey (EHIS), the European Union statistics on income and living conditions (EU-SILC), the EU labour force survey (EU-LFS), the structure of earnings survey (SES), and the European Institute for Gender Equality (EIGE). In addition, the mutual information system on social protection (MISSOC) was used to underpin certain policy levers. See Annex 1 for a full overview.

To enhance the availability, quality, and coverage of data on LTC in the EU, the Commission established a Task Force on Long-Term Care Statistics (TF LTC). Led by Eurostat, the TF LTC started work in February 2023 with the overall aim to develop comparable EU statistics

[1] In four Member States (AT, BE, EE, IT) the rules and benefits are decentralised, and municipal-, regional- or state-level information is shown instead of Member State level. Further, the analysis for BG, CY and RO is work in progress.

on LTC. It works to produce methodological guidelines for European statistics on LTC, including on the estimate of the population in need of LTC, the LTC workforce, informal carers, and LTC expenditure and recipients.

The TF LTC will conclude its work at the end of 2025, with a report on methodological guidelines for European statistics on LTC. Upon finalisation of the task force's work, the Commission will analyse implications for the LTC monitoring framework and propose any adaptations as needed and relevant.

The framework will be updated in time to feed into the next joint EC-SPC report and the Commission report to the Council, both planned for 2027. It should thereafter be fully updated every three years, in line with the frequency of triannual data from the EC-EPC Ageing Report, and a triannual data update from the OECD. Data from Eurostat or MISSOC will be updated more frequently, as and when available (e.g. annually).

2.1 Scope of LTC Recommendation

Definition of LTC

The definitions set out in the LTC Recommendation, as listed below, underly the monitoring framework.

LTC	A range of services and assistance for people who, as a result of mental and/or physical frailty, disease and/or disability over an extended period of time, depend on support for daily living activities and/or are in need of some permanent nursing care. The activities of daily living (ADL) for which support is needed may be the self-care activities that a person typically performs every day (such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling bladder and bowel functions) or may be related to independent living, namely instrumental activities of daily living (IADL) (such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone).
Formal LTC	LTC provided by professional LTC workers, which can take the form of home, community-based or residential care.
Home care	Formal LTC provided in the recipient's private home, by one or more professional LTC workers.
Community-based care	Formal LTC provided and organised at community level, for example, in the form of adult day services or respite care.
Residential care	Formal LTC provided to people staying in a residential LTC setting.
Informal care	LTC provided by an informal carer, namely someone in the social environment of the person in need of care, including a partner, child, parent or other person, who is not hired as a professional LTC worker.
Independent living	A situation where all people in need of LTC can live in the community with choices equal to others, have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others, and are not obliged to live in a particular living arrangement.
Domestic LTC workers	All people engaged in domestic work who provide LTC within an employment relationship.
Live-in care workers	Domestic LTC workers who live with the care recipient and provide LTC.

Although the concept of a "worker" is not defined in EU legislation, for the purpose of the monitoring framework, LTC workforce is defined as formal care workers employed in various LTC settings – residential care, community-based care, and home care. The LTC workforce includes key occupational categories such as nurses, personal care workers, social workers, and other healthcare professionals providing direct or indirect care. For statistical analysis, the LTC workforce is composed of people in employment[2,3] (for pay or profit) providing LTC services as their main job; it is identified through a combination of classifications such as NACE codes (economic activity) and ISCO codes (occupation) – see Annex 1.

EU-wide data collections on LTC do not include community-based care as a separate category. Depending on the national classifications, community-based care could be categorised either as home care or as residential care[4].

Age group

The LTC Recommendation concerns all people in need of LTC and all carers. However, as LTC needs become mostly prevalent in old age, most LTC indicators that pertain to people in need of LTC focus on those aged 65+. The significance of this age group is further underlined by the fact that several indicators are only available for older age groups (e.g. from the EHIS). Where available, the reference group (those aged 65+) can be complemented with data for other age groups (such as the 16+ group) or for the whole population.

For the LTC workforce and informal carers, adults of all ages are considered. For statistical purposes, for the relevant indicators under these two dimensions, the framework is aligned with the age brackets used in the EU-LFS (15-64), the EHIS (15 or over), and the EIGE survey of gender gaps in unpaid care, individual and social activities (CARE) (16-74 for most Member States).

Scope of the monitoring framework

The monitoring framework covers most aspects of the LTC Recommendation, providing measures of the different elements of the key dimensions. However, certain policy dimensions cannot be assessed quantitatively or via policy levers. This applies, for instance, to the aspects regarding innovation and technology (5c), accessibility (5d) and co-ordination (5e) within the dimension of availability.

[2] The size of the LTC sector may in practice be bigger, as some domestic workers active in LTC may remain outside the NACE/ ISCO intersection used as baseline for identifying LTC workers and the sector also has a significant incidence of undeclared work.

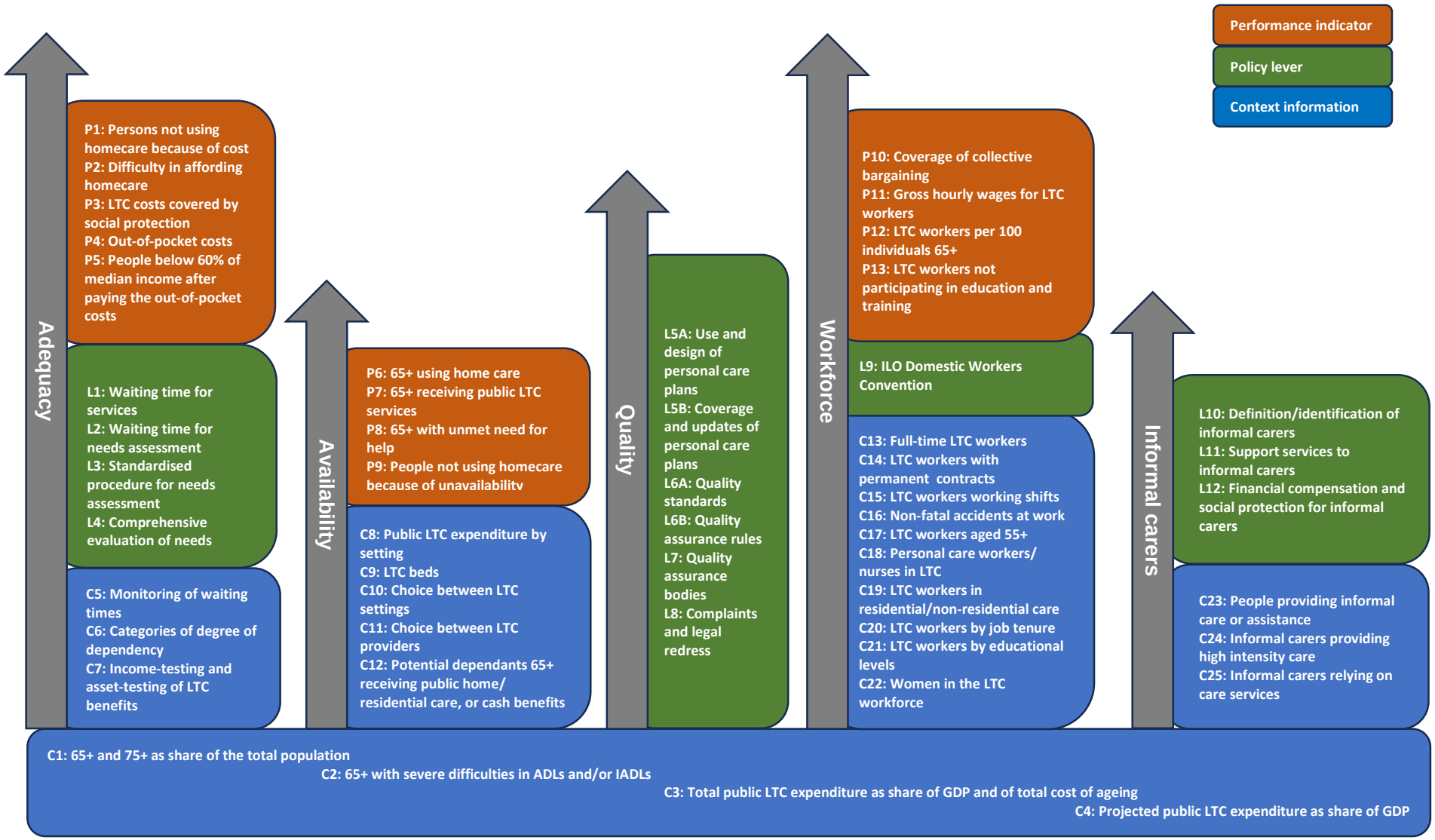
[3] EU-LFS data showed that in 2023 only 1.8% of LTC workers were self-employed.

[4] The Ageing Report uses the SHA definition, according to which these would be counted as residential care. However, there will be variations in how Member States report community-based care.

3 Detailed presentation of the monitoring framework

The different dimensions of the monitoring framework have different mixes of indicators, depending on the utility and availability of quantitative or qualitative assessments. Some dimensions may be underpinned more by policy levers, others more by performance indicators, overall resulting in a balanced overview.

The graphic below presents all indicators and policy levers used in the monitoring framework, organised by dimension and categorised by type, to allow for a comprehensive overview, numbered as follows: **P1-13** refer to the quantitative performance indicators, **L1-L12** to the qualitative policy levers, and **C1-C25** to the context information items available. A more detailed overview table can be found in Annex 2.


Performance indicator
Policy lever
Context information
Adequacy
P1: Persons not using homecare because of cost
P2: Difficulty in affording homecare
P3: LTC costs covered by social protection
P4: Out-of-pocket costs
P5: People below 60% of median income after paying the out-of-pocket costs
L1: Waiting time for services
L2: Waiting time for needs assessment
L3: Standardised procedure for needs assessment
L4: Comprehensive evaluation of needs
C5: Monitoring of waiting times
C6: Categories of degree of dependency
C7: Income-testing and asset-testing of LTC benefits
Availability
P6: 65+ using home care
P7: 65+ receiving public LTC services
P8: 65+ with unmet need for help
P9: People not using homecare because of unavailability
C8: Public LTC expenditure by setting
C9: LTC beds
C10: Choice between LTC settings
C11: Choice between LTC providers
C12: Potential dependants 65+ receiving public home/ residential care, or cash benefits
Quality
L5A: Use and design of personal care plans
L5B: Coverage and updates of personal care plans
L6A: Quality standards
L6B: Quality assurance rules
L7: Quality assurance bodies
L8: Complaints and legal redress
Workforce
P10: Coverage of collective bargaining
P11: Gross hourly wages for LTC workers
P12: LTC workers per 100 individuals 65+
P13: LTC workers not participating in education and training
L9: ILO Domestic Workers Convention
C13: Full-time LTC workers
C14: LTC workers with permanent contracts
C15: LTC workers working shifts
C16: Non-fatal accidents at work
C17: LTC workers aged 55+
C18: Personal care workers/ nurses in LTC
C19: LTC workers in residential/non-residential care
C20: LTC workers by job tenure
C21: LTC workers by educational levels
C22: Women in the LTC workforce
Informal carers
L10: Definition/identification of informal carers
L11: Support services to informal carers
L12: Financial compensation and social protection for informal carers
C23: People providing informal care or assistance
C24: Informal carers providing high intensity care
C25: Informal carers relying on care services
C1: 65+ and 75+ as share of the total population
C2: 65+ with severe difficulties in ADLs and/or IADLs
C3: Total public LTC expenditure as share of GDP and of total cost of ageing
C4: Projected public LTC expenditure as share of GDP

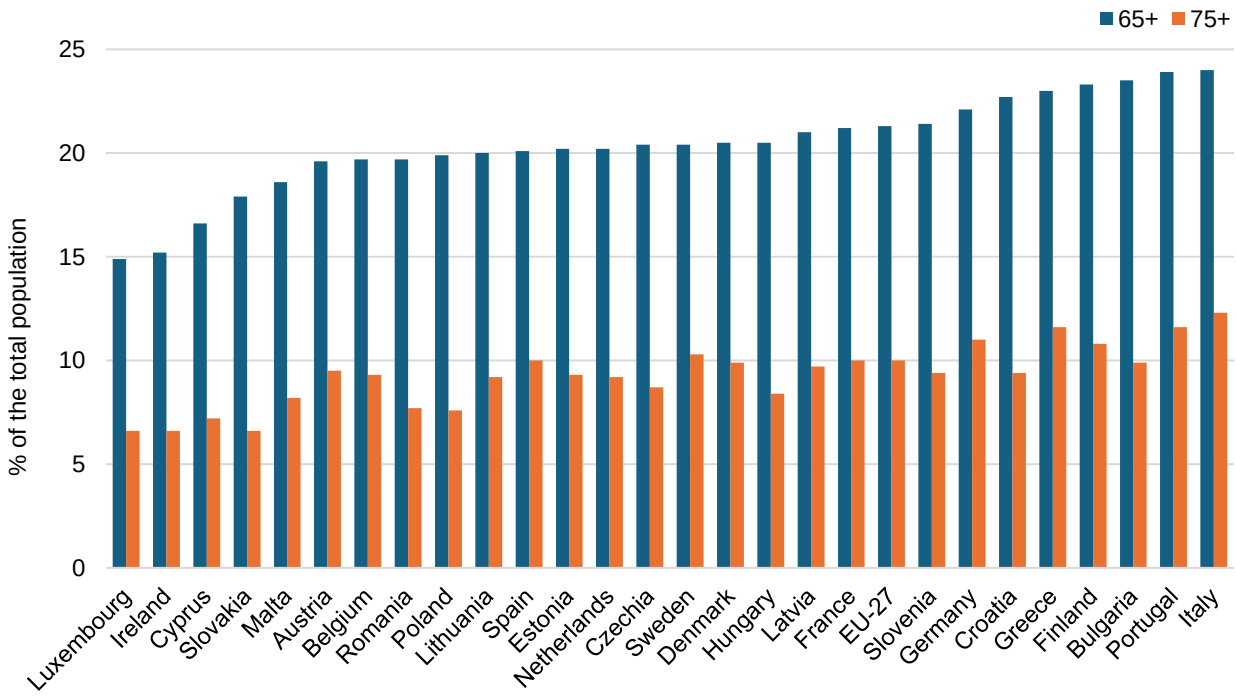
3.1 General context: Europe's ageing population and spending on LTC

A few general context information items apply across all dimensions, since they illustrate and inform the current situation. They quantify Europe's ageing population and the share of older people who may require LTC and show current and projected public expenditure on LTC.

C1: People aged 65+ and 75+ as a share of the total population

The rising number of old and very old people is likely to lead to an increase in the number of people who need LTC (see Figure 1). The impact of population ageing on care needs depends on the extent to which greater longevity is accompanied by a corresponding improvement or worsening in the health status of the population. The prevalence of physical or mental disability, which increases with age, often leads to dependency on help with ADL and/or IADL.

Figure 1: People aged 65+ and 75+ as share of total population (%), 2023



Source: Eurostat, demo_pjanind, 2023

C2: People aged 65+ with severe difficulties in ADL/IADL as a share of the population aged 65+

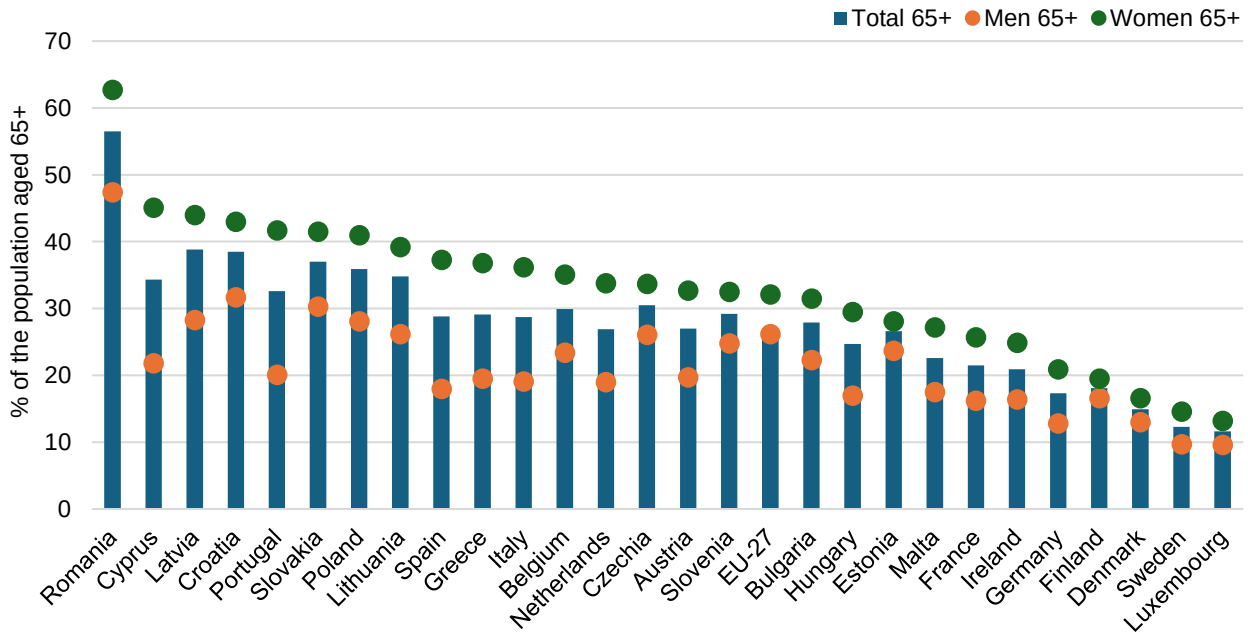
There is no single internationally accepted and standardised definition of what constitutes LTC needs. As a result, it is currently not possible to unambiguously identify the number of people in need of LTC. Member States typically perform an individual needs-assessment that takes into account the presence and extent of difficulties with ADL/IADL, cognitive limitations, and other criteria (e.g. social environment, availability of family support, and medical history) to determine a person's need for care or services and the corresponding social protection coverage. In line with the usual eligibility conditions of public schemes that define a

minimum threshold for LTC needs, it is common to focus on difficulties categorised as "severe".

Because the EHIS focuses on limitations with ADL and IADL, which are the most important and common criteria Member States apply to define LTC needs, EHIS data are here used to operationalise the number of people in need of LTC[5]. According to 2019 data[6] (see Figure 2), 26.6% of people in the EU aged 65+ living in private households needed LTC, with marked differences between women and men (32.1% of women versus 19.2% of men). Furthermore, older people with lower levels of income were more likely to need LTC than people with higher incomes. In the first (i.e. lowest) income quintile, 35.9% needed LTC, compared with 17.2% in the fifth income quintile across the EU-27.

A wide range can be observed across Member States regarding the share of people with severe difficulties, extending from almost 60% in Romania to around 10% in Luxembourg. This may be explained by differences in national income levels, as poverty influences health outcomes throughout the life course (WHO/OECD, 2003)[7], which in turn affects LTC needs.

Figure 2: People aged 65+ with severe difficulties in ADL/IADL as share of population aged 65+ (%), 2019



Note: For ADL, respondents are asked whether they have problems "feeding yourself / getting in and out of a bed or chair / dressing and un-dressing / using toilets / bathing or showering". IADL include "preparing meals / using the telephone / shopping / managing medication / light housework / occasional heavy housework / taking care of finances and everyday administrative tasks".

Source: Eurostat, EHIS wave 3, 2019, hlth_ehis_tadle.

[5] The TF LTC is working on a statistical definition of "LTC need"' to be applied in European statistics.

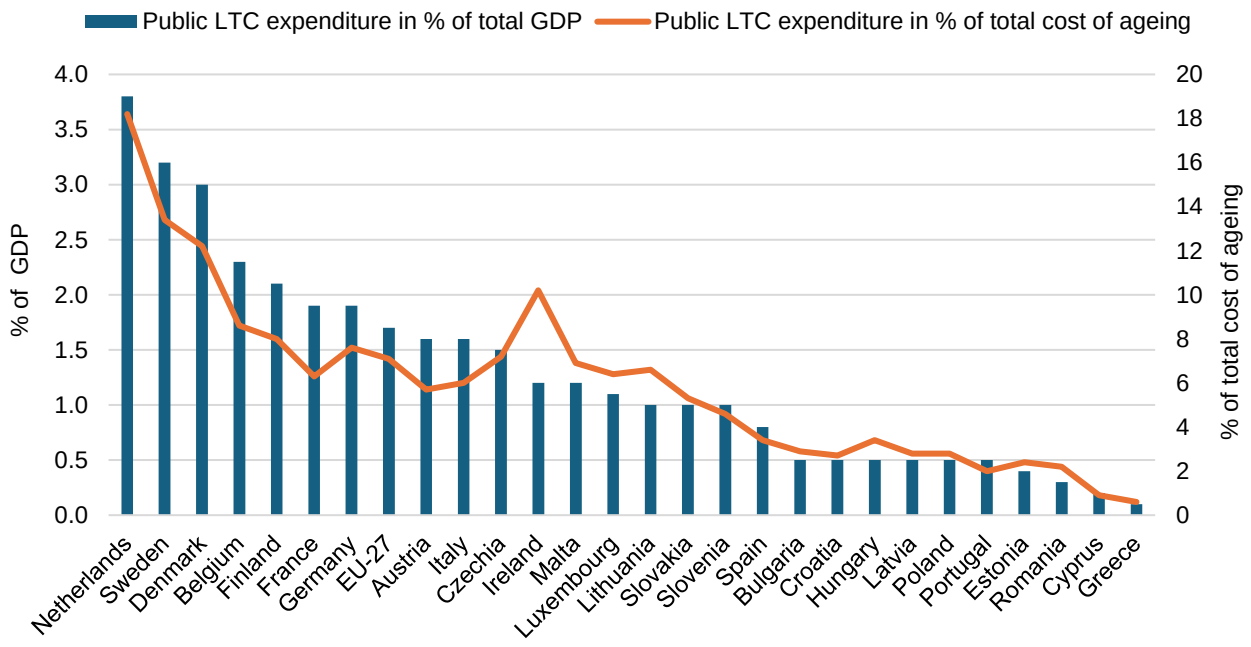
[6] Data for EHIS wave 4 will be collected between 2025 and 2026.

[7] OECD/WHO (2003), *Poverty and Health*, DAC Guidelines and Reference Series, OECD Publishing, Paris (https://doi.org/10.1787/9789264100206-en).

C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing

Population ageing has placed LTC at the forefront of policy concerns in Europe, and also raised concerns about the fiscal sustainability and adequacy of social protection systems. Ensuring fiscal sustainability in view of the rising demand expected due to ageing is indeed also important from the social policy perspective and to ensure the adequacy of the system in the long term. The aim is to make sure that social protection systems can continue to serve a growing share of citizens in need of LTC in the long run. In this regard, fiscal sustainability is interlinked with the objective of ensuring the adequacy of social protection for LTC, in particular that all people with LTC needs can access quality and affordable LTC services. Figure 3 shows the levels of Member States' public expenditure on LTC as a share of their GDP, ranging from 3.8% in the Netherlands to 0.1% in Greece, with an EU average of 1.7% in 2022. Its share in the total cost of ageing (which combines pensions, healthcare, LTC and education expenditure) broadly follows the same trend in most Member States.

Figure 3: Public expenditure on LTC as a share of GDP and of the total cost of ageing (2022) (%)



Note: Member States that do not report some public expenditure data on social LTC as part of the SHA data collection by Eurostat, have reported it directly to the Ageing Working Group (AWG); the public expenditure recorded in the Ageing Report may therefore exceed the LTC expenditure as reported by Eurostat.

The total cost of ageing is a critical indicator that represents the fiscal burden of an ageing population on a Member State's economy. It encompasses pension, healthcare, LTC and education expenditure (Ageing Report, 2024).

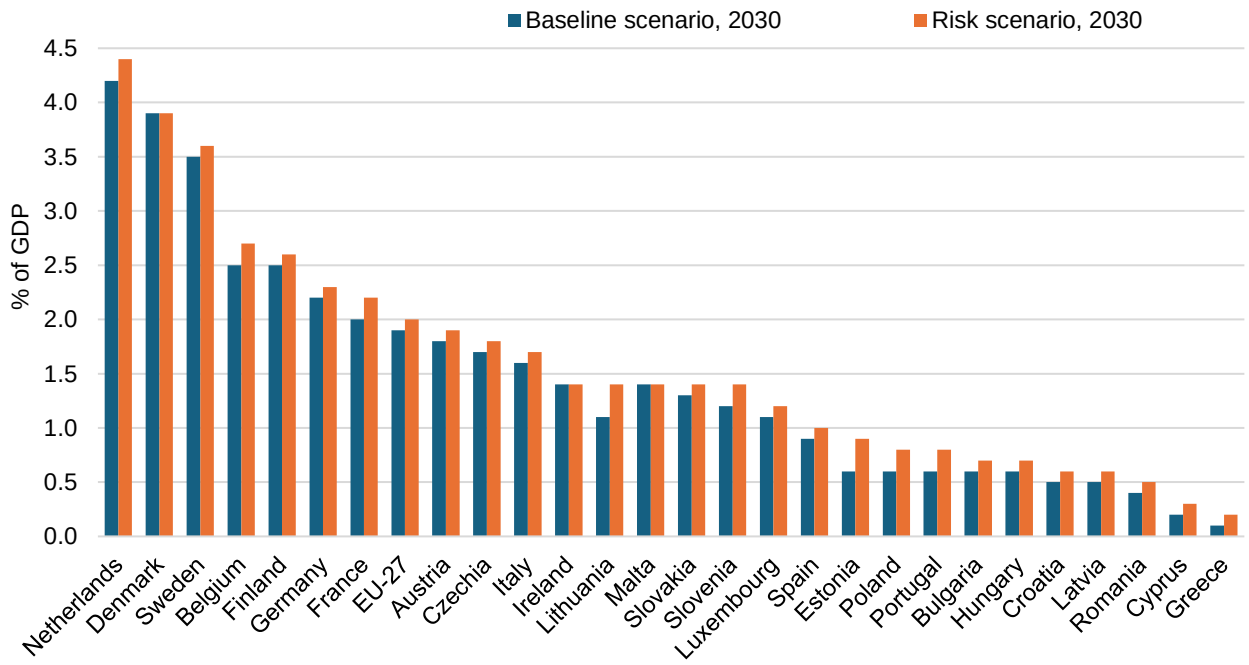
Source: 2024 Ageing Report.

C4: Projected public spending on LTC as a share of GDP in 2030

The Ageing Report provides long-term projections of LTC expenditure. Based on the current total public expenditure, different LTC expenditure scenarios are projected until 2070. The baseline scenario, used in the EU fiscal surveillance framework, is based on a "no policy

change" assumption. Alternative scenarios either assume no policy changes and capture the isolated effects that ageing, health status and the labour intensity of LTC have on expenditure, or include varying assumptions on changing costs and LTC coverage. The ISG has agreed to use the Ageing Working Group (AWG) "reference scenario (now baseline)" and "risk scenario". The former shows the expenditure effects of no policy change regarding the availability of each type of care (see Figure 4). The latter demonstrates the effects of upward convergence in formal LTC coverage and age-related expenditure to the EU average.

Figure 4: Projected public LTC expenditure as share of GDP in 2030 (%)



Source: Ageing Report 2024

3.2 Adequacy

"4. It is recommended that Member States ensure the adequacy of social protection for long-term care, by ensuring that all people with long-term care needs have access to long-term care that is:

(a) timely, allowing people in need of long-term care to receive the necessary care as soon as, and for as long as, needed;

(b) comprehensive, covering all long-term care needs, arising from mental and/or physical decline in functional ability identified through an assessment based on clear and objective eligibility criteria, and in coordination with other support and welfare services;

(c) affordable, enabling people in need of long-term care to maintain a decent standard of living and protecting them from poverty and social exclusion due to their long-term care needs as well as ensuring their dignity."

Source: LTC Recommendation

Key areas for ensuring adequate social protection are the timeliness, comprehensiveness and affordability of LTC. **Timeliness** is necessary both in terms of a swift needs-assessment and regarding the provision of services. In the absence of comparable quantitative data collection on waiting times, timeliness is monitored via policy levers on the legal situation based on MISSOC data. **Comprehensiveness** relates to both the needs-assessment process for LTC and the provision of services. To achieve comprehensiveness, all relevant needs of a care recipient have to be taken into account to provide a range of services. Comprehensiveness is assessed qualitatively via policy levers based on MISSOC data and the OECD social protection questionnaire. The **affordability** of LTC requires adequate social protection and public investment in the sector. The lack of financial resources is the main reason preventing people in need from using LTC services. Affordability is assessed mainly via performance indicators based on the EU-SILC and based on a joint EC-OECD co-operation to compare the affordability of LTC across the EU via typical cases[8].

Measures to ensure and improve the timeliness of services are currently insufficient across the EU: most Member States lack legislation on maximum waiting times for services and needs-assessment and do not have monitoring systems in place for all care settings.

Standardised procedures for LTC needs-assessments exist in all Member States, many including clear categories of dependency. However, needs-assessments differ in how comprehensive they are. Assessments with a high level of comprehensiveness recognise the multi-dimensional nature of LTC needs and include all functional (ADL and IADL) as well as cognitive, behavioural and social limitations. Eleven Member States are currently categorised as highly comprehensive systems, while seven have low levels of comprehensiveness (BG, HR, EL, HU, IT, LV, PT). The comprehensiveness of needs-assessment has an impact on the adequacy of LTC services and public support.

[8] Mutual learning workshop on adequate social protection in long-term care (OECD).

The affordability of services is a core challenge for people with LTC needs. Especially in lower-income Member States, financial reasons are cited as the main reason for not using (more) professional home care services. Among those who do use professional home care services in the EU, more than half experience difficulty in affording them, with figures exceeding 90% in some Member States (EL, CY).

While public social protection can help ease the financial burden on LTC users, its adequacy varies significantly between Member States as well as care needs and care settings: whereas home care costs are fully covered for all needs in Denmark or the Netherlands, coverage does not reach 50% for moderate needs in a third of all Member States. Generosity of public support in relation to home care costs is often greater for higher severity, which translates into absence of support for those with low needs in several cases (EL, HR, LT, LV, HU).

Residential care entails in many cases high costs and public social protection covers even lower shares of the costs than for home care in most cases. Hence, significant improvements are needed in almost all Member States to reduce the out-of-pocket (OOP) costs after public support, which are particularly high for residential care. Overall, social protection in most Member States is not sufficient to significantly reduce the increased risk of poverty LTC users face.

3.2.1 Timeliness

L1, L2, C5: Maximum (legal) waiting time for needs-assessment and service-provision

The LTC Recommendation emphasises that social protection should ensure timely access to LTC, allowing people in need of LTC to receive the necessary care as soon as, and for as long as, needed. It is important that people in need of LTC can effectively take up the social protection benefits they are entitled to. There is also concern over a certain degree of inequality in waiting times by socio-economic status, and that rationing through waiting times might lead to a deterioration in the physical and mental health of people in need of LTC due to a lack of care – and ultimately to higher care needs.

It is therefore important to ensure timeliness in processing requests for support (e.g. in the conduct of needs-assessments). Especially when social protection is provided via benefits in kind, public care services should be available shortly after the request, in the area where people in need live and/or via accessible digital means. For urgent cases, many Member States offer care services outside the normal procedures.

Waiting times are assessed regarding three aspects (see Table 1):

- L1: Are there maximum waiting times for service-provision specified in legislation? A Member State is categorised as “yes” if there is legislation in place defining maximum waiting times for both home care and residential care. It is categorised as “partly” if there is legislation on waiting times only pertaining to one care setting, only to some regions, or if there is no legislation but there are agreed norms on waiting times at federal or regional level. It is categorised as “no” if there are no waiting times specified by law or by norms.

- L2: Are there maximum waiting times for the needs-assessments specified in legislation? A Member State is categorised as “yes” if there is legislation in place. A Member State is categorised as “partly” if there is legislation only pertaining to some regions, or if there are agreed norms on the waiting time for a needs-assessment at federal or regional level. It is categorised as “no” if there are no waiting times specified by law or by norms.
- C5: Are the maximum waiting times monitored? A Member State is categorised as “yes” if there is monitoring of waiting times for home care, residential care and the needs-assessment. A Member State is categorised as “partly” if there is monitoring of one or two of those, or only in some regions; and as “no” if there are no monitoring arrangements in place.

Table 1: Maximum waiting time for needs-assessment and service-provision

Member State	POLICY LEVER Maximum (legal) waiting time for services	POLICY LEVER Maximum (legal) waiting time for needs-assessment	CONTEXT INFORMATION Monitoring of waiting times
Austria	No	No	Partly
Belgium	No	Partly	No
Bulgaria	Yes	Yes	Yes
Croatia	N/A	N/A	N/A
Cyprus	No	No	Partly
Czechia	No	No	Partly
Denmark	N/A	N/A	N/A
Estonia	Yes	Yes	Partly
Finland	Yes	Yes	Partly
France	No	Partly	Partly
Germany	N/A	Yes	Partly
Greece	No	No	No
Hungary	No	No	No
Ireland	No	N/A	Partly
Italy	N/A	Yes	N/A
Latvia	No	Yes	Partly
Lithuania	No	Yes	Partly
Luxembourg	Partly	N/A	Yes
Malta	N/A	Partly	N/A
Netherlands	Partly	Yes	Partly
Poland	No	No	Yes
Portugal	Partly	Partly	Yes
Romania	No	No	No
Slovakia	No	Yes	No
Slovenia	N/A	N/A	N/A
Spain	Yes	Yes	Yes
Sweden	Yes	No	Yes

N/A: not available.

Source: MISSOC

3.2.2 Comprehensiveness

L3, C6: Standardised procedure for LTC needs-assessment and clear categories of degrees of dependency

To ensure the adequacy of social protection for LTC, the LTC Recommendation invites Member States to apply clear and objective eligibility criteria regarding the LTC needs-assessment. Clear and objective criteria can ensure fairness and transparency and help encourage people in need of LTC to apply for social protection, as it can make the application process more comprehensible and transparent. Clear procedures and criteria can also help to ensure that people in need of care have access to adequate LTC, by reducing waiting times, streamlining the administrative process, and reducing the fragmentation of the assessments.

For this dimension, one policy lever (L3) and one context information item (C6) were conceptualised (see Table 2).

Firstly, the policy lever “standardised procedure for LTC needs-assessment” indicates whether there is a standardised procedure for the assessment of LTC needs. This procedure can be standardised at national, regional or local level.

Secondly, the context information “clear categories of degrees of dependency” shows whether different levels, or degrees, of need for LTC are provided for in the legislation. LTC benefits are usually provided based on the categories of degrees of dependency determined during the needs-assessment.

On the one hand, the lack of standardised categories of degrees of dependency can be an indication that it is difficult for people in need of LTC to receive the care they need, and therefore there is an adequacy challenge. On the other hand, it may also be an indication that Member States have developed a more person-centred, integrated care approach, where several aspects of each individual’s well-being and wishes are taken into consideration. For example, in Finland, which does not have standardised categories, care recipients participate in assessing their needs and drawing up their care plans.

“Clear categories of degree of dependency” are therefore classified as context information, as Member States developing person-centred care models usually evolve from a strict assessment of ADL and IADL to an individualised assessment of the care needs of the people concerned.

Table 2: Evaluation of dependency

Member State	POLICY LEVER Standardised procedure for LTC needs-assessment (can vary between regions)	CONTEXT INFORMATION Clear categories of degrees of dependency
Austria	Yes*	Yes
Belgium	Yes*	Yes
Bulgaria	Yes	Yes
Croatia	Yes	No
Cyprus	Yes	No
Czechia	Yes	Yes
Denmark	Yes*	No
Estonia	Yes*	No
Finland	Yes*	No
France	Yes	Yes
Germany	Yes	Yes
Greece	Yes	Yes
Hungary	Yes	Yes
Ireland	Yes**	No
Italy	Yes	Yes
Latvia	Yes	No
Lithuania	Yes	No
Luxembourg	Yes	Yes
Malta	Yes	No
Netherlands	Yes	No
Poland	Yes	Yes
Portugal	Yes	Yes
Romania	Yes	Yes
Slovakia	Yes	Yes
Slovenia	Yes	Yes
Spain	Yes	Yes
Sweden	Yes*	No

* Member States that have standardised the procedure at regional or local level.

** Ireland is currently implementing standardised evaluation tools at national level.

Source: MISSOC

L4: Comprehensive evaluation (coverage) of LTC needs

The LTC Recommendation emphasises the need for comprehensive LTC, recommending that Member States ensure that LTC covers all needs arising from a mental and/or physical decline in functional ability. Although all EU Member States provide some social protection coverage for LTC needs, the comprehensiveness of the LTC needs that are recognised can vary significantly, which influences the effective level of social protection benefits.

In order to make meaningful international comparisons of the level of coverage by such social schemes in different Member States, a set of “typical cases” of LTC needs were defined as part of an EC-OECD co-operation that measures the effectiveness of social protection for LTC in old age. LTC needs include help with activities such as washing and getting dressed – grouped under personal care, or ADL – as well as housekeeping tasks, such as

cleaning and shopping – grouped under IADL. As people become more dependent, they may also find it difficult to maintain social relationships and participate in their community. They may need help with social activities, for example attending a community club or going out for a walk. This provides a sound basis for an indicator regarding this dimension of adequacy.

The policy lever (L4) illustrates the extent to which Member States conduct a comprehensive evaluation of LTC needs in determining eligibility for benefits and/or the generosity of public support. Service-delivery is then based on the needs-assessment.

Member States with a comprehensive to mid-level needs-assessment scale are categorised as “yes” (comprehensive), while those with a low-level needs-assessment scale are categorised as “no” (not comprehensive). The following criteria are employed to categorise the level of comprehensiveness of needs-assessment scales in the EU (see Table 3):

a) **Low level:** A Member State is ranked as low if its needs-assessment primarily focuses on limitations with ADL, such as difficulties with dressing or bathing independently. This limited focus indicates a narrower approach to assessing LTC needs.
b) **Medium level:** A Member State is ranked as mid-level if its assessment process considers all six ADL, as well as some of the eight IADL defined for the typical cases. For example, difficulties in preparing a hot meal or taking medications are some of the limitations considered. This category reflects a more inclusive approach by encompassing a broader range of functional tasks than the low level.
c) **High level:** A Member State is ranked as comprehensive when its needs-assessment adopts a holistic approach to determine individuals' care needs. This includes conducting a broad functional assessment, including all ADL and IADL used in the typical cases. Additionally, the evaluation considers cognitive, behavioural, and social limitations. This level refers to systems that, through their needs-assessment, recognise the multi-dimensional nature of LTC needs by evaluating not just functional limitations but cognitive, behavioural and social ones.

It is important to acknowledge certain limitations in the proposed approach. The scarcity of information for some Member States poses challenges in accessing detailed descriptions of their respective needs-assessment tools, potentially having an impact on the accuracy of certain evaluations.

Table 3: Policy lever illustrating level of comprehensiveness for evaluating LTC needs

Member State	LTC needs-assessment comprehensiveness	Comprehensiveness level
Austria	Yes	Medium
Belgium	Yes	High
Bulgaria	No	Low
Croatia	No	Low
Czechia	Yes	Medium
Cyprus	Yes	Medium
Denmark	Yes	High
Estonia	Yes	High
Finland	Yes	High
France	Yes	High/medium
Germany	Yes	High
Greece	No	Low
Hungary	No	Medium/low
Ireland	Yes	High
Italy	No	Low
Latvia	No	Low
Lithuania	Yes	Medium
Luxembourg	Yes	Medium
Malta	Yes	Medium
Netherlands	Yes	High
Poland	Yes	Medium
Portugal	No	Low
Romania	Yes	High
Slovakia	Yes	Medium
Slovenia	Yes	High
Spain	Yes	High
Sweden	Yes	High

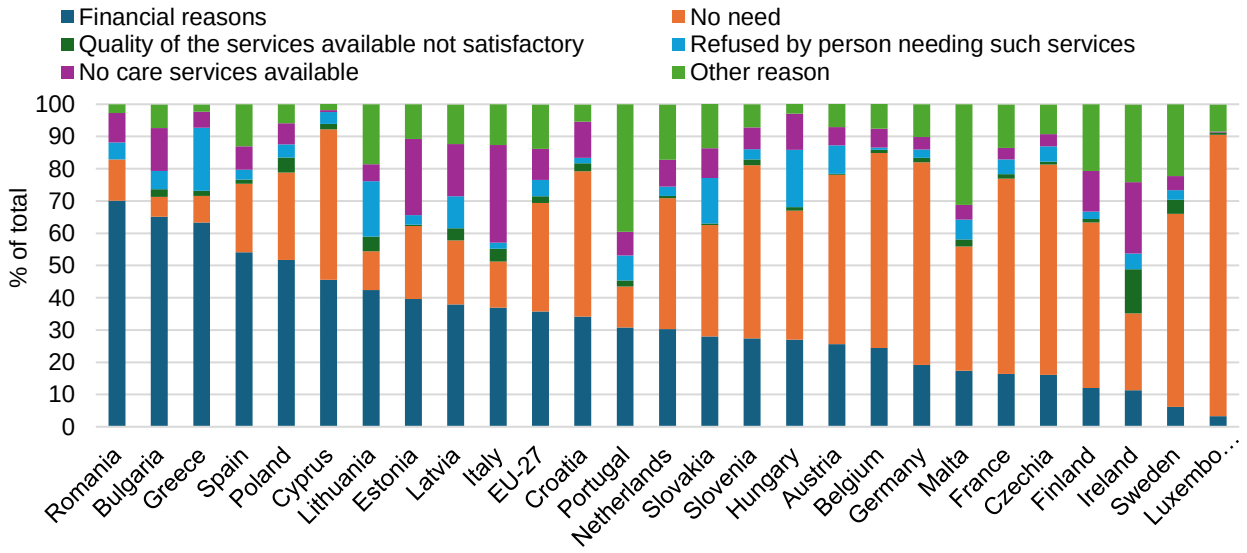
3.2.3 Affordability

P1: People in need of LTC not using (more) professional home care services primarily due to cost

The significant non-use of home care services for financial reasons highlights the importance of factors determining affordability, where the adequacy of social protection is key. EU-SILC data inform the performance indicator (P1) and illustrate the extent of this challenge: for households with people needing home care services provided by professional health or care workers due to long-term physical or mental ill-health, infirmity or old age, respondents are asked if they need more of these services than they actually receive. If they confirm that they do, they are asked to “state the main reason for not receiving home care services provided by professional health or care workers or more care services than re-

ceived at present". Financial reasons are reported as the most common factor for the majority of Member States, in cases of unmet needs for professional home care services (see Figure 5).

Figure 5: People in need of LTC not using (more) professional home care services by main reason (%), 2016



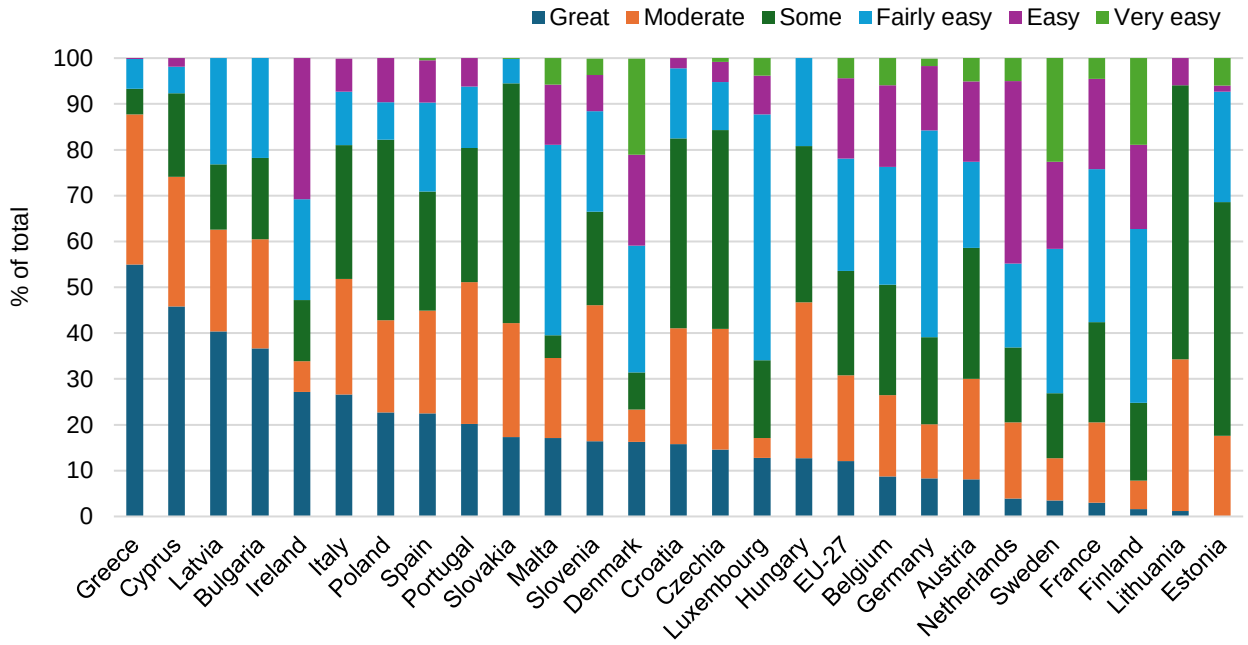
Source: Eurostat, EU-SILC, 2016, ilc_ats15

P2: Difficulty in affording professional home care service

Complementary to the previous indicator, the EU-SILC ad hoc module on access to services also asked households who are using professional home care services about the level of difficulty they experience in paying for these services. It is important to consider that some people may have to forgo other spending or ask relatives for financial help in order to be able to afford professional home care services (see Figure 6).

Respondents indicate whether the costs for these home care services are paid by their household: (a) with great difficulty; (b) with difficulty; (c) with some difficulty; (d) fairly easily; (e) easily; or (f) very easily. For the interpretation of this indicator (P2), it is thus important to consider that only households who do have OOP expenditure on LTC are part of the sample. If LTC costs are fully covered by the state providing the services, the households are not asked this question.

Figure 6: Difficulty in affording professional home care services by degree (%), 2016



Source: Eurostat, EU SILC ad hoc module, 2016, ilc_ats16

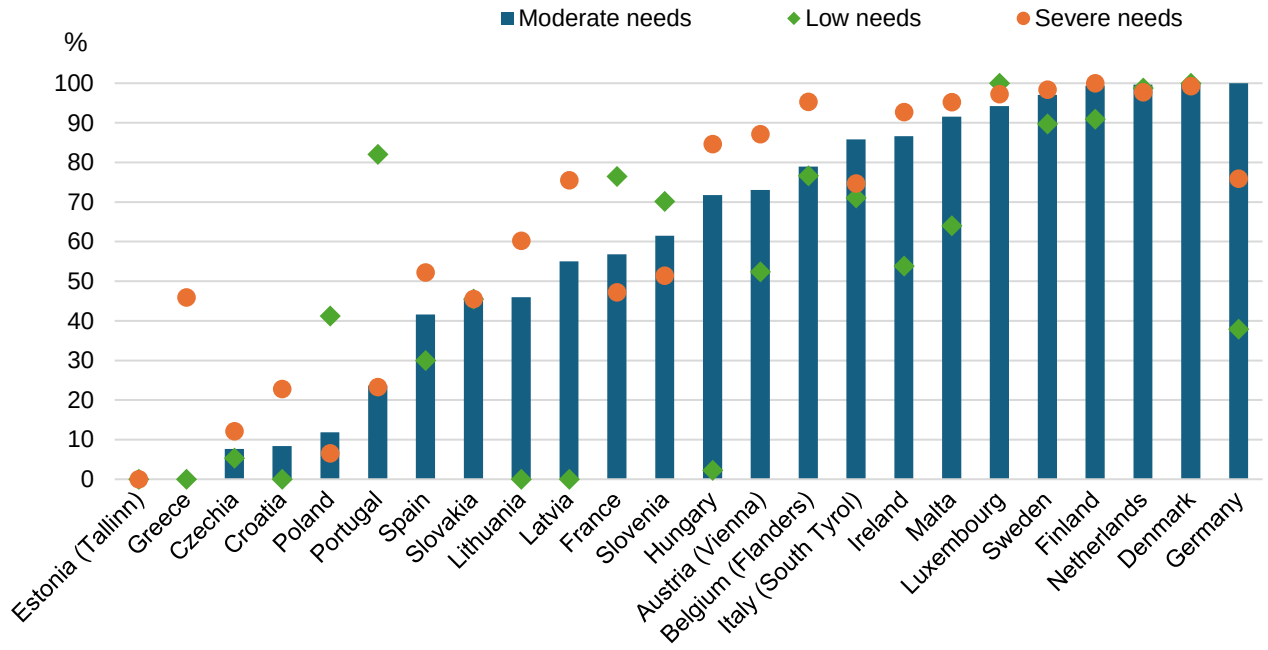
P3: Share of costs covered by public social protection

Given the wide heterogeneity of LTC systems, it is difficult to make meaningful cross-country comparisons of the generosity of social protection for LTC, as provision for LTC needs may be covered by a specific LTC branch, or under the healthcare, disability or social assistance branches. An approach that can capture the different types of variation relies on social protection coverage for typical cases of LTC needs. A joint EC-OECD project entitled “Measuring social protection for long-term care in old age”, the results of which have been regularly presented to the ISG, makes it possible to determine the level of public support in different Member States and sub-national areas and to compare it for a defined level of LTC needs.

The proportion of total LTC costs that public systems cover varies both between and within Member States and sub-national areas, as well as across levels of care recipient need, income and net wealth, and home care versus residential care.

The typical cases used to compare the social protection in LTC across Member States describe an older person in terms of the types and severity of their needs, the professional services they would require, and their level of income and assets. Low, moderate and severe needs correspond to 6.5, 22.5 and 41.25 hours of care per week, respectively. The typical cases are analysed for low income, median income and high income and illustrate the most generous support assuming no assets. The shares of total home care costs for different severities that are covered by public social protection systems – for an older person with a median income and no net total wealth – vary between Member States, ranging from full coverage for all care needs in Denmark to no coverage for low and moderate care needs in Estonia (see Figure 7).

Figure 7: Share of costs for home care covered by public social protection systems for care recipients (aged 65+) earning a median income and with no net wealth, by severity level (%), 2021/2022

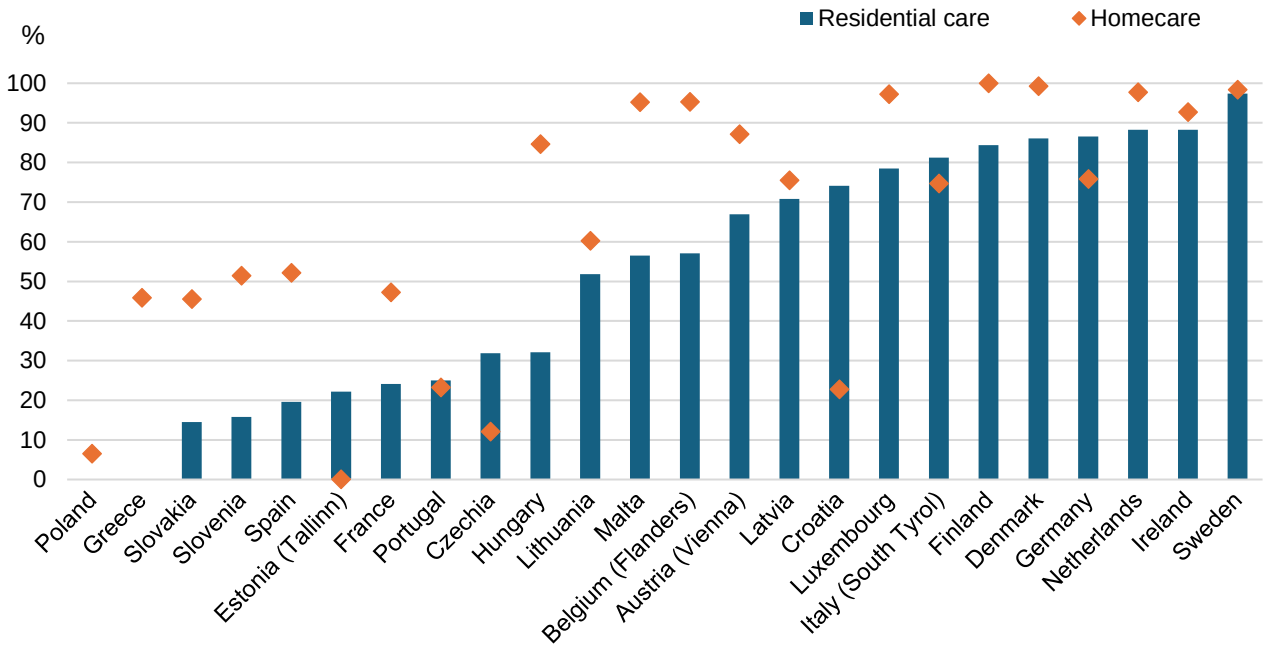


Note: Data not available for BG, CY and RO.

Source: OECD analyses based on the OECD questionnaire on LTC social protection, the OECD income distribution database, and the OECD wealth distribution database. 2022 data for all Member States except AT and SK (2021 data).

For severe care needs, the share of total LTC costs covered differs between residential care and home care, with the majority of Member States covering a greater proportion of home care costs for recipients with median incomes and no net wealth (see Figure 8).

Figure 8: Share of costs for home and residential care covered by public social protection for care recipients (aged 65+) with severe needs earning a median income and with no net wealth (%), 2021/2022



Note: Data not available for BG, CY and RO.

Source: OECD analyses based on the OECD questionnaire on LTC social protection, the OECD income distribution database, and the OECD wealth distribution database. 2022 data for all Member States except AT and SK (2021 data).

P4: Out-of-pocket costs of care as a share of income for care recipients aged 65+

Although public social protection systems tend to provide greater support to those with fewer means (income and net wealth), even a small share of OOP payments for LTC can represent a large proportion of people's income. OOP costs (the part of the costs left to be paid after considering public support) may be very high compared with disposable incomes, especially for older people with severe needs receiving home care.

The LTC Recommendation specifies that LTC should be affordable, enabling people in need of LTC to maintain a decent standard of living, protecting them from poverty and social exclusion due to their LTC needs, and ensuring their dignity. While the next indicator will look more closely at people at risk of poverty, OOP costs are considered high if they exceed 50% of median income[9/10].

As residential care costs include board and lodging, older people living in residential care might be able to spend all their income on the OOP costs of care. However, if people are

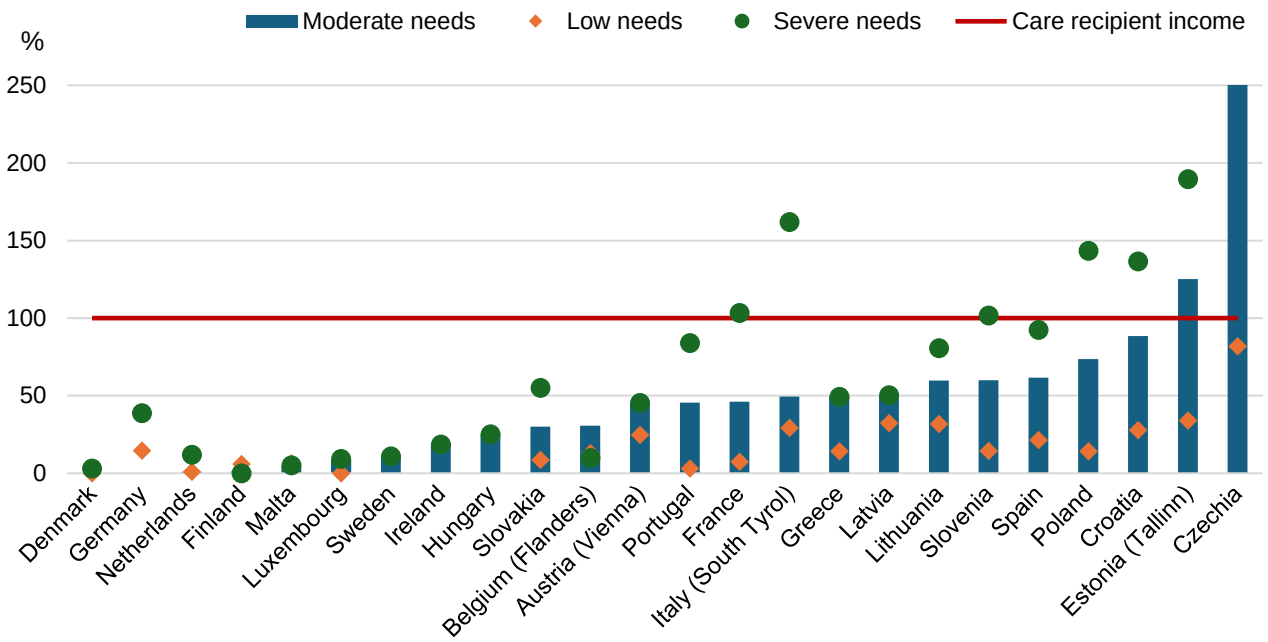
[9] Oliveira Hashiguchi T. and Llena-Nozal A (2020), The effectiveness of social protection for long-term care in old age: Is social protection reducing the risk of poverty associated with care needs?, *OECD Health Working Papers*, No. 117, OECD Publishing, Paris, https://doi.org/10.1787/2592f06e-en.

[10] A study looking at the associated socio-demographic and economic factors of catastrophic LTC expenditure in Spain found that when the percentage of OOP payments increases to over 40% of household income, the risk of catastrophic payments and associated factors is similar to the risk of impoverishment. See: del Pozo-Rubio R., Mínguez-Salido R., Pardo-García I. et al., Catastrophic long-term care expenditure: associated socio-demographic and economic factors, *European Journal of Health Economics*, 20, 691-701 (2019) (https://www.sciencedirect.com/science/article/pii/S0168851019300843).

left with very limited financial resources, they lose the independence to spend their income on other things they might need. Several Member States (such as FR, LU and CZ) include rules that explicitly ensure that people in residential care are left with at least a certain share of their income (around 9%-15% of the median pensioner's income)[11].

Figures 9 and 10 show (respectively) the share of OOP costs for home care by level of needs, and the share of OOP costs for residential care by level of income.

Figure 9: Out-of-pocket costs of home care as a share of income after public support for care recipients (aged 65+) earning a median income and with no net wealth, by severity level (%), 2021/2022

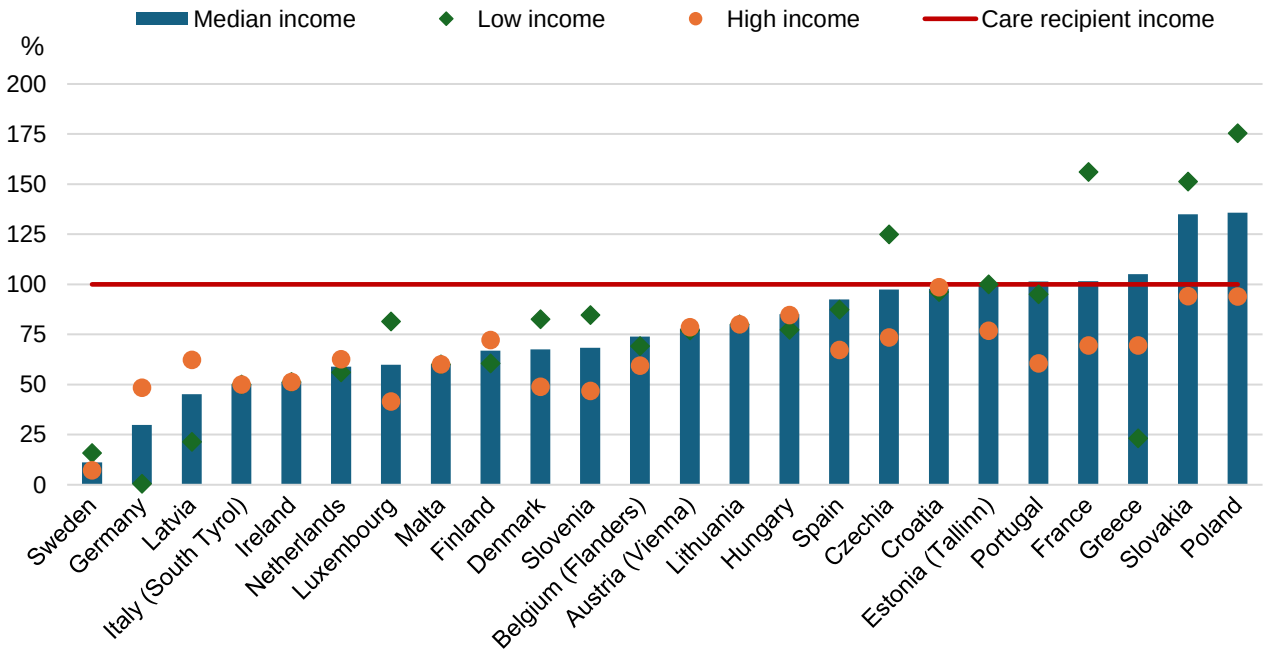


Note: Data not available for BG, CY and RO. In SE, IE and HU, the ceiling for the copayment is independent of the level of needs.

Source: OECD analyses based on the OECD questionnaire on LTC social protection, the OECD income distribution database, and the OECD wealth distribution database. 2022 data for all Member States except AT and SK (2021 data).

[11] Oliveira Hashiguchi and Llena-Nozal (2020), op. cit.

Figure 10: Out-of-pocket costs of care as a share of old-age income after public support for residential care for care recipients (aged 65+) and with no net wealth, by level of income (%), 2021/2022



Note: Data not available for BG, CY and RO. Low income is the upper boundary of the 20th percentile of income, and high income is the upper boundary of the 80th percentile of income – both among people aged 65 or older. In IT, MT, and LT, the ceiling for the copayment is independent of the level of needs.

Source: OECD analyses based on the OECD questionnaire on LTC social protection, the OECD income distribution database, and the OECD wealth distribution database. 2022 data for all Member States except AT and SK (2021 data).

P5: Share of population aged 65+ who would have below 60% of median income after paying for the out-of-pocket costs of home care

The LTC Recommendation states that adequate public social protection for LTC should protect people from falling into poverty due to developing LTC needs.

An adjusted measure to assess the performance of social protection to "protect from poverty and social exclusion due to LTC needs" looks at the risk of poverty associated with the OOP costs of LTC. Although people in need may be able to pay for care, they often cannot afford it without going below a certain level of remaining income. This remaining income is needed to cover all the other normal expenses of daily life. For this purpose, poverty is measured based on the threshold of 60% of equivalised median disposable income, before any expenditure and after social transfers (i.e. the at-risk-of-poverty threshold used at EU level). Disposable income is then adjusted for OOP expenditure on LTC. This assumes that people with LTC needs living in their own homes will still face living expenses that are similar to people without LTC needs (namely rent, electricity, food, and clothing, among others).

Figure 11 compares the share of the population aged 65+ who would be at risk of poverty after paying for the OOP costs of home care with access to social protection (LTC use and social protection) with: (a) the share of the population aged 65+ who would be at risk of poverty after paying for the full costs of home care (LTC use and no social protection); and

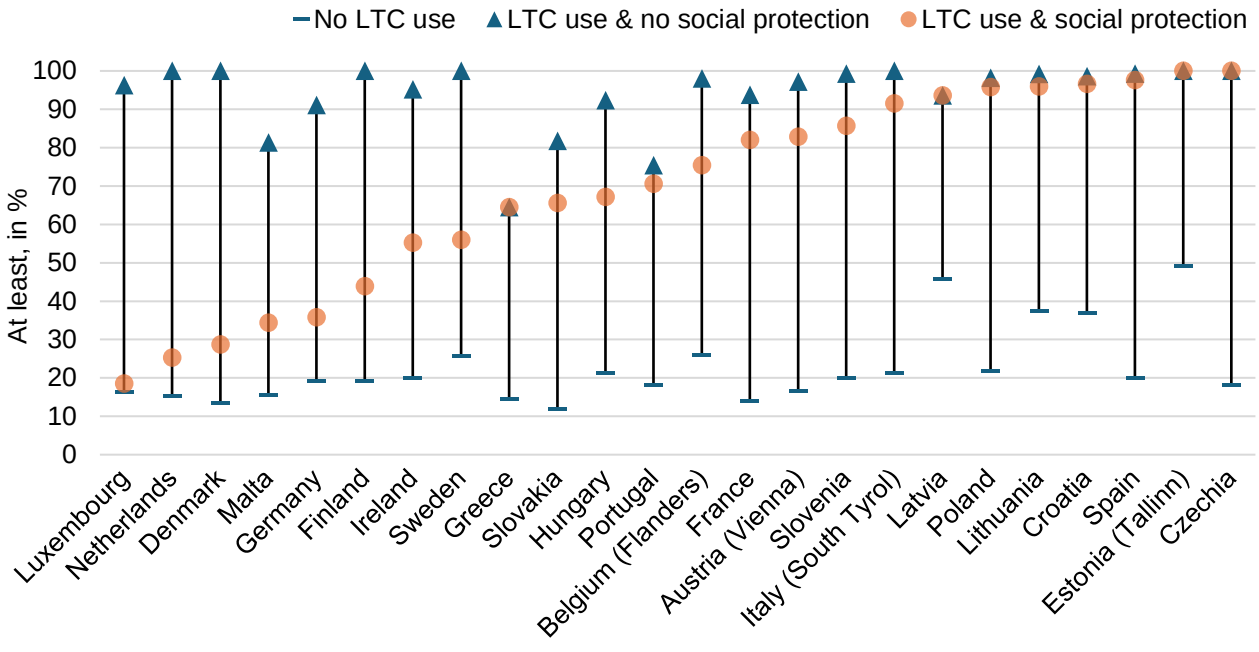
(b) the share of the overall population aged 65+ at risk of poverty (no LTC use). The comparison shows whether social protection for LTC is reducing the risk of poverty associated with LTC, compared with overall poverty risks among older populations.

In estimating "LTC use and social protection" in Figure 11, the indicator works on the assumption that individuals with LTC needs actively seek and have access to public support and the available benefits. The results would vary if access barriers to LTC benefits were considered.

The data for "no LTC use" capture the risk of poverty rates among the entire population aged 65+. Looking at the financial situation of older people across the income distribution, in a hypothetical situation where they faced care needs and needed to pay for home care services, shows whether they would be able to afford home care from their income alone without social protection (i.e. whether they would be at risk of poverty). The percentages show the share of the older population that would have below 60% of median income after paying for the OOP costs of home care (after social protection).

Figure 11 illustrates the extent to which social protection systems for LTC reduce the risk of poverty associated with LTC needs. In almost all Member States, more than 70% of LTC users would be at risk of poverty without social protection. In only two Member States (LU, NL), does the social protection available result in LTC users being at around the same risk of poverty as non-LTC users. In many Member States (EL, PL, LV, PL, LT, HR, ES, BG, EE, CZ), social protection for LTC appears to not/barely change the increased risk of poverty of LTC users, suggesting adequacy challenges.

Figure 11: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs, 2017/2024



Note: Data not available for BG, CY and RO.

Source: For all Member States except PT and IE, OECD analyses based on the OECD Long-Term Care Social Protection questionnaire, and Survey of Health, Ageing and Retirement in Europe (SHARE), wave 8 (for PT wave 6).
For IE: The Irish longitudinal study on ageing (TILDA) wave 3, 2014-2015 [dataset] version 3.6, Irish social science data archive (2024).

C7: Income-testing and asset-testing of LTC benefits

Public social protection systems use a myriad of ways to organise their LTC benefits and schemes, mixing different forms of means-testing (including different types of rules) with non-means-tested benefits and schemes. To better understand social protection systems in the EU, it is important to consider information related to the use of means-testing for determining the eligibility for, and generosity of, LTC benefits. This provides valuable insights into the balance between efficiency and coverage. Although means-testing effectively targets assistance at those in greatest need, it can also result in higher administrative costs and barriers for people just above the income or asset thresholds. This information is used to contextualise the social protection systems.

Table 4 categorises Member States and sub-national areas in two groups: (a) does the system include benefits that apply income-testing? (yes or no?); and (b) does the system include benefits that apply asset-testing? (yes or no?). In Member States and sub-national areas such as Belgium (Flanders) and France, the LTC system applies both income- and asset-testing. Systems such as those in Austria (Vienna) or Finland focus on using income-testing only, while in Hungary only asset criteria are applied. In contrast, Denmark and Czechia do not apply any means-testing, offering LTC benefits based purely on needs.

Table 4: Overview of use of means-testing to determine level of public support for LTC

Country/sub-national area	Is the system comprised of benefits that apply income-testing?	Is the system comprised of benefits that apply asset-testing?
Austria (Vienna)	Yes	No
Belgium (Flanders)	Yes	Yes
Croatia	Yes	Yes
Czechia	No	No
Denmark	No	No
Estonia (Tallinn)	Yes	No
Finland	Yes	No
France	Yes	Yes
Germany	Yes	Yes
Greece	Yes	Yes
Hungary	Yes	No
Ireland	No	No
Italy (South Tyrol)	Yes	Yes
Latvia	Yes	No
Lithuania	Yes	No
Luxembourg	No	No
Malta	No	No
Portugal	No	No
Slovakia	No	No
Slovenia	Yes	Yes

Spain	Yes	Yes
Sweden	Yes	No

Note: Countries and sub-national areas may have different benefits for LTC, some of which may involve means-testing, while others may not follow any financial criteria. In the table, when a system includes at least one benefit that applies income- and/or asset-testing, it is categorised accordingly. The above methodology refers to home care, as for residential care there are some additional requirements in terms of asset-testing in some Member States.
Source: OECD

3.3 Availability

"5. It is recommended that Member States continuously align the offer of long-term care services to long-term care needs, while providing a balanced mix of long-term care options and care settings to cater for different long-term care needs and supporting the freedom of choice, and participation in decision-making, of people in need of care, including by:

(a) developing and/or improving home care and community-based care;

(b) closing territorial gaps in availability of and access to long-term care, in particular in rural and depopulating areas;

(c) rolling-out accessible innovative technology and digital solutions in the provision of care services, including to support autonomy and independent living, while addressing potential challenges of digitalisation;

(d) ensuring that long-term care services and facilities are accessible to persons with specific needs and disabilities, and respecting the equal right of all persons with disabilities to live independently in the community, with choices equal to others;

(e) ensuring that long-term care services are well-coordinated with prevention, healthy and active aging and health services and that they support autonomy and independent living, restoring as far as possible, or preventing the deterioration of physical or mental condition."

Source: LTC Recommendation

Member States are recommended to invest in LTC with a focus on aligning LTC services with LTC needs, while providing a balanced mix of different LTC services. Monitoring of this dimension is underpinned by context information on demography, including the share of older people with LTC needs and the share of older age groups in the population. Offering a balanced mix of LTC options and care settings caters for different LTC needs and supports the freedom of choice of people in need of LTC. Such a balanced mix is monitored via: the relative expenditure of Member States in the different LTC settings from the EC-EPC Ageing Report; annual data on the number of LTC beds in residential care from Eurostat, to provide context on the prevalence of residential care in the balance of care settings; and qualitative context information on the existence of choice for people in need in LTC regarding their care setting and care-provider. To ensure a sufficient offer of LTC services, it is important that Member States develop and improve home care and community-based care. A performance indicator from the EHIS illustrates the share of people with LTC needs who use professional home care services, complemented by data from the Ageing Report showing the share of people aged 65+, and of potential dependants aged 65+, receiving publicly provided or financed care services or cash benefits – revealing a gap between the number of people who

are in need of LTC and the number of people who receive formal support. An indicator from the EHIS also illustrates the lack of help with ADL/IADL that people experience. Finally, territorial gaps are illustrated via an indicator from the EHIS on the availability of LTC by degree of urbanisation.

The data demonstrate an imbalance of public spending between care settings. Spending is skewed towards residential care, demonstrating the need to invest more in home and community-based care to expand and improve these services. Currently, access to home care services is limited: on average in the EU, only 28.6% of those with severe difficulties self-reported the use of home care, with proportions exceeding 50% in just three Member States (BE, DK, NL). Aside from the above-mentioned concerns around the affordability of home care, poor availability also contributes to this low proportion, as a shortage of supply is reported particularly in rural areas. Concerning residential care, the number of beds available varies drastically between Member States, reflecting shortages in some, or choices to prioritise home care and/or to focus on better targeting residential LTC provision in others.

Hence, even though most Member States offer a free choice of care settings and providers for those receiving public support, limited availability may pose a significant barrier to the receipt of care in a preferred setting. Shortcomings in the availability of formal care services also result in care needs remaining unmet, with almost 50% of Europeans with LTC needs reporting a perceived lack of assistance.

3.3.1 Balanced mix of LTC options

C8: Share of public LTC expenditure by setting

The LTC Recommendation recommends that Member States provide a balanced mix of LTC options and care settings to cater for different LTC needs. While policy-makers distinguish between home, community-based and residential care, European data collections only distinguish between home and residential care. Home care means LTC provided in the recipient's private home, by professional LTC workers. Community-based care means LTC provided and organised at community level, for example in the form of adult daycare services or respite care (semi-residential care), meaning that people in need of LTC continue to live in their private homes but receive LTC services outside of their home in a building within their community. Community-based semi-residential care is thus often statistically recorded as residential care[12]. By comparison, full residential care is provided to people living in a residential LTC setting. In practice, home, community-based and residential care services are available in all Member States, but to a different extent.

The Ageing Report[13] collects data triennially from Member States on public spending on the different care settings. The mix of LTC options and care settings can be illustrated to some

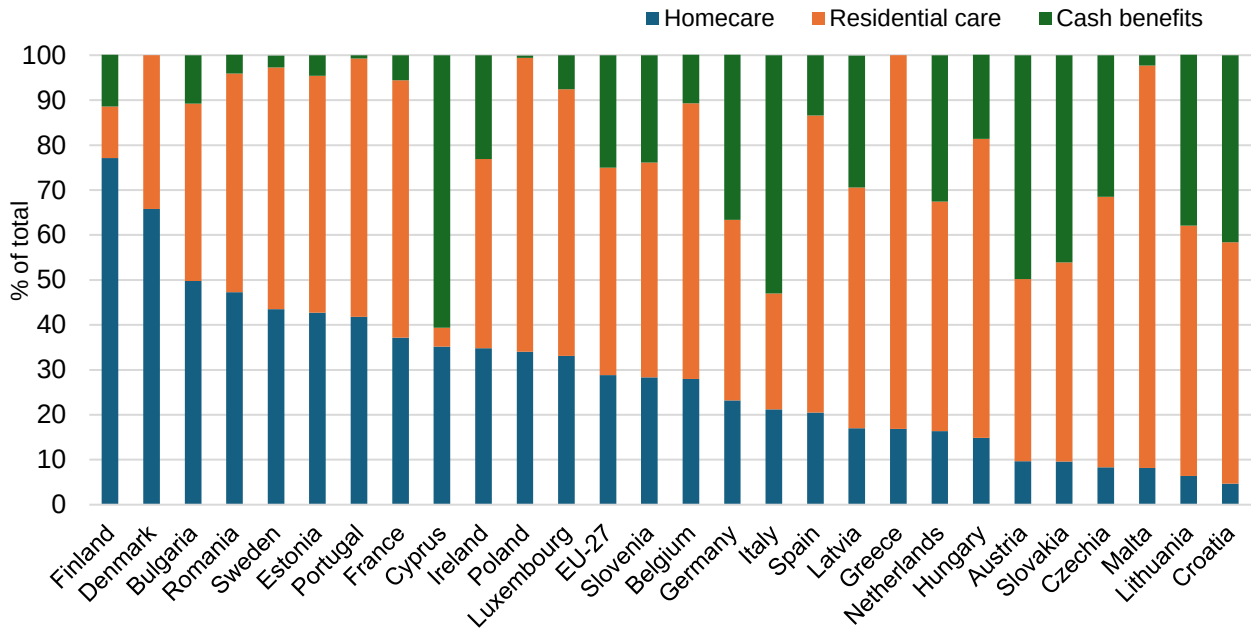
[12] The Ageing Report uses the SHA definition, according to which this would be counted as residential care. However, there will be variations in how Member States report community-based care.

[13] https://economy-finance.ec.europa.eu/publications/2021-ageing-report-economic-and-budgetary-projections-eu-member-states-2019-2070_en

extent by the public LTC expenditure that is allocated to each setting, including cash benefits.

Data from the Ageing Report indicate that Member States spend most on residential care. Out of total current public LTC expenditure in the EU-27 in 2022, 28.8% went on home care, 46.2% on residential care, and 25% on cash benefits, with marked variations from these averages across the Member States (see Figure 12). Typically, the average cost of residential care per person is higher, but that is also influenced by the fact that the population concerned has a greater degree of dependency. One key element to manage the upward pressure on expenditure is to provide LTC in the most cost-effective setting, which depends on the specific needs of the care recipient, while also considering their preferences. Figure 12 also shows that there is ample room for some Member States to strengthen the support for home care services.

Figure 12: Share of public LTC expenditure by setting (%), 2022



Source: Ageing Report 2024

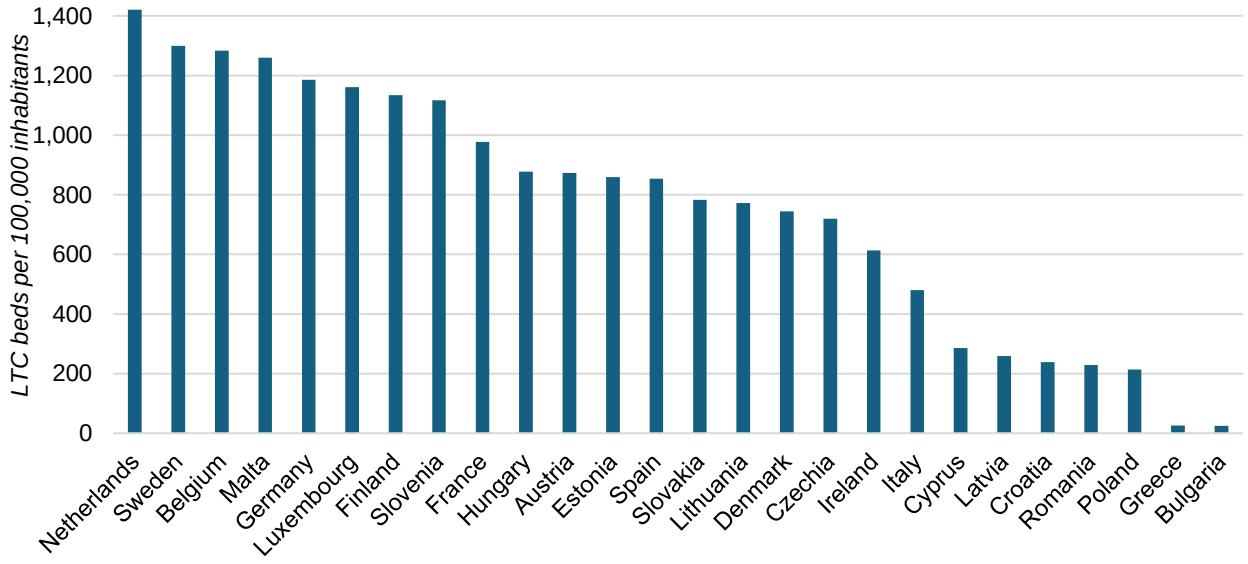
C9: Number of LTC beds

The LTC Recommendation calls on Member States to offer a balanced mix of high-quality LTC options and care settings to cater for different LTC needs and support freedom of choice. While home and community-based care settings are more likely to provide person-centred approaches, high-quality residential care remains an important option for those needing 24/7 support and supervision to ensure their well-being.

Data on the residential care infrastructure suggest very heterogeneous availability across the EU-27 (see Figure 13). The number of LTC beds per 100,000 inhabitants of all ages ranged from 25 in Bulgaria to 1,420 in the Netherlands in 2022. This spread underlines the

fact that while some Member States lack residential care options, other Member States could focus more on reinforcing home care, in particular for people with low and medium care needs. In addition to enabling freedom of choice as regards the care setting, ensuring that people can choose the setting corresponding to their level of LTC need would also increase the efficiency of the system.

Figure 13: Number of LTC beds per 100,000 inhabitants, 2022



Source: Eurostat, joint questionnaire on non-monetary healthcare statistics, hlth_rs_bdltc, 2022

C10 and C11: Existence of choice between care settings and between providers for people in need of LTC

The LTC Recommendation invites Member States to support the freedom of choice of people in need of LTC among the different LTC options and care settings, catering for different LTC needs. Member States ensure this freedom of choice in different ways. Some Member States offer a choice between the type of benefit (cash versus in-kind). In cases where in-kind benefits are provided, many Member States offer a free choice between the various care settings. In cases where a cash benefit is received, there can be legal requirements on how it is spent – for example, whether it can be used to compensate informal carers, or no restrictions at all (the latter means that it could be spent as an income supplement to pay for basic expenses, for formal care services and/or to pay undeclared workers).

To assess whether the LTC system supports freedom of choice over the preferred care option, information from the MISSOC database is available illustrating the regulatory situation. It should be noted that some restrictions can enhance the efficiency of the LTC system – for example, when people with a low level of needs are not admitted into residential care, or when there is a pre-selection or accreditation of providers of public LTC services.

Regarding the free choice of care setting (C10), a Member State is categorised as "yes" if people receiving public benefits can choose whether to use home, community based or residential care, in line with their care needs, while accounting for situations where a certain level of needs requires a specific setting. For example, residential care would usually only be available to people with a certain level of care needs that require more intensive care. In addition, people who need formal care 24/7 might be offered residential care rather than home care to ensure their care needs are fully met. Some limitations regarding the freedom of choice can thus allow for care to be better tailored to the individual needs and circumstances of each care recipient while remaining affordable.

Regarding the free choice of provider (C11), a Member State is categorised as "yes" if a person receiving public benefits has, based on the regulatory system, some options to choose between different (pre-selected / accredited) providers of care services, either by using cash benefits to pay for care, or by being able to choose between different in-kind service providers.

Table 5 shows the assessment with regards to the freedom of choice based on data available in the MISSOC database. Where no data were available to enable an assessment, Member States are categorised as N/A.

Table 5: Free choice of care recipients

Member State	Free choice of care setting	Free choice of provider
Austria	Yes	Yes
Belgium	Yes	Yes
Bulgaria	Yes	Yes
Croatia	Yes	Yes
Cyprus	Yes	Yes
Czechia	Yes	Yes
Denmark	No	Yes
Estonia	Yes	Yes
Finland	N/A	No
France	Yes	Yes
Germany	Yes	Yes
Greece	Yes	Yes
Hungary	Yes	N/A
Ireland	Yes	Yes
Italy	N/A	No
Latvia	Yes	Yes
Lithuania	Yes	Yes
Luxembourg	Yes	Yes
Malta	Yes	N/A
Netherlands	Yes	Yes
Poland	Yes	Yes
Portugal	Yes	Yes
Romania	Yes	Yes
Slovakia	N/A	Yes
Slovenia	Yes	Yes
Spain	N/A	No

Sweden	No	No

N/A: not available.

Source: MISSOC

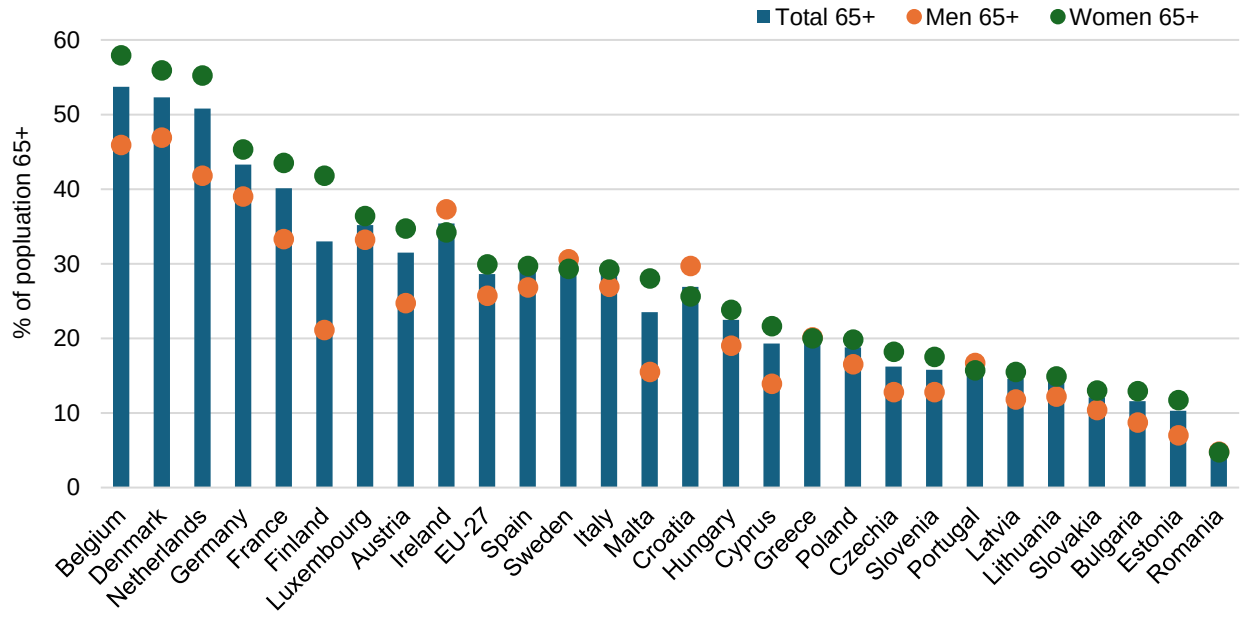
3.3.2 Developing home and community-based care

P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months

The LTC Recommendation invites Member States to develop and/or improve home care and community-based care. EHIS survey data illustrate the share of people with LTC needs who use professional home care services, which could be either publicly or privately provided or financed[14]. The performance indicator shows the self-reported use of home care among people aged 65+ living in private households needing LTC (at least one severe difficulty in ADL or IADL) The EHIS illustrates the significant differences across the EU. According to the EU-27 2019 data, home care services were used by on average 28.6%, but this share ranged from 4.7% in Romania to 53.7% in Belgium (see Figure 14). Among the respective populations with LTC needs, slightly more women than men used home care services (29.9% versus 25.7%). The use of home care services is also influenced by household composition. Although 37.2% of older people with LTC needs living alone used home care, only 22.4% of people living with others did so. Furthermore, there was a regional dimension in the coverage of home care services. In cities, 29.7% of older people in need used home care services, compared with 28.7% in towns and suburbs, and only 26.4% in rural areas.

[14] By contrast, the Ageing Report only includes administrative data on publicly provided or financed LTC services.

Figure 14: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months (%), 2019



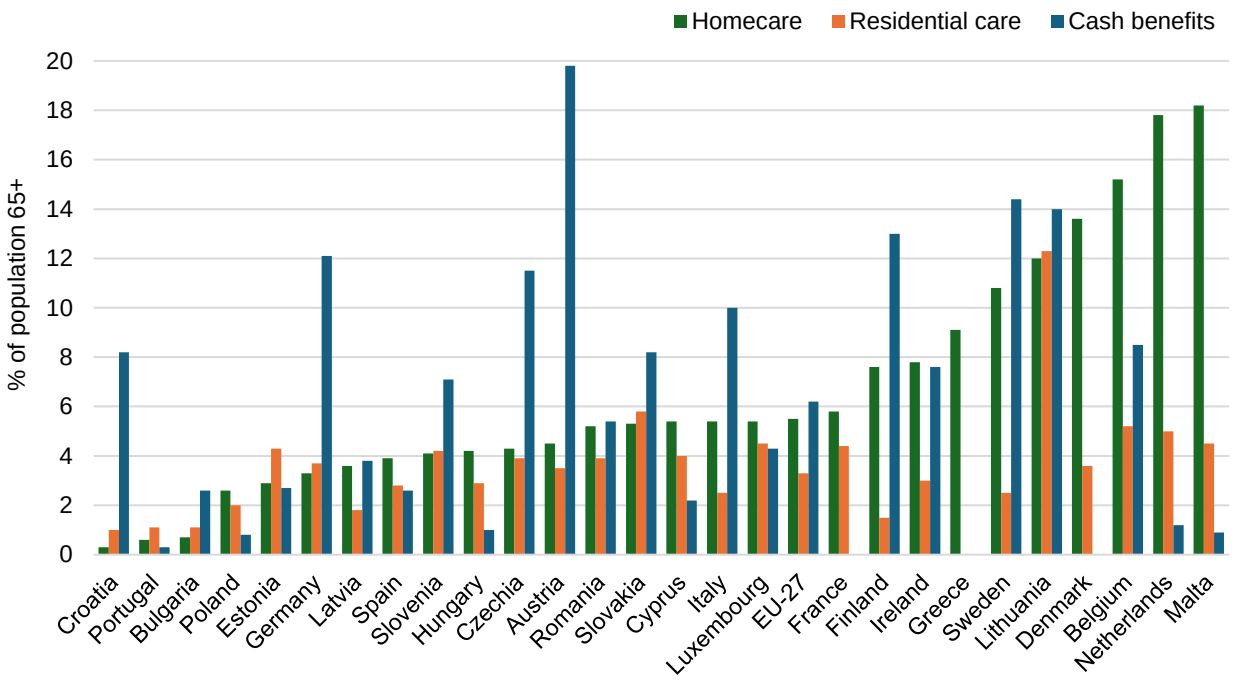
Source: Eurostat, EHIS wave 3.2019, hlth_ehis_am7ta

P7: Share of people aged 65+ who receive public home care, residential care or cash benefits

Member States provide formal LTC either as in-kind services, cash benefits or combinations of both. This indicator is relevant as it measures the *overall coverage* of public LTC, providing a picture of the extent of formal support available to all people aged 65+, regardless of degree of dependency. On the other hand, the following context information item (C12) provides an additional nuance by considering the share of the *potential* dependent population within the same age group, thus providing an estimate of *coverage relative to need*. In-kind services usually include home care or a place in residential care but may also cover other necessities such as home adaptations (e.g. lifts) or technical devices (as part of home care). Cash benefits are funds that recipients can use to purchase services themselves, and are often used to compensate informal carers. As Figure 15 shows, in some (mostly Nordic) Member States, help is mostly delivered in the form of services (e.g. DK, FI, SE); in others, LTC coverage is predominantly based on cash benefits (e.g. AT, CY, IE, IT, RO); and in yet others, beneficiaries have a choice between cash benefits, in-kind services, or a combination of the two (e.g. DE).

The AWG collects data on the number of people of all ages who receive public home care, residential care or cash benefits, with the possibility to disaggregate by five-year age brackets. It is important to note that there can be double counting of people receiving both cash and in-kind benefits, and therefore no absolute coverage rates can be computed. In some Member States, benefits are granted by different entities (e.g. when the national level administers cash benefits, and regions and municipalities offer in-kind services).

Figure 15: Share of population aged 65+ receiving public home care, residential care or cash benefits, 2022



Source: Ageing Report 2024

C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits

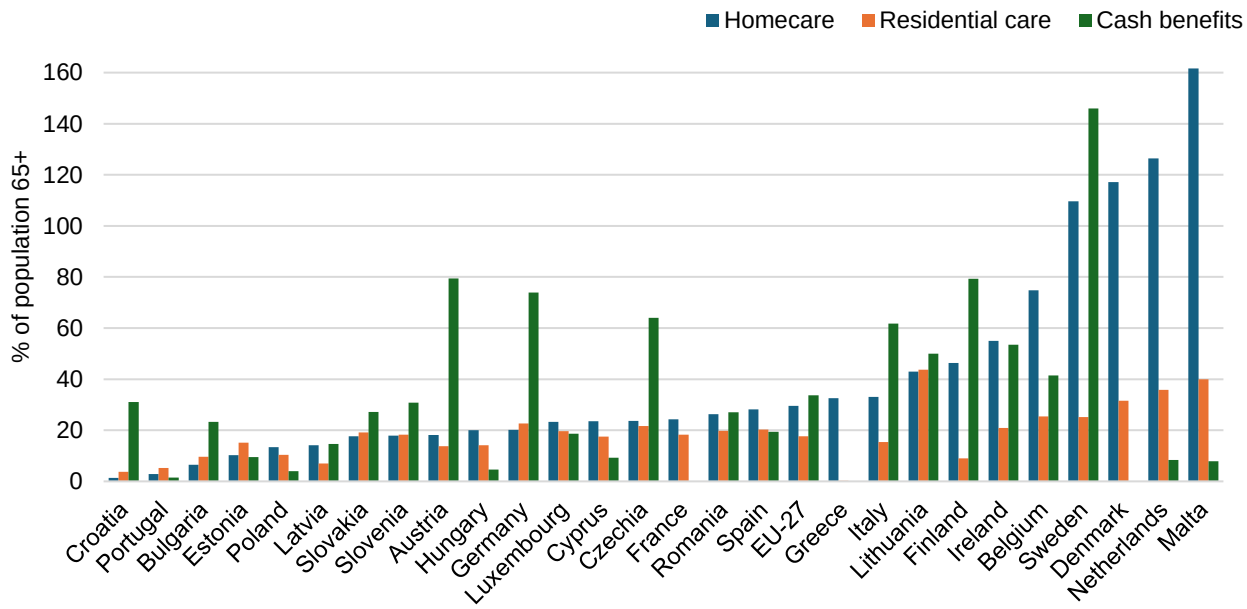
In order to assess gaps in LTC coverage, the previous indicator, which measures the availability of public support, is set with this context information item in relation to the population *potentially* in need of LTC. This is an important complement, considering that the demographic context information showing the share of people in need of LTC can vary significantly among Member States. To estimate the number of potential dependants, the AWG uses annual data on self-reported degree of dependency in the EU-SILC. This indicator is also known as the global activity limitation indicator, and is conventionally used to measure disability. As it is also important to include the number of people in residential care when estimating the number of people in need of LTC, the AWG then adds the number of people receiving publicly provided or financed residential care to the EU-SILC estimate. The EU-SILC variable used to define dependency status focuses on (self-reported) “severe” limitations only, whereas some social protection systems may also provide coverage for less severe needs, such as people who need help with IADL: this biases the coverage estimate upwards, as it under-estimates the dependent population.

Moreover, the EHIS data that the ISG uses as context information to illustrate the share of people in need of LTC, and also Ageing Report data, refer to different groups and concepts and could thus complement each other. The reference population and the definition of dependency differ between the EHIS and the Ageing Report: the EHIS includes all home care services (whether paid for by cash benefits or private means), while the Ageing Report only includes publicly provided or financed home care. While on average in the EU 29.6% of

potential dependants received public home care according to the AWG in 2022, 28.6% of people with LTC needs did so according to the EHIS in 2019, with marked variations between Member States (see Figure 16). To reflect the considerations of Member States, it was agreed to use these data as context information[15].

In preparing the 2024 Ageing Report, the AWG has improved the quality of the data, including levels of coverage above 100%. The data are used to produce expenditure projections of LTC according to the methodology agreed by AWG delegates for the last decade. The data were published in the 2024 Ageing Report.

Figure 16: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits (%)



Note: This context information item can complement other indicators by pointing towards a gap in the provision of LTC services. Data limitations apply in particular as data for some settings may be imputed in a small number of cases in which a Member State was not able to provide data on recipients for a specific setting (typically settings with few recipients). Coverage is estimated as the ratio between recipients aged 65+ and potential dependants aged 65+. Recipient data are provided by Member States. Coverage may be above 100%, as the EU-SILC variable used to define dependency status focuses on (self-reported) “severe” limitations only, whereas some social protection systems may also provide coverage for less severe needs, such as people who need help with IADL: this biases the coverage estimate upwards as it under-estimates the dependent population, but relative comparisons of coverage across Member States are still valid in most cases. In addition, some recipients may receive cash benefits and in-kind benefits at the same time, which is why this indicator is separate for each care setting. For Germany, coverage refers to the social insurance funds’ members only.

Source: Ageing Report 2024

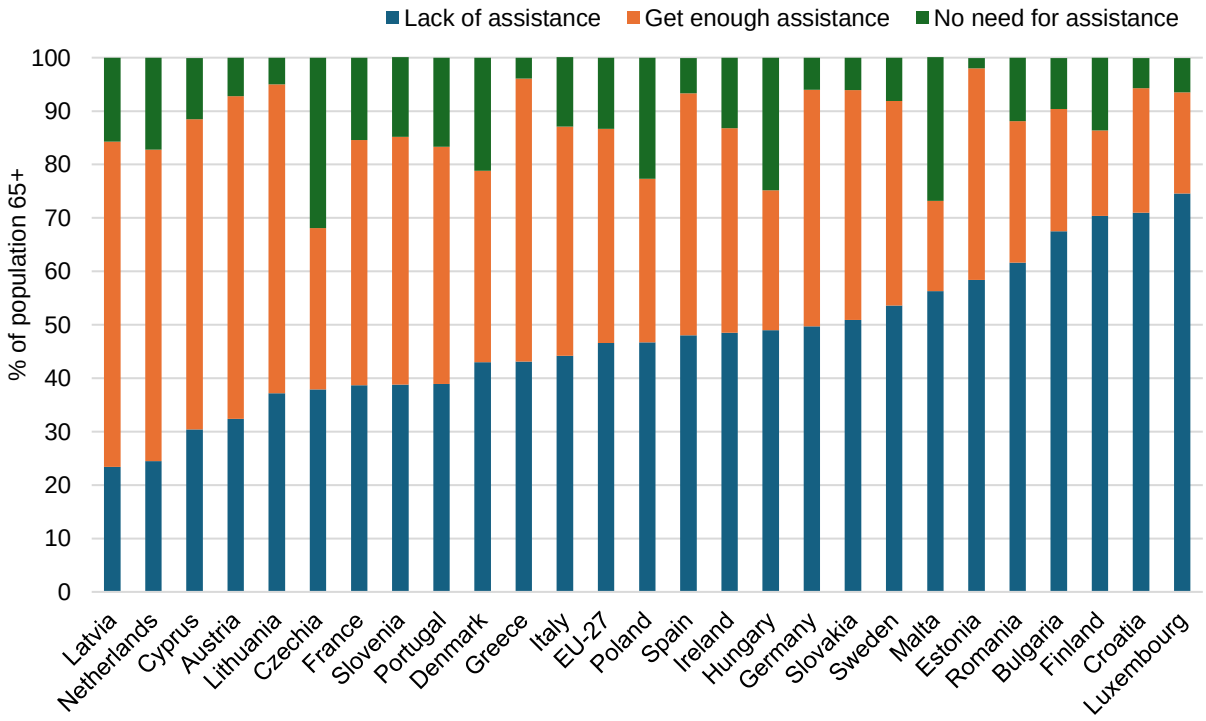
[15] This context information item can complement other indicators by pointing towards a gap in the provision of LTC services. Data limitations apply in particular as data for some settings may be imputed in a small number of cases in which a Member State was not able to provide data on recipients for a specific setting (typically settings with few recipients). Coverage is estimated as the ratio between recipients aged 65+ and potential dependants aged 65+. Recipient data are provided by Member States. Coverage may be above 100%, as the EU-SILC variable used to define dependency status focuses on (self-reported) “severe” limitations only, whereas some social protection systems may also provide coverage for less severe needs, such as people who need help with IADL: this biases the coverage estimate upwards as it under-estimates the dependent population, but relative comparisons of coverage across Member States are still valid in most cases. In addition, some recipients may receive cash benefits and in-kind benefits at the same time, which is why this indicator is separate for each care setting. For Germany, coverage refers to the social insurance funds’ members only.

P8: Share of people aged 65+ with unmet need for help with ADL/IADL, with at least one severe difficulty in ADL/IADL

The above indicators from the EHIS and Ageing Report reveal a gap between the number of people who are in need of LTC and the number of people who receive formal support. If formal care services are not available and the care tasks are also not taken over by informal carers, people have an unmet need for LTC. Unfortunately, many Member States face an insufficient supply of formal care services due (for instance) to financial constraints, or work-force shortages. In 2019, 46.6% of people aged 65+ with severe difficulties in ADL/IADL reported that they had an unmet need for help in those activities (see Figure 17). This lack of help was more pronounced for older women (47.7%) than for older men (44.2%), and for the lowest income quintile (51.2%) than for the highest (39.9%).

Considering the differing levels of unmet needs across Member States, no clear pattern in relation to public expenditure on LTC or the nature of the welfare system emerges, with Luxembourg, Croatia, Finland and Bulgaria reporting the highest shares of lack of assistance. This may be explained by the subjectivity of self-reported unmet needs, which has been shown to be influenced by cultural perceptions as well as individual and systemic effects (Tinios et al., 2022)[16].

Figure 17: Share of people aged 65+ in need of LTC with lack of assistance in ADL/IADL (%), 2019



Note: Data not available for BE.

Source: Eurostat, EHIS wave 3.2019, hlth_ehis_tadlh

[16] Tinios P., Valvis Z. Georgiadis T. (2022), Heterogeneity in long-term care for older adults in Europe: between individual and systemic effects. *Journal of Ageing and Longevity*, *2*(2), 153-177.

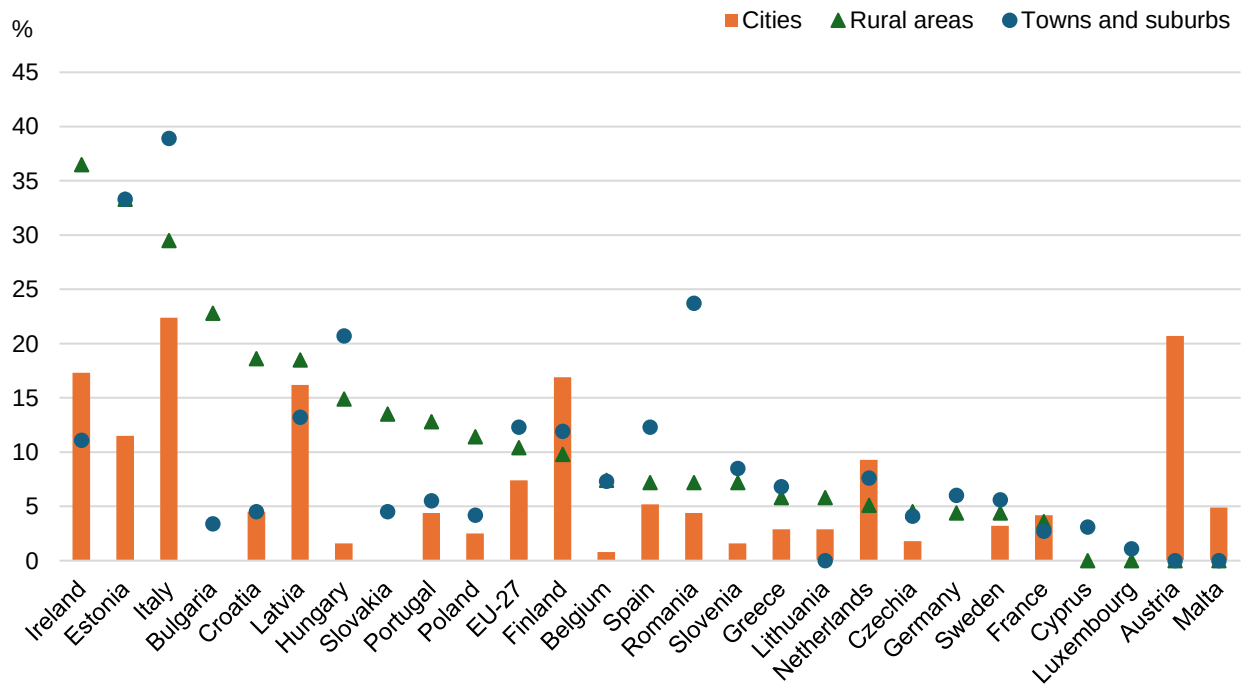
3.3.3 Closing territorial gaps

P9: People in need of LTC not using (more) professional home care services primarily due to poor availability

Rural areas and rural populations all around the EU can face challenges related to access to care services, which has a negative impact on economic and living conditions. In addition, depopulation and population ageing affect many rural areas of the EU, which also often experience a lack of affordable and accessible basic services – hence the LTC Recommendation encourages Member States to close territorial gaps in LTC availability and accessibility.

Respondents with a need for LTC are asked if they need more of these services than they actually receive, and in the case of giving a positive answer, they are asked to "state the main reason for not receiving home care services provided by professional health or care workers or more care services than received at present" (see also Figure 5). For 35.7% of households with a person in need of LTC, the cost of the services was the main reason for not using (more of) them despite needing (more) assistance; 9.7% mentioned shortages in supply, and 2.1% cited quality concerns, as the main reasons across the EU-27. Among the 9.7% whose main reason was shortage of supply, this lack of care services was more pronounced in towns and suburbs (12.3%) and rural areas (10.4%) than in cities (7.4%), as illustrated in Figure 18.

Figure 18: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation (%), 2016



Note: Data not available for DK (LTC mostly free of charge). Data not available for both towns and suburbs for MT and LT, and for rural areas for MT.

Source: Eurostat, EU-SILC ad hoc module, 2016, ilc_ats15

3.4 Quality

"6. It is recommended that Member States ensure that high-quality criteria and standards are established for all long-term care settings, tailored to their characteristics and to apply them to all long-term care providers irrespective of their legal status. To that effect, Member States are invited to ensure a national quality framework for long-term care in accordance with the quality principles set out in the Annex and to include in it an appropriate quality assurance mechanism that:

(a) ensures compliance with quality criteria and standards across all long-term care settings and providers in collaboration with long-term care providers and people receiving long-term care;

(b) provides incentives to and enhances the capacity of long-term care providers to go beyond the minimum quality standards and to improve quality continuously;

(c) allocates resources for quality assurance at national, regional and local levels and encourages long-term care providers to have financial resources for quality management;

(d) ensures, where relevant, that requirements regarding the quality of long-term care are integrated in public procurement;

(e) promotes autonomy, independent living, and inclusion in the community in all long-term care settings;

(f) ensures protection against abuse, harassment, neglect and all forms of violence for all persons in need of care and all carers."

Source: LTC Recommendation

Member States are recommended to ensure high-quality LTC. Care should be person-centred and integrated, meeting the individual needs of care recipients in a comprehensive and inclusive way. Protection against abuse and neglect in the care sector is crucial, requiring the means to prevent it as well as to report and legally redress potential breaches to ensure the dignity and well-being of care recipients. Further, the training and size of the workforce are key to underpinning the quality of the services provided[17]. Relevant legislation is needed for a strong legal framework supporting quality-assurance and management. Hence, four qualitative policy levers, based on the MISSOC database and complementary expert input from the European Social Policy Analysis Network (ESPAN), are used to measure quality. The first lever assesses the existence of legislation around comprehensive care plans – which should cover all needs, be drawn up in a participatory process with the care recipient, and be updated regularly. The second lever concerns the existence of quality standards, which need to apply across care settings (such as at home and in residential care) as well as for all types of providers. Thirdly, the presence of quality-assurance bodies covering the entirety of the care sector is considered. The final policy lever focuses on complaints procedures and avenues for legal redress.

[17] Therefore, a range of indicators underpinning the workforce dimension, e.g. P12 and C21, are also relevant for describing the quality of the services provided.

Member States differ in their progress across the policy levers proposed for monitoring LTC quality, most having the required elements in place but with varying levels of completeness. Regarding personal care plans, 20 Member States meet the criterion fully, while six do so only partially (BE, CY, EE, IE, PL, SI) with Greece not meeting the criterion at all. Similarly, 17 Member States ensure that personal care plans are comprehensive and participatory, four Member States partially meet the criterion (IE, PL, SI, HR) and two Member States not meeting this criterion (CY, EL). Quality standards exist in 19 Member States, but only partially in seven (EL, IE, LV, LT, MT, PL, SI), with Cyprus lacking them entirely. Those LTC quality standards apply to all types of providers fully in 18 Member States, at least partially in five (EE, IE, LV, LT, MT) and are not applicable to all providers in three (CY, EL, PL), with information for Slovenia missing. Quality-assurance bodies exist in 23 Member States, with Croatia, Latvia, and Slovenia partially meeting the criterion for this policy lever and Cyprus not meeting it. Lastly, procedures for complaints and the signalling of potential cases of abuse or neglect by LTC providers, and of means for legal redress, exist fully in 24 Member States, but remain partial in two (BG, PL) with Greece lacking them entirely. These findings highlight areas requiring improvement, particularly in Cyprus and Greece, and regarding specific elements of the policy levers in a few other Member States.

It is important to note that the information on policy levers for monitoring the LTC quality dimension may not reflect fully the situation in Member States with devolved responsibilities. In addition, the policy levers only capture what exists in terms of legislation and procedures, not the extent to which they are effectively implemented and enforced.

3.4.1 Person-centred / integrated LTC

L5: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans

To measure the person-centred and integrated nature of LTC systems, a policy lever with two dimensions is used, based on MISSOC data. It assesses, firstly, whether rules exist that regulate the use of personal care plans and co-operation between different services in their design and implementation; and secondly, whether such plans cover all the LTC needs of individuals, are drawn up with the participation of them or their representatives, and are regularly updated.

Member States are categorised as “yes”, if national legislation clearly mentions an individual care plan (the names of which may vary) and co-operation between different services. The legislation includes a provision that such plans cover all the LTC needs of individuals, are drawn up with the participation of them or their representatives, and are regularly updated. “Yes*” indicates a decentralised system in which central guidance on this issue exists.

A categorisation as “partial” implies shortcomings, such as the absence of information on further action and updates, a lack of clarity regarding the existence of both the personal care plan and co-operation between different services, the issue being of regional competence, or the legislation being incomplete or in preparation. Table 6 gives an overview of how the Member States perform on this policy lever. The vast majority of Member States have legislation in place that regulates the use of personal care plans and co-operation between

different services in their design and implementation: 20 Member States (AT, FI, BG, DK, FR, DE, HU, IT, LV, LT, LU, MT, NL, PT, RO, SK, ES, SE, HR, CZ) fully meet the criteria, six do so partially (BE, CY, EE, IE, PL, SI). Only one Member State (EL) does not meet the requirements altogether. Similarly, in 17 Member States such plans cover all the LTC needs of individuals, are drawn up with the participation of them or their representatives, and are regularly updated (CZ, DK, EE, FI, FR, DE, HU, IT, LV, LT, LU, MT, PT, RO, SK, ES, SE). They do so partially in four Member States (IE, PL, SI, HR) and not at all in two (CY, EL), while no data are available for four (AT, BE, BG, NL)

Table 6: Person-centred / integrated LTC

Member State	(a) Existence of rules regulating the use of personal care plans and co-operation between different services in their design and implementation	(b) Such plans cover all the LTC needs of individuals, are drawn up with the participation of the individual (or their representatives) and are regularly updated
Austria	Yes*	N/A[18]
Belgium	Partial	N/A
Bulgaria	Yes	N/A
Croatia	Yes	Partial
Cyprus	Partial	No
Czechia	Yes	Yes
Denmark	Yes	Yes
Estonia	Partial	Yes
Finland	Yes	Yes
France	Yes	Yes
Germany	Yes	Yes
Greece	No	No
Hungary	Yes	Yes
Ireland	Partial	Partial
Italy	Yes	Yes
Latvia	Yes	Yes
Lithuania	Yes	Yes
Luxembourg	Yes	Yes
Malta	Yes	Yes
Netherlands	Yes	N/A
Poland	Partial	Partial
Portugal	Yes	Yes
Romania	Yes	Yes
Slovakia	Yes	Yes
Slovenia	Partial	Partial
Spain	Yes*	Yes*
Sweden	Yes	Yes

N/A: not available.

Source: MISSOC, except when the information was not available/clear/comprehensive in MISSOC, in which case information provided by the ESPAN was used.

[18] LTC in AT is governed by individual federal states (*Länder*), and as such the regulations concerning personal care plans and the involvement of those in need of care can vary from region to region.

3.4.2 Quality standards

L6: Existence of quality standards that apply to different care settings and to all types of providers

The policy lever measuring quality standards assesses the existence of quality standards in home, community-based and residential care, as well as of rules regulating quality-assurance in public and private providers. Being categorised as "yes" indicates that quality standards exist and apply to different care settings (at least residential care and home care) and to all type of providers. "Yes*" again indicates decentralised systems with central administration on the issue, whereas "no" suggests the absence of quality standards. "Partial" quality standards describe national cases in which standards do not cover all settings or providers or compliance is non-compulsory, as well as indicating the issue being of regional competence, or legislation being incomplete or in preparation.

Table 7 shows that in 19 Member States quality standards exist across care settings (AT, BE, BG, CZ, DK, HR, EE, HU, FI, FR, DE, IT, LU, PT, RO, SK, ES, SE, NL) and at least partially in seven Member States (EL, IE, LV, LT, MT, PL, SI), with only one (CY) lacking such quality standards.

Those LTC quality standards apply to all types of providers in 18 Member States (AT, BE, BG, CZ, DE, DK, HR, FI, FR, HU, IT, LU, PT, RO, SK, ES, SE, NL) and at least partially in five (EE, IE, LV, LT, MT). They are not applicable to all providers in three Member States (CY, EL, PL), with information for one (SI) missing.

Table 7: LTC quality standards

Member State	(a) Existence of quality standards in home care, community-based and residential care	(b) Existence of rules regulating quality-assurance in public and non-public providers
Austria	Yes*	Yes*
Belgium	Yes*	Yes*
Bulgaria	Yes	Yes
Croatia	Yes	Yes
Cyprus	No	No
Czechia	Yes	Yes
Denmark	Yes	Yes
Estonia	Yes	Partial
Finland	Yes	Yes
France	Yes	Yes
Germany	Yes	Yes
Greece	Partial	No
Hungary	Yes	Yes
Ireland	Partial	Partial
Italy	Yes	Yes
Latvia	Partial	Partial
Lithuania	Partial	Partial
Luxembourg	Yes	Yes

Member State	(a) Existence of quality standards in home care, community-based and residential care	(b) Existence of rules regulating quality-assurance in public and non-public providers
Malta	Partial	Partial
Netherlands	Yes	Yes
Poland	Partial	Partial
Portugal	Yes	Yes
Romania	Yes	Yes
Slovakia	Yes	Yes
Slovenia	Partial	N/A
Spain	Yes*	Yes*
Sweden	Yes	Yes

N/A: not available.

Source: MISSOC, except when the information was not available/clear/comprehensive in MISSOC, in which case information provided by the ESPAN was used.

3.4.3 Quality-assurance bodies

L7: Existence of quality-assurance bodies for all elements and types of LTC

The next policy lever covers the existence of quality-assurance bodies in a binary manner. Assessment as “partial” indicates that the said body or bodies do not cover all elements and types of LTC, or that legislation is incomplete or in preparation.

Table 8 outlines the existence of quality-assurance bodies in 23 Member States (AT, BE, BG, CZ, EE, EL, FI, FR, DK, DE, HU, IE, IT, LT, LU, MT, PL, PT, RO, SK, ES, SE, NL) and their partial coverage of the LTC sector in three Member States (HR, LV, SI), with only one (CY) failing to have such a body.

Table 8: LTC quality-assurance bodies

Member State	Existence of LTC quality-assurance body
Austria	Yes*
Belgium	Yes*
Bulgaria	Yes
Croatia	Partial
Cyprus	No
Czechia	Yes
Denmark	Yes*
Estonia	Yes
Finland	Yes
France	Yes
Germany	Yes
Greece	Yes*
Hungary	Yes*
Ireland	Yes
Italy	Yes*
Latvia	Partial

Member State	Existence of LTC quality-assurance body
Lithuania	Yes
Luxembourg	Yes
Malta	Yes
Netherlands	Yes
Poland	Yes*
Portugal	Yes
Romania	Yes*
Slovakia	Yes
Slovenia	Partial
Spain	Yes*
Sweden	Yes

Source: MISSOC, except when the information was not available/clear/comprehensive in MISSOC, in which case information provided by the ESPAN was used.

3.4.4 Procedures for complaints

L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect

To prevent and address ongoing cases of abuse or neglect by LTC providers, it is crucial for care recipients or those representing them to have channels to voice their complaints and concerns. Hence, procedures for complaints and means for legal redress in case of breaches are vital for the quality of LTC. Again, the binary "yes"/"no" categories assess their existence, whereas assessment as "partial" indicates either the issue being of regional competence or the absence of clear follow-up measures for dealing with complaints, related for instance to their analysis or means of legal redress.

As shown in Table 9, 24 Member States have adequate procedures for complaints and legal redress in place (AT, BE, CY, CZ, HR, DK, EE, FI, FR, DE, HU, IE, IT, LV, LT, LU, MT, PT, SK, SI, ES, SE, NL, RO). Two Member States only partially meet the requirements (BG, PL), whereas one fails to do so altogether (EL).

Table 9: Procedure for complaints and signalling of potential cases of abuse or neglect by LTC providers, and of means for legal redress if breaches occur

Member State	Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect by LTC providers, and of means for legal redress if breaches occur
Austria	Yes*
Belgium	Yes*
Bulgaria	Partial
Croatia	Yes
Cyprus	Yes
Czechia	Yes
Denmark	Yes
Estonia	Yes
Finland	Yes

Member State	Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect by LTC providers, and of means for legal redress if breaches occur
France	Yes
Germany	Yes
Greece	No
Hungary	Yes
Ireland	Yes
Italy	Yes
Latvia	Yes
Lithuania	Yes
Luxembourg	Yes
Malta	Yes*
Netherlands	Yes
Poland	Partial
Portugal	Yes
Romania	Yes
Slovakia	Yes
Slovenia	Yes
Spain	Yes*
Sweden	Yes

Source: MISSOC, except when the information was not available/clear/comprehensive in MISSOC, in which case information provided by the ESPAN was used.

3.5 Workforce

"7. It is recommended that Member States support quality employment and fair working conditions in long-term care, in particular by:

(a) promoting national social dialogue and collective bargaining in long-term care, including supporting the development of attractive wages, adequate working arrangements and non-discrimination in the sector, while respecting the autonomy of social partners;

(b) without prejudice to Union law on occupational health and safety and while ensuring its effective application, promoting the highest standards in occupational health and safety, including protection from harassment, abuse and all forms of violence, for all long-term care workers;

(c) addressing the challenges of vulnerable groups of workers, such as domestic long-term care workers, live-in care workers and migrant care workers, including by providing for effective regulation and professionalisation of such care work.

8. It is recommended that Member States, in collaboration, where relevant, with social partners, long-term care providers and other stakeholders, improve the professionalisation of care and address skills needs and worker shortages in long-term care, in particular by:

(a) designing and improving the initial and continuous education and training to equip current and future long-term care workers with the necessary skills and competences, including digital ones;

(b) building career pathways in the long-term care sector, including through upskilling, reskilling, skills validation, and information and guidance services;

(c) establishing pathways to a regular employment status for undeclared long-term care workers;

(d) exploring legal migration pathways for long-term care workers;

(e) strengthening professional standards, offering attractive professional status and career prospects and adequate social protection to long-term care workers, including to those with low or no qualifications;

(f) implementing measures to tackle gender stereotypes and gender segregation and to make the long-term care profession attractive to both men and women."

Source: LTC Recommendation

The LTC Recommendation sets out several recommendations to improve the situation for workers employed in LTC in EU Member States, specifically regarding high-quality employment, fair working conditions, improving the professionalisation of LTC workers, and addressing skills needs and labour shortages. It is fundamental to have quantitative evidence on the number and situation of people working in LTC for policy-making, particularly because this domain is characterised by high labour intensity (due to the importance of personal interaction), severe labour shortages, and the particular vulnerability of some LTC workers (i.e. domestic, live-in, migrant, and undeclared LTC workers). In the absence of any administrative data-collection on the number of LTC workers at EU level, LTC workers are identified on the basis of survey data using EU-LFS, more specifically intersecting NACE (economic activity) codes 87.1, 87.3, 88.1[19] with ISCO codes (occupation) 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322[20] for the purposes of this monitoring framework. It is important that a common approach is agreed on and used consistently going forward to ensure comparability. The calculations and definitions used here are clearly outlined in the indicator descriptions in the Annex.

The LTC Recommendation contains several definitions relevant to the LTC workforce. The term "formal" is intended to indicate LTC services provided by professionals, working for pay or profit, as opposed to "informal" where the carer is not hired as a professional. Informal carers are family members, friends and neighbours, who provide unpaid care based on the personal relationship with the care recipient, in contrast to the contractual relationship an

[19] NACE Rev. 2 codes 87.1 (Residential Nursing Care Activities), 87.3 (Residential Care Activities for the Elderly and Disabled), 88.1 (Social Work Activities without Accommodation for the Elderly and Disabled).

[20] ISCO codes 2221 (Nursing Professionals), 2264 (Physiotherapists), 2266 (Audiologists and Speech Therapists), 2634 (Psychologists), 2635 (Social Work and Counselling Professionals), 3221 (Nursing Associate Professionals), 3255 (Physiotherapy Technicians and Assistants), 5321 (Healthcare Assistants), 5322 (Home-Based Personal Care Workers).

employed person would have. They may receive allowances or benefits but they are not hired as care professionals.

The situation of the formal workforce is monitored and assessed using a variety of performance indicators, context information and policy levers. These provide an overview of who the LTC workforce are, where they work, the nature of their work contracts and contexts, and their rights and protections.

Regarding wages, in 13 Member States (BG, IT, EE, PL, PT, MT, LV, ES, CY, RO, FI, DK, SE) LTC workers earn less than 80% of the earnings across all sectors in the EU. For instance, in Bulgaria the mean gross hourly wage for LTC workers is as low as 64% of the overall mean gross hourly wage (in all other sectors). In contrast, some Member States offer better relative rates; for instance, in Slovenia, Austria and the Netherlands the mean gross hourly wage for LTC workers is 90% of the overall mean gross hourly wage, while in Luxembourg it is 4% higher than the overall mean gross hourly wage.

In Member States such as Greece and Bulgaria, the average wages for LTC workers are substantially lower than the EU average, reflecting the challenges in attracting and retaining personnel in these regions. Some Member States offer better wages and conditions for LTC workers: for example, Denmark and Sweden have relatively high wages for LTC workers, which can be in line with or slightly above the mean gross hourly wage for all sectors. These Member States often provide comprehensive benefits and better working conditions as well.

The wage disparity emphasises the struggle to attract and retain qualified care workers in the sector. The LTC Recommendation advocates that Member States enhance support for fair wages to improve workforce stability.

As for employment contracts, across the EU around 84% of LTC workers hold permanent contracts, compared with 88% of all workers. However, significant variations exist. Greece and Bulgaria show a gap of nearly 30 percentage points in the prevalence of permanent contracts among LTC workers versus the general workforce. In some Member States, such as Cyprus and Ireland, LTC workers may be more likely to have permanent contracts than those in all other sectors.

LTC workers in most Member States are less likely to hold full-time positions than the overall workforce average. This situation contributes to concerns about job quality and training opportunities. Eurofound[21] highlights the prevalence of involuntary part-time work among LTC workers compared with other sectors, though data for specific Member States are not provided. The share of full-time employment among LTC workers is frequently lower than that of the overall workforce. In Greece and Bulgaria a considerable portion of LTC workers are engaged in part-time roles, which exacerbates issues of job retention and worker morale. In contrast, Member States such as Denmark report higher rates of full-time employment among LTC workers in urban and metropolitan areas, largely due to stronger labour protections.

[21] Eurofound (2020), *Long-term care workforce: Employment and working conditions*, Publications Office of the European Union, Luxembourg.

Concerning involuntary part-time work, the data also suggest that many LTC workers do not choose part-time work voluntarily, particularly in Member States such as Hungary and Portugal, where insufficient job opportunities compel workers to accept part-time or precarious contracts. This situation limits career advancement and access to training programmes.

On work-life balance, Member States such as Finland have implemented more flexible working arrangements for LTC workers, allowing for better work-life balance and job satisfaction. Conversely, in Poland and Romania rigid work schedules and limited shifts can lead to lower job satisfaction and higher turnover.

Approximately 45% of LTC workers are employed on shiftwork, compared with less than 20% of the overall workforce. The implications of shiftwork are particularly concerning for workers' health and work-life balance, as highlighted by some research.

As far as accidents at work are concerned, the care sector experiences a higher incidence of non-fatal accidents, with 2,637 accidents per 100,000 LTC workers, compared with 1,506 for all workers. This statistic emphasises the unique risks associated with LTC jobs across Member States, particularly aggravated by the pressures of the COVID-19 pandemic.

Finally, when it comes to the ratification of International Labour Organization (ILO) Convention 189 (detailing the rights of domestic and LTC workers), only nine EU Member States have ratified it (BE, FI, DE, IE, IT, MT, PT, ES, SE), while 18 have not (AT, BG, HR, CY, CZ, DK, EE, FR, EL, HU, LV, LT, LU, NL, PL, RO, SK, SI).

3.5.1 High-quality employment and fair working conditions

P10: Coverage of collective bargaining for LTC workers

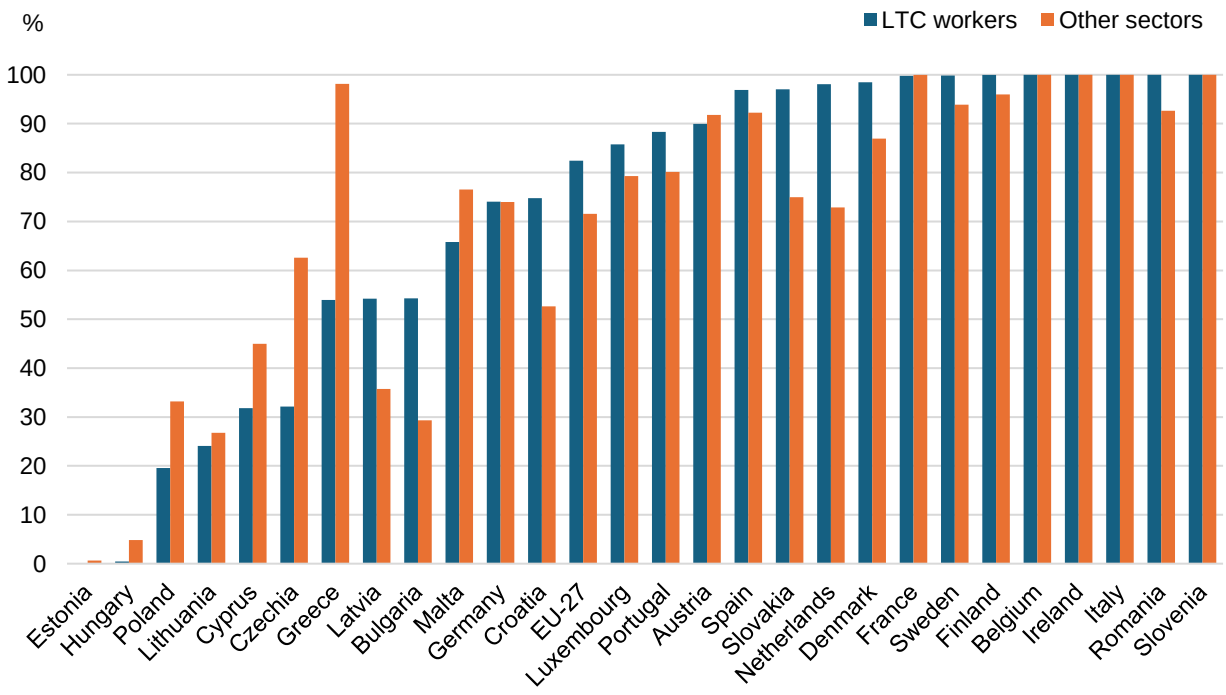
The LTC Recommendation invites Member States to "support quality employment and fair working conditions in long-term care, in particular by promoting national social dialogue and collective bargaining in long-term care". Collective bargaining can play an important role in improving working conditions, better enforcing labour contracts and increasing wages in the sector. Effective social dialogue can also have a positive impact on upskilling and reskilling the workforce. The first performance indicator therefore considers the coverage of collective bargaining for LTC workers, based on data from the SES.

The extent of unionisation and social dialogue is uneven across and within Member States in the LTC sector[22]. Home care workers are less likely to be organised and unionised than workers in residential care settings, and private for-profit providers are less likely to have collective agreements than the public sector. According to Eurofound (2020), sometimes only those employees who are members of the trade union that took part in the agreement are covered, so working conditions and wages can differ between members and non-members working for the same LTC service provider. In addition, many central and eastern European Member States lack appropriate representative employer organisations in the sector,

[22] In some Member States collective agreements are less relevant than in others, since the main form of LTC provision is provided by public employees, with wages controlled by law, rather than resulting from bargaining among social partners. See also footnote 25.

which renders the dialogue process more difficult. The performance indicator looks at whether a collective pay agreement exists. The types of agreement included are national or inter-confederal level agreements, industry agreements, agreements for individual industries in individual regions, enterprise or single-employer agreements, agreements applying only to employees in one local unit, and any other type of agreement. The results can be aggregated in two categories, as respondents are either covered by an agreement or not. Such a binary categorisation respects the national structure of collective bargaining. Moreover, the coverage of workers in all other sectors is used as a baseline against which to illustrate the coverage of LTC workers. Figure 19 from the SES, based on enterprises with 10 or more employees, suggests that, on average in the EU, LTC workers are more likely to be covered by collective agreements than in other sectors. For some Member States, the SES does not yet include those working in enterprises with fewer than 10 employees: LTC workers who are self-employed or working for smaller companies would thus not be included in this statistic for some Member States.

Figure 19: Coverage of collective bargaining for LTC workers compared with other sectors (%), 2022



Source: DG EMPL calculation on special extraction from Eurostat, SES 2022

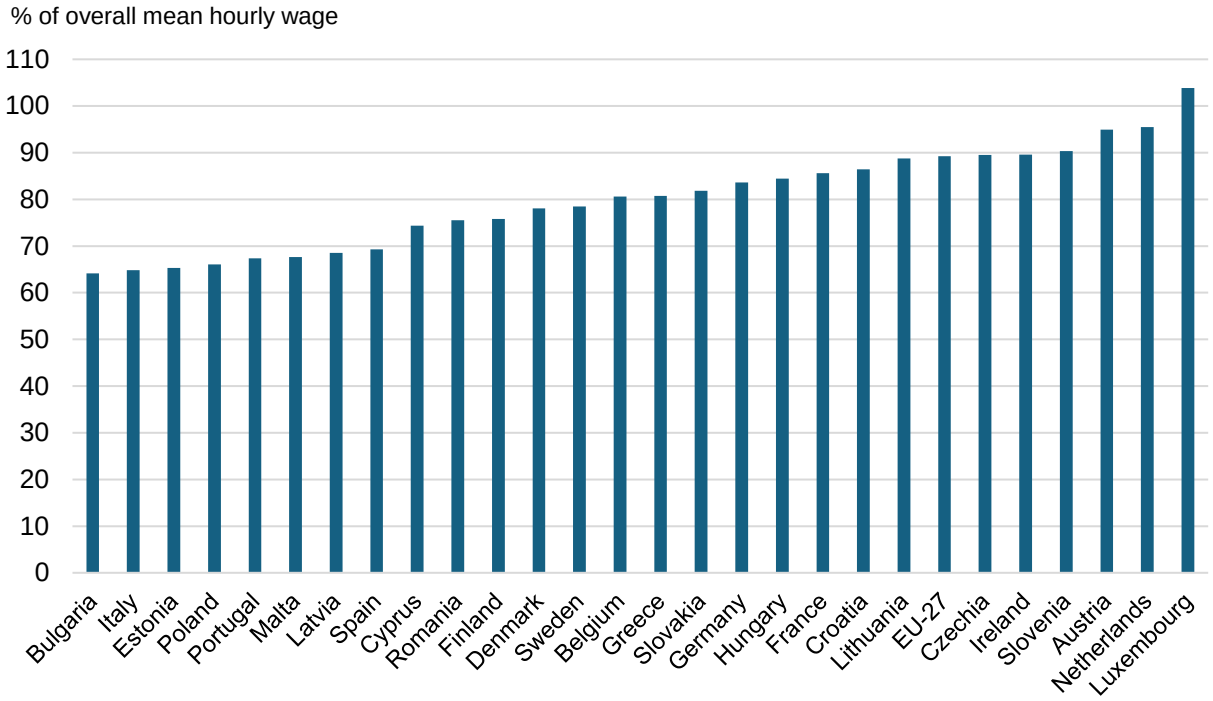
P11: Mean gross hourly wages for LTC workers compared with other sectors

The LTC Recommendation highlights the low wages of LTC workers and links them to the "difficulty to attract and retain care workers". It therefore invites Member States to "support quality employment and fair working conditions in long-term care". A performance indicator assesses the mean wage of LTC workers compared with the mean wage in all sectors to understand the earnings gap and to serve as a basis to improve wages for carers.

Based on the SES, the indicator looks at the mean gross hourly wages in the reference month. The gross hourly wage is used as a basis for monitoring instead of monthly/yearly, as a high share of part-time workers among LTC workers in some Member States would distort the mean. The mean gross hourly wage for the LTC workforce is compared with the mean gross hourly wage in all other sectors in a Member State, therefore calculating the proportion of the overall mean gross hourly wage across all sectors that carers receive. It must be noted that the SES does not include self-employed LTC workers or workers working in enterprises with fewer than 10 employees for some Member States.

Figure 20 shows that, in around half of Member States, LTC workers earn less than 80% of the mean gross hourly wage, with figures dropping as low as 64-65% in Bulgaria, Italy and Estonia.

Figure 20: LTC workers' mean gross hourly wage as a share of overall mean gross hourly wage (%), 2022



Source: DG EMPL calculation on special extraction from Eurostat, SES 2022

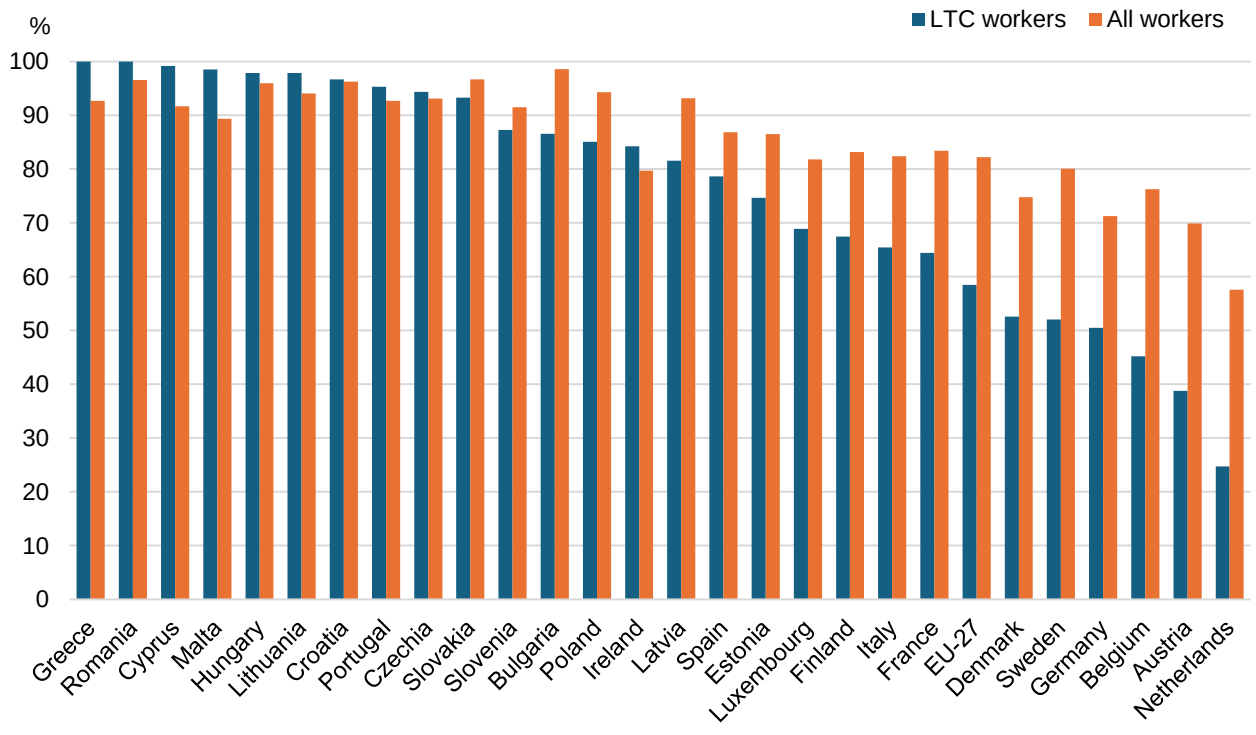
C13: Share of LTC workers in full-time employment

The LTC Recommendation highlights that LTC has an important social value and job-creation potential; but Member States struggle to attract and retain care workers, inter alia due to inadequate skills, difficult working conditions and low wages. There are untapped opportunities to address workforce shortages in the sector such as developing measures targeting part-time workers who want to increase their working hours. This requires context information on the prevalence of part-time work among LTC workers, compared with national averages of part-time workers.

Monitoring this is relevant since part-time work can be linked to a lower availability of education and training opportunities, limited career prospects and less autonomy. Part-time workers are also somewhat disadvantaged in the labour market as they are less likely to be unionised, and as some managers may take working part time as a signal of low career commitment. In addition, the high prevalence of part-time work has a strong impact on the monthly earnings of care workers (2021 LTC Report). The OECD (2023) has already highlighted the prevalence of involuntary part-time work among LTC workers compared with other sectors, including the health sector. Monitoring involuntary part-time work can therefore illustrate Member States' support for adequate working arrangements, which in turn could facilitate the support of other related aspects such as fair wages, training and union coverage.

Due to reliability issues, data from the EU-LFS, the largest sample survey of European households or individuals, are used to measure the share of full-time work (instead of part-time[23]) in Member States generally and among LTC workers in particular. Figure 21 shows that, in most Member States, LTC workers are less likely to be in full-time employment than the overall workforce.

Figure 21: Share of LTC workers in full-time employment compared with all workers (%), 2023



Source: DG EMPL calculation on special extraction from Eurostat, EU-LFS 2023

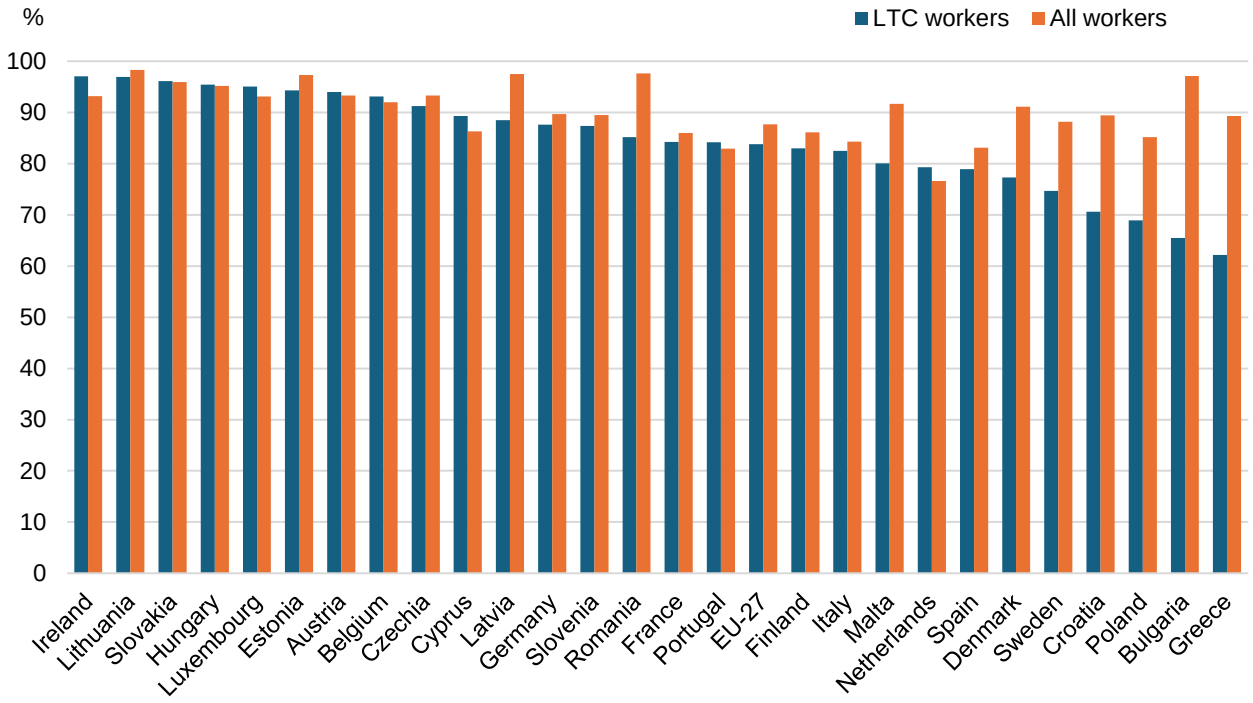
[23] Due to low reliability, the share of LTC workers in involuntary part-time work is available for nine Member States. Data are not available due to data reliability issues for Member States with a very low share of part-time workers (the share of full-time LTC workers is higher than 80% in 15 Member States). The share of voluntary part-time work is 96% in AT and 86% in CZ.

C14: Share of LTC workers with permanent contracts

The share of temporary contracts can be linked to several aspects related to job security and precarity, including the lack of training, skills and union coverage. The performance indicator measuring the share of fixed-term contracts can help to explain both labour market security, which refers to the risk of job loss and the economic consequences for the worker, and job precarity. People employed on fixed-term contracts, and *a fortiori* those employed through temporary employment agencies, face several disadvantages in the labour market. They are less likely to be unionised, and their voices are less likely to be considered within the organisation. Employers are less likely to invest in the education or training of these employees. Overall, within similar occupations, job quality is lower for workers on temporary contracts: beyond higher labour market insecurity and reduced education and training opportunities, they receive lower earnings on average, have less autonomy in their work, and experience lower levels of support from their peers, while being more exposed to health risks. The OECD (2023) has already highlighted the wide variation between Member States in the use of fixed-term contracts in LTC, although this largely follows differences in the use of such contracts in the entire economy. Monitoring the use of fixed-term contracts can illustrate Member States' support of adequate working arrangements, which in turn could facilitate the support of other related aspects of the LTC Recommendation, including union representation and training.

Based on the LFS, the indicator contextualises the share of LTC workers with permanent contracts compared with the share of all workers with permanent contracts. Figure 22 shows that, on average in the EU, 84% of LTC workers have permanent contracts, compared with 87.7% of all workers. Variation exists between Member States: in some the difference is marginal, with LTC workers in some cases even being more likely to have permanent contracts. In other Member States, however, the gap is rather wide, standing at almost 30 percentage points in Greece and Bulgaria.

Figure 22: Share of LTC workers with permanent contracts compared with all workers (%), 2023



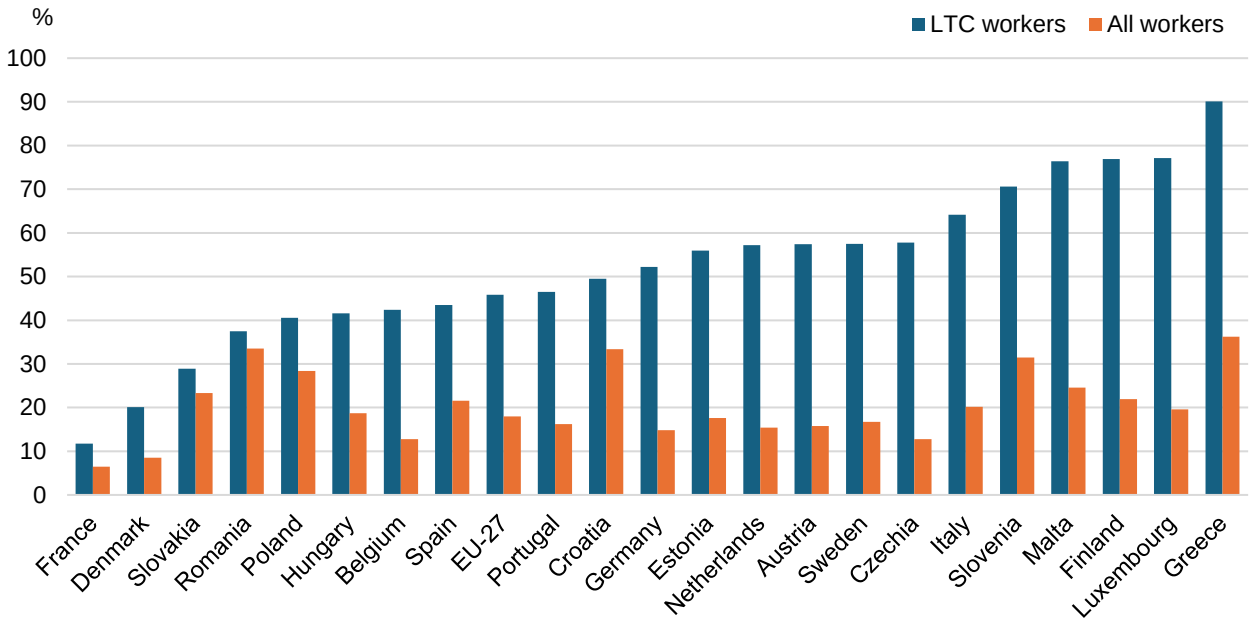
Source: DG EMPL calculation on special extraction from Eurostat, EU-LFS 2023

C15: Share of LTC workers working shifts

The OECD highlights that burdensome working times, including shiftwork, are one of the main drawbacks of the working environment in LTC. Indeed, shiftwork is common in LTC, and associated with a wide range of health risks, such as anxiety, burn-out and depression but also other serious physical health issues. Moreover, it affects LTC workers' work-life balance: compared with those on standard working arrangements, shift workers are less likely to say that their working hours fit "very well" with their family or social commitments. Introducing flexible working time arrangements with a choice of hours can help to address work-life balance concerns and improve job satisfaction. Some approaches to improving time organisation are being experimented with, for example in Austria and outside Europe. Thus, monitoring the share of shift workers is useful context information to understand both the social situation and the health risks of LTC workers.

Using LFS data, the share of LTC workers working shifts as a percentage of the total number of employees is contextualised, compared with the share of the overall workforce doing shiftwork. It defines shiftwork as an atypical working arrangement that includes any method of organising work in shifts whereby workers succeed each other at the same workstation according to a certain pattern, including a rotating pattern, and which may be continuous or discontinuous, entailing the need for workers to work at different times over a given period of days or weeks. Figure 23 shows that, on average in the EU, 45% of LTC workers do shiftwork, compared with less than 20% of the overall workforce.

Figure 23: Share of LTC workers working shifts compared with all workers (%), 2023



Note: The percentage of LTC workers working shifts is not available for BG, CY, IE, LT, LV, due to low reliability. The percentage of LTC workers not working shifts is available for BG (93.5%) and LT (84.6%).

Source: DG EMPL calculation on special extraction from Eurostat, EU-LFS 2023

C16: Non-fatal accidents at work in the care sector

The LTC Recommendation invites Member States to promote "the highest standards in occupational health and safety, including protection from harassment, abuse and all forms of violence, for all long-term care workers".

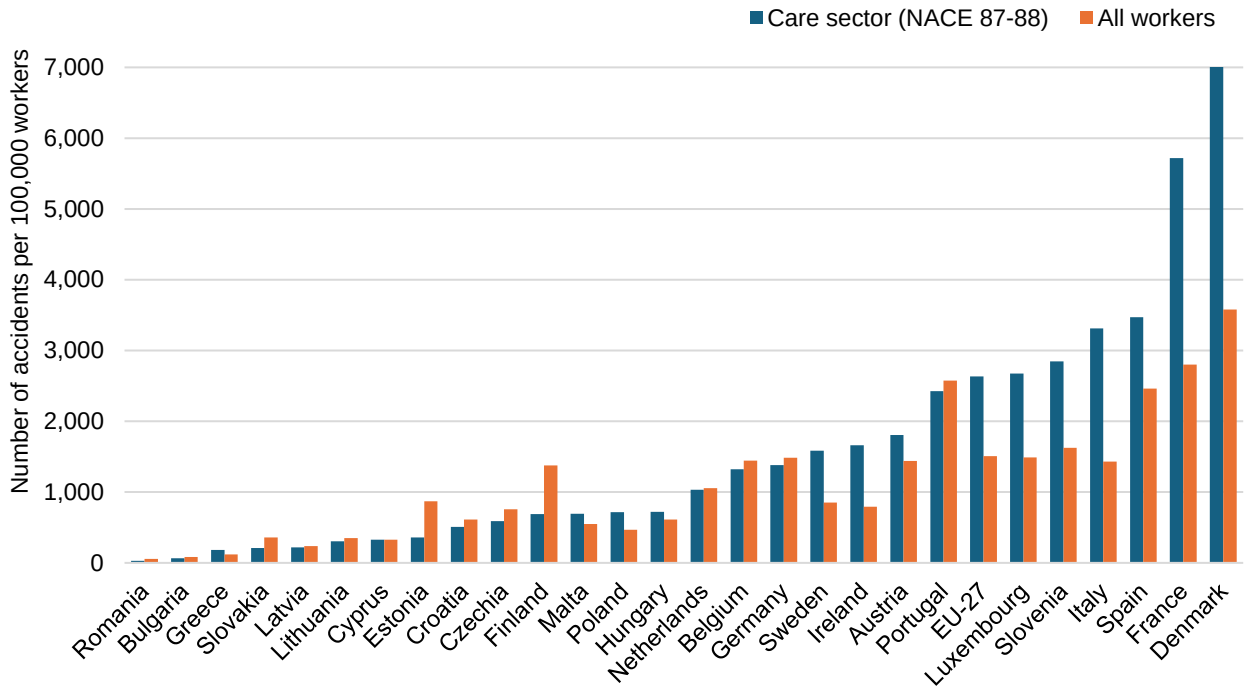
Accidents at work may result in a considerable number of working days being lost and often involve significant harm for the workers concerned and their families. They have the potential to force people, for example, to live with a permanent disability, to leave the labour market, or to change job. Accidents at work can also lower the attractiveness of the sector. According to Eurofound, LTC workers suffer from many work-related accidents. Further, typical working times such as shiftwork are correlated with an increased risk of accidents at work, cardiovascular disease and depression. Workers in LTC do not feel very well informed about the health and safety risks related to the performance of their job. This contrasts with healthcare, where many workers do feel very well informed.

Using ESAW data, context information on the incidence of accidents at work is provided. Due to different recognition systems for work accidents across Member States affecting the cross-country comparability of ESAW data, these data will not be used as a performance indicator.

The data express the number of accidents in relation to the number of people employed. They show that (in 2022) workers in the care sector had a higher incidence of non-fatal accidents (2,637 accidents per 100,000 workers) than all workers (1,506 accidents per 100,000 workers), confirming the critical aspects reported by Eurofound (see Figure 24).

In addition, it should be noted that the COVID-19 pandemic had a significant impact on the care sector. Particularly from 2020 onwards, the number of accidents at work reported in the care sector may have increased due to the heightened pressure caused by the pandemic on this sector specifically. Additionally, in some Member States, occupational COVID-19 has been recognised as an accident at work.

Figure 24: Incidence rates of non-fatal accidents at work in the care sector and for all workers (per 100,000 workers), 2022



Note: DK reported a significant number of occupational COVID-19 cases as accidents at work in the care sector; the incidence rate for 2022 was 14,467 accidents per 100,000 workers. The recognition practices for occupational COVID-19 cases vary among Member States. The figure for Denmark has been cut at 7,000 to allow a better visualisation of other Member States' data.

Source: Special extraction, Eurostat, ESAW 2022.

L9: Ratification of ILO Domestic Workers Convention (No 189)

Among carers, domestic workers face particularly difficult working conditions, including low wages, unfavourable working-time arrangements, undeclared work, inadequate social protection, and non-compliance with essential labour protection rules and irregular forms of employment. The LTC Recommendation therefore invites Member States to address the challenges of vulnerable groups of workers – such as domestic, live-in and migrant LTC workers – including by providing for effective regulation and professionalisation of such care work.

The 2011 ILO Domestic Workers Convention (No 189) lays down basic rights and principles and requires national competent authorities to take a series of measures with a view to ensuring decent working conditions for domestic workers. It recognises the "special conditions under which domestic work is carried out and the specific standards for domestic workers" that need to supplement the general standards. The convention states, among other

things, the duty of Member States to ensure freedom of association and the effective recognition of the right to collective bargaining, the elimination of all forms of forced or compulsory labour, and the elimination of discrimination in respect of employment and occupation. The European care strategy also calls on Member States to ratify and implement the convention.

A policy lever therefore assesses whether a Member State has ratified the ILO convention or not. Table 10 shows that nine Member States have done so, as of 2025.

Table 10: Policy lever on ratification of ILO Convention 189

Member State	Ratified	Date of entry into force
Austria	No	
Belgium	Yes	10 June 2015
Bulgaria	No	
Croatia	No	
Cyprus	No	
Czechia	No	
Denmark	No	
Estonia	No	
Finland	Yes	8 January 2015
France	No	
Germany	Yes	20 September 2013
Greece	No	
Hungary	No	
Ireland	Yes	28 August 2014
Italy	Yes	22 January 2013
Latvia	No	
Lithuania	No	
Luxembourg	No	
Malta	Yes	14 May 2021
Netherlands	No	
Poland	No	
Portugal	Yes	17 July 2015
Romania	No	
Slovakia	No	
Slovenia	No	
Spain	Yes	28 February 2023
Sweden	Yes	4 April 2019

Source: ILO 2025

3.5.2 Addressing skills needs and worker shortages in LTC

P12: Number of LTC workers per 100 people aged 65+

The LTC Recommendation invites Member States to, “in collaboration, where relevant, with social partners, long-term care providers and other stakeholders, improve the professionalisation of care and address skills needs and worker shortages in long-term care”.

Across the EU, significant staff shortages lead to an inadequate provision of high-quality LTC services. On the demand side, rapid population ageing is adding pressure on the LTC workforce to step up efforts to have sufficient workers to meet the growing demand. Other adverse factors include: the preference of older people for independent living and ageing in place; and the reduced availability of informal carers (family, friends and neighbours) due to greater mobility, more nuclear families, and a growing number of women in the labour market. On the supply side, staff and skills shortages are driven by the low attractiveness of the sector, related to low wages and difficult working conditions.

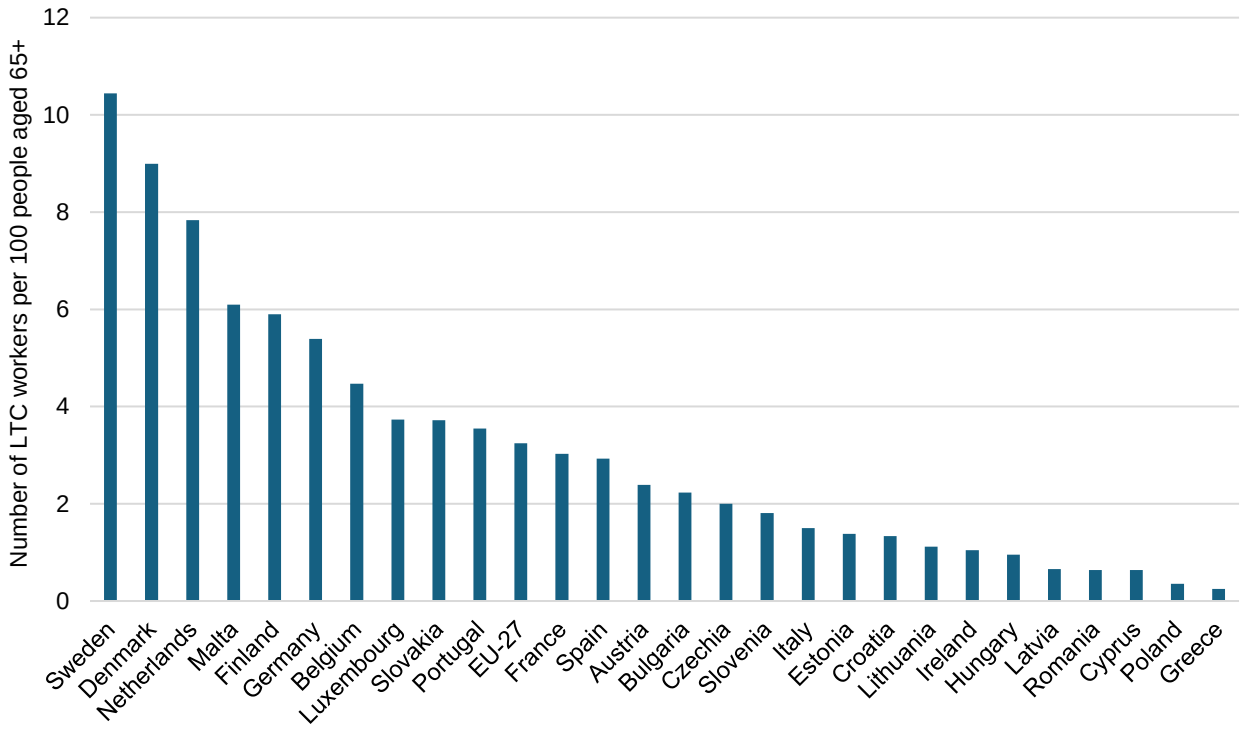
According to European Centre for the Development of Vocational Training (CEDEFOP), whereas the population aged 65+ will grow by 23% by 2035, projected employment growth in the care sector is just 7%. In only eight Member States is employment growth in the care sector expected to exceed growth in the population aged 65+. Inadequate staffing of LTC, due to shortages of LTC workers and high turnover rates as well as inadequate skills, can negatively affect the quality of LTC, as it is heavily dependent on human contact.

Many Member States are discussing staffing ratio requirements to ensure adequate levels of LTC staffing. Such staff ratios are specific to the individual levels of care needs and to the professional profiles of staff (i.e. whether it is nurses or personal carers and the sub-categories within). Although it is not possible to formulate “one-size-fits-all” staff ratios, it is therefore relevant to compare the number of LTC workers with that of older people potentially in need of care in order to understand the impact on the availability and quality of care.

This performance indicator measures the number of LTC workers in employment (in full-time-equivalents) in relation to every 100 people aged 65+, using data from the LFS. On average in the EU, there are 3.2 LTC workers per 100 people aged 65+.

Figure 25 shows significant variation in that number between Member States: in Sweden and Denmark, there are 10 and 9 LTC workers per 100 older people, respectively, whereas that number drops below 2 for around half of the EU-27.

Figure 25: Number of LTC workers per 100 people aged 65+, 2023



Source: DG EMPL calculation on special extraction from Eurostat, EU-LFS 2023

C17: Share of LTC workers aged 55+

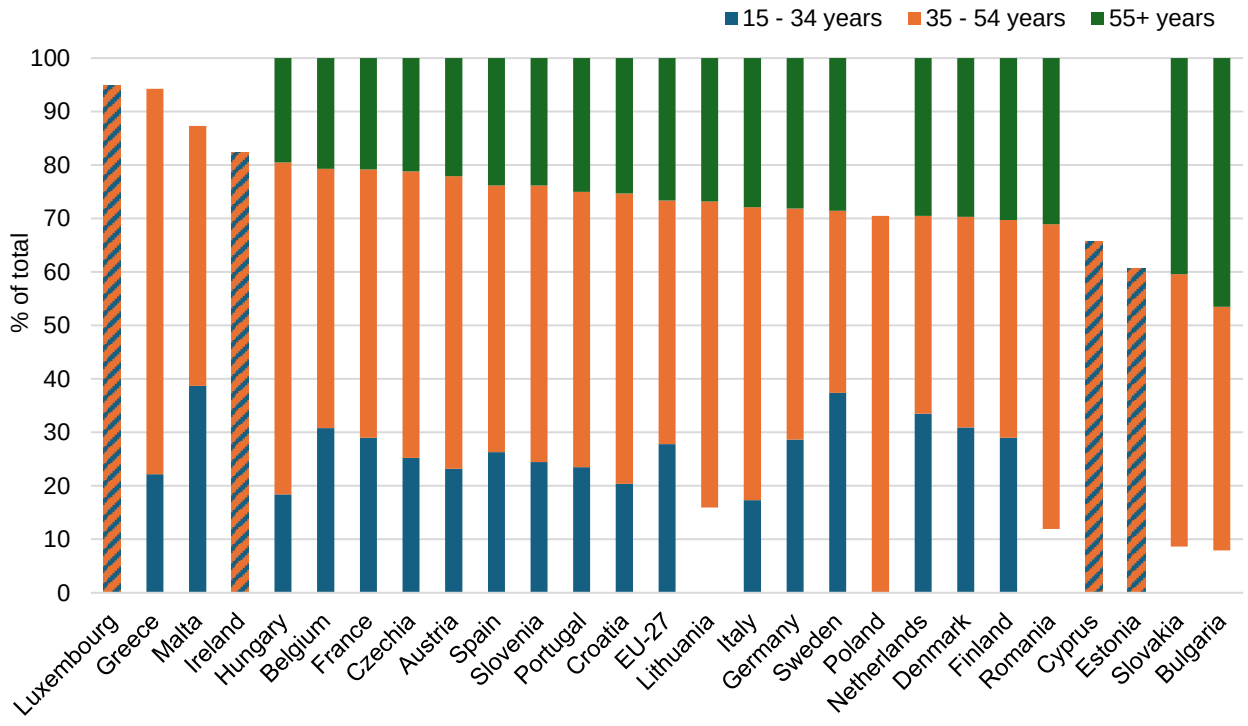
There has been a rapid ageing of the workforce, including in the LTC sector, across much of the EU as the baby-boomer generation reaches retirement age. The share of LTC workers aged 55+ indicates the impending outflows of LTC workforce, which will contribute to staff shortages. According to CEDEFOP, job openings for health professionals, health associate professionals and personal care workers will predominantly reflect replacement demand driven by the retirement of health and care workers rather than employment growth.

This indicator can thus provide context information on the replacement needs of the LTC workforce in the near future by indicating the shares of older LTC workers compared with other age groups in the sector.

Figure 26 shows that, in those Member States for which data are available, between 20% and 45% or more of the workforce are aged 55+, thereby constituting a substantial share of the LTC workforce in some Member States.

Within that, the LTC workforce is considerably older than the overall workforce in these Member States, as shown by comparing the share of workers aged 55+ in the LTC sector with that for the overall workforce (see Figure 27).

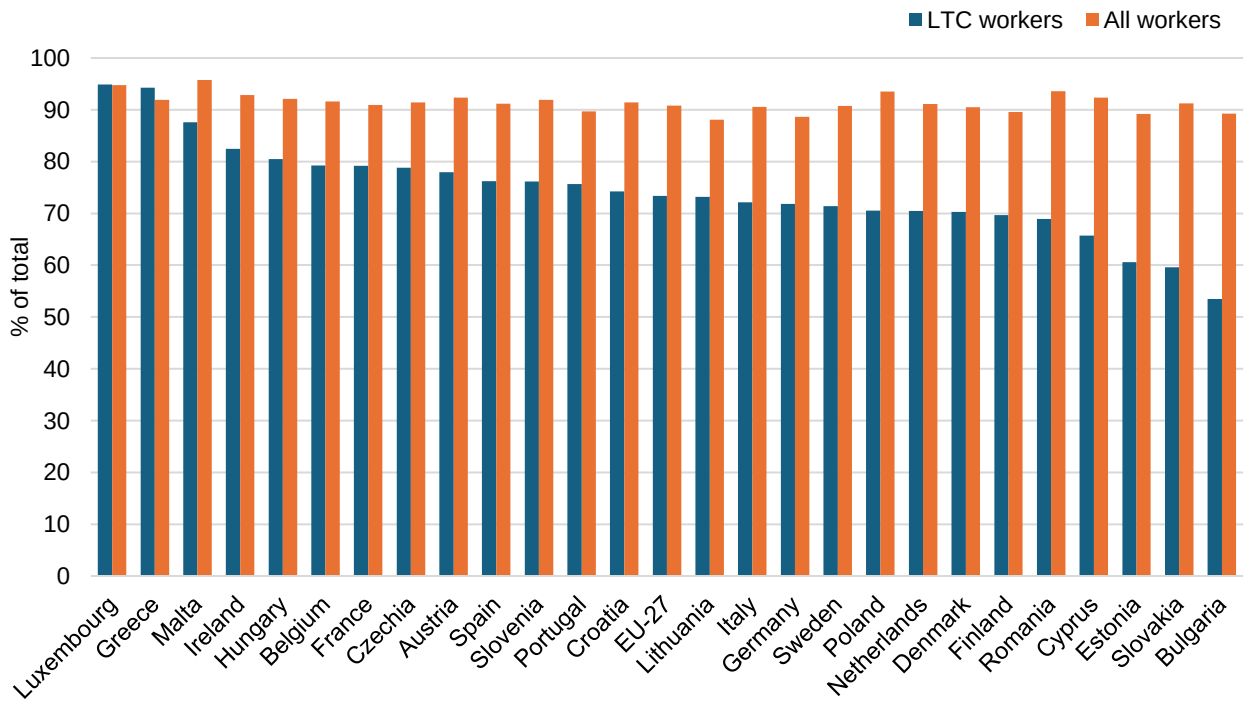
Figure 26: Share of workers aged 15-34, 35-54, and 55+ in total LTC workforce (%), 2023



Note: Due to low reliability, the share of workers aged 15-34 is not published for LT, RO, SK and BG; the share of workers aged 55+ is not published for LU, EL, MT, IE, PL, CY and EE; and data for LU, IE, CY and EE are published only for workers aged 15-54. Data from LV are not published for all age groups.

Source: DG EMPL calculation on special extraction from Eurostat, LFS 2023

Figure 27: Share of LTC workers aged 15-54 compared with all workers (%), 2023



Note: Data for LV are not published due to low reliability.

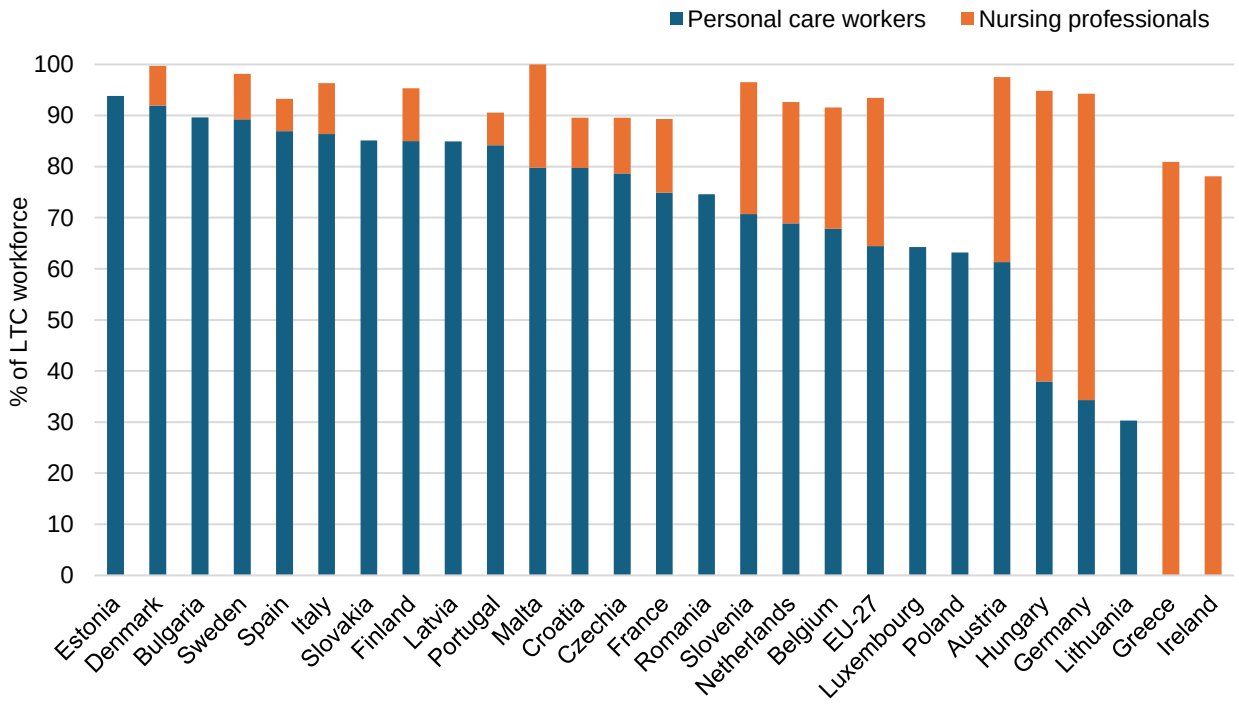
Source: DG EMPL calculation on special extraction from Eurostat, LFS 2023

C18: Share of LTC workers who are personal care workers or nurses

The LTC workforce consists of a range of professions, most importantly personal care workers and nurses. Context information on the distribution of LTC workers by role is crucial for understanding the LTC workforce composition and addressing shortages to meet the needs of an ageing population. Training programmes based on the proportions of personal care workers and nurses could be tailored, ensuring skill requirements are met. The balance between these roles affects service quality, with more nurses indicating clinical capacity and more personal care workers suggesting a focus on daily living support.

Figure 28 shows that, on average in the EU, the majority of those in the LTC sector are personal care workers. Differences in the workforce composition are present between Member States, however: in Greece, Ireland, Germany and Hungary the share of nursing professionals is greatest. Personal care workers also face the lowest wages in the sector, earning only 69% of the mean gross hourly wage, compared with 80% for all LTC workers[24].

Figure 28: Share of personal care workers and nursing professionals in total LTC workforce (%), 2023



Note: Due to low reliability, data for CY are not published; the share of nursing professionals is not published for EE, BG, SK, LV, RO, LU, PL and LT; and the share of personal care workers is not published for EL and IE. For the EU-27, physiotherapists are 1.2% of the LTC workforce, and social work, counselling professionals and psychologists are 5.3%. In LT, social work, counselling professionals and psychologists are 48.6% of the LTC workforce.

Source: DG EMPL calculation on special extraction from Eurostat, LFS 2023

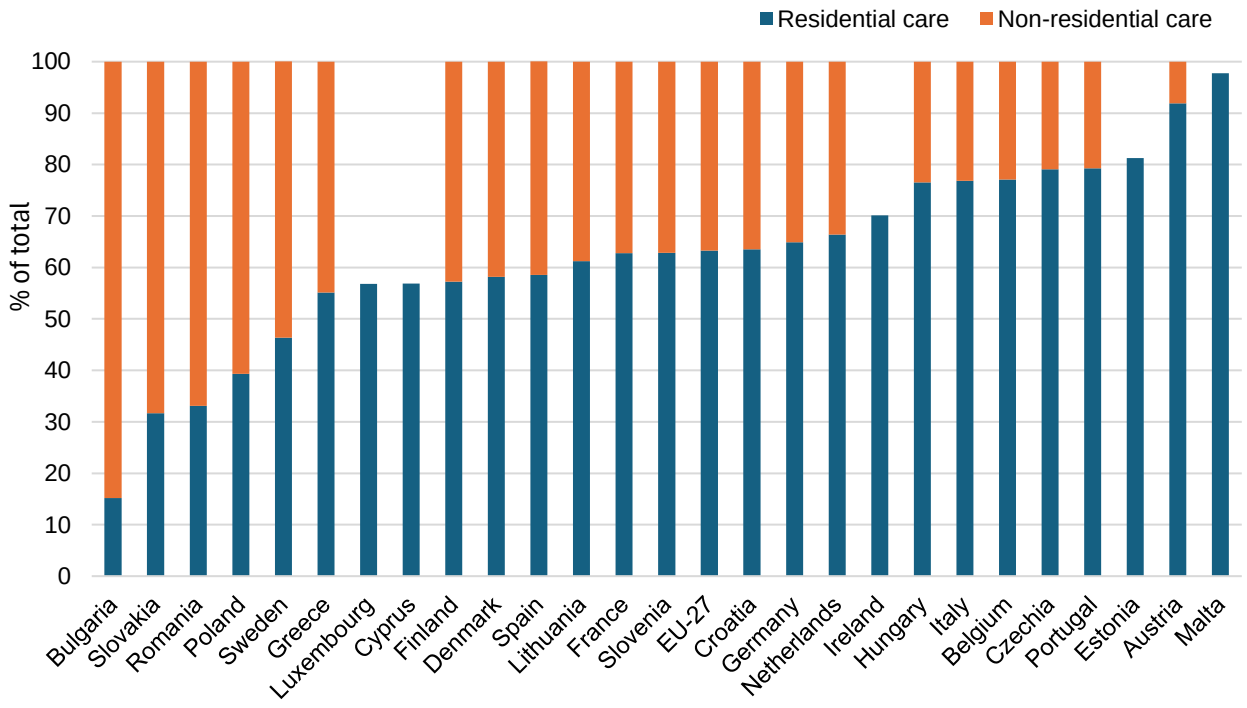
[24] This figure is based on LFS data and stems from: Ghailani D., Marlier E., Baptista I., Deruelle T., Duri I., Guio A-C, Kominou K., Perista P. and Spasova S. (2024), Access for domestic workers to labour and social protection: An analysis of policies in 34 European countries, European Social Policy Analysis Network (ESPAN), Luxembourg: Publications Office of the European Union.

C19: Share of LTC workers in residential and non-residential care

Within LTC formal provision, there is a diversity of models for the delivery of care services, combining to a different extent residential care with home care and community-based care. The LTC Recommendation invites Member States to continuously align the offer of LTC services with needs, while providing a balanced mix of LTC options and care settings to cater for different needs and supporting the freedom of choice, and participation in decision-making, of people in need of care. This includes inter alia developing and/or improving home care and community-based care and closing territorial gaps in LTC availability and accessibility in rural and depopulating areas.

Context information on the relative balance between workers engaged in residential care versus other care options, based on LFS, thus contributes to a better overview of the mix of care options available. Figure 29 shows that, on average in the EU, the majority (63%) of LTC workers work in residential care. Only in five Member States are the majority of LTC workers in non-residential care.

Figure 29: Share of LTC workers in residential care and non-residential care (%), 2023



Note: Due to low reliability, data for LV are not published; the share for residential care is not published for LU, CY, IE, EE and MT.

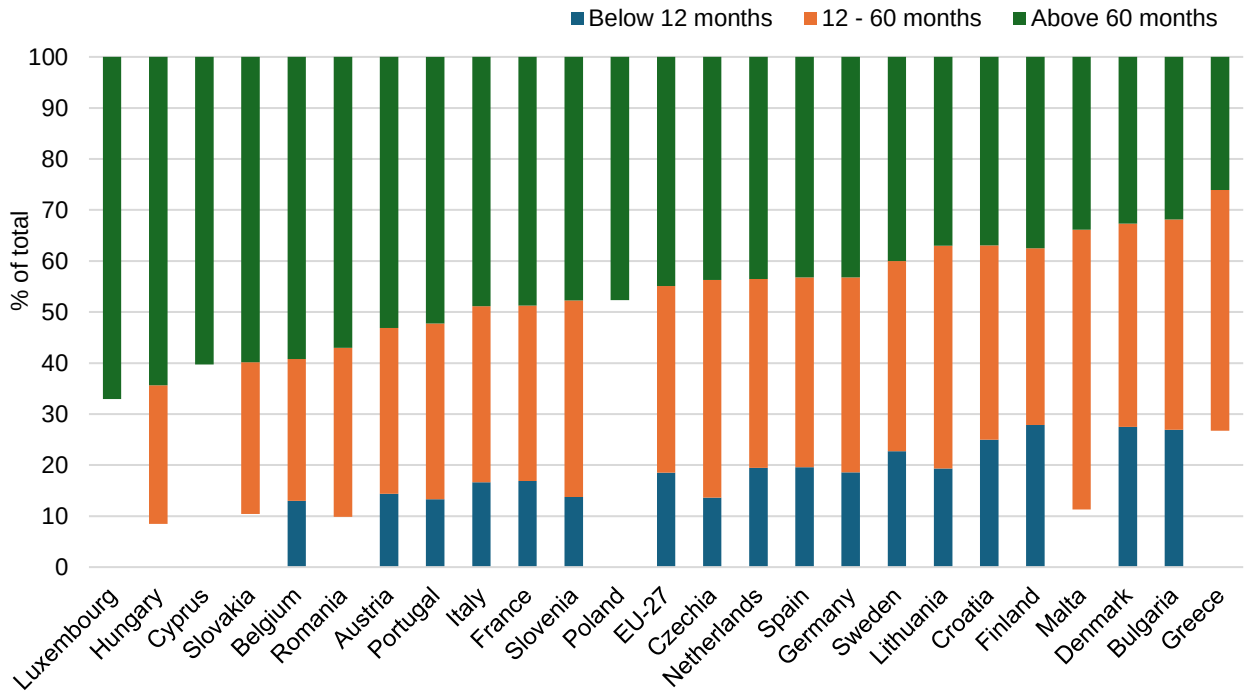
Source: DG EMPL calculation on special extraction from Eurostat, LFS 2023

C20: Share of LTC workers by job tenure

Low retention in the LTC workforce has been an important topic in recent years and is a major policy challenge encountered in many Member States. This is explained by factors

such as the low competitiveness of wages, precarious job status, demanding jobs with high exposure to physical and mental risk factors, and low job satisfaction. High rates of LTC staff turnover result in a lower quality of care, and higher costs. Turnover is particularly high in the first year of work, while the median tenure rate was five years in OECD countries in 2016. Context information on the job tenure of LTC workers across Member States gives an indication of retention rates. Based on LFS data, Figure 30 shows that, on average in the EU, 44.9% of LTC workers had been with their employer for more than five years, 36.6% between one and five years, and 18.5% for less than 12 months.

Figure 30: Share of LTC workers by job tenure (%), 2023



Note: Due to low reliability, data for EE, IE and LV are not published; the share for job tenure below 12 months is not published for LU, CY, SK, RO, PL, MT and EL; and the share for job tenure of 12-60 months is not published for LU, CY and PL.

Source: DG EMPL calculation on special extraction from Eurostat, LFS 2023

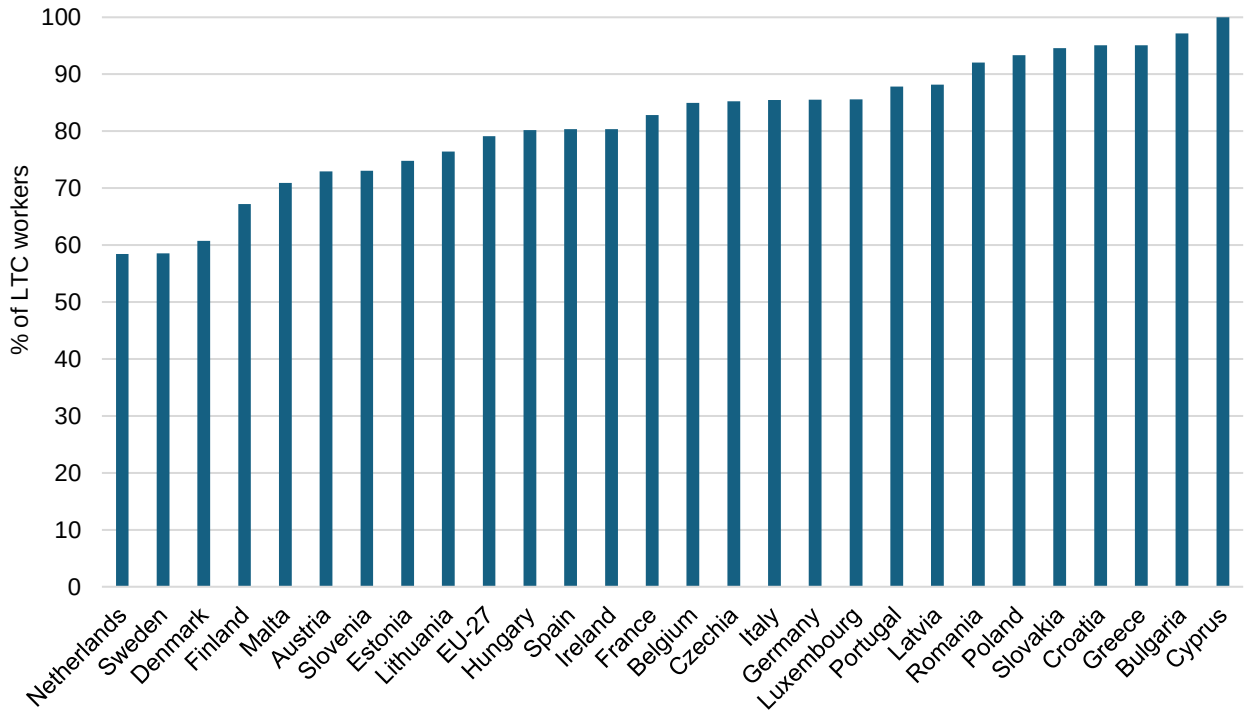
P13: Share of LTC workers not participating in education and training

The care sector requires increasingly complex skills, including proficiency in new technologies, digital tools, effective communication (often in a foreign language), and work in multidisciplinary teams. In line with the LTC Recommendation, fostering continuous learning supports workforce sustainability and enhances quality.

This indicator reflects the extent of adult learning and upskilling in the sector, essential for adapting to these demands. Education and training policies, including formal qualifications and on-the-job training, can help workforce entry, career progression, and retention.

Figure 31 shows that, on average in the EU, almost 80% of LTC workers had not participated in education and training in the previous four weeks, with the share exceeding 90% in seven Member States.

Figure 31: Share of LTC workers who did not participate in education and training in the last four weeks (%), 2023



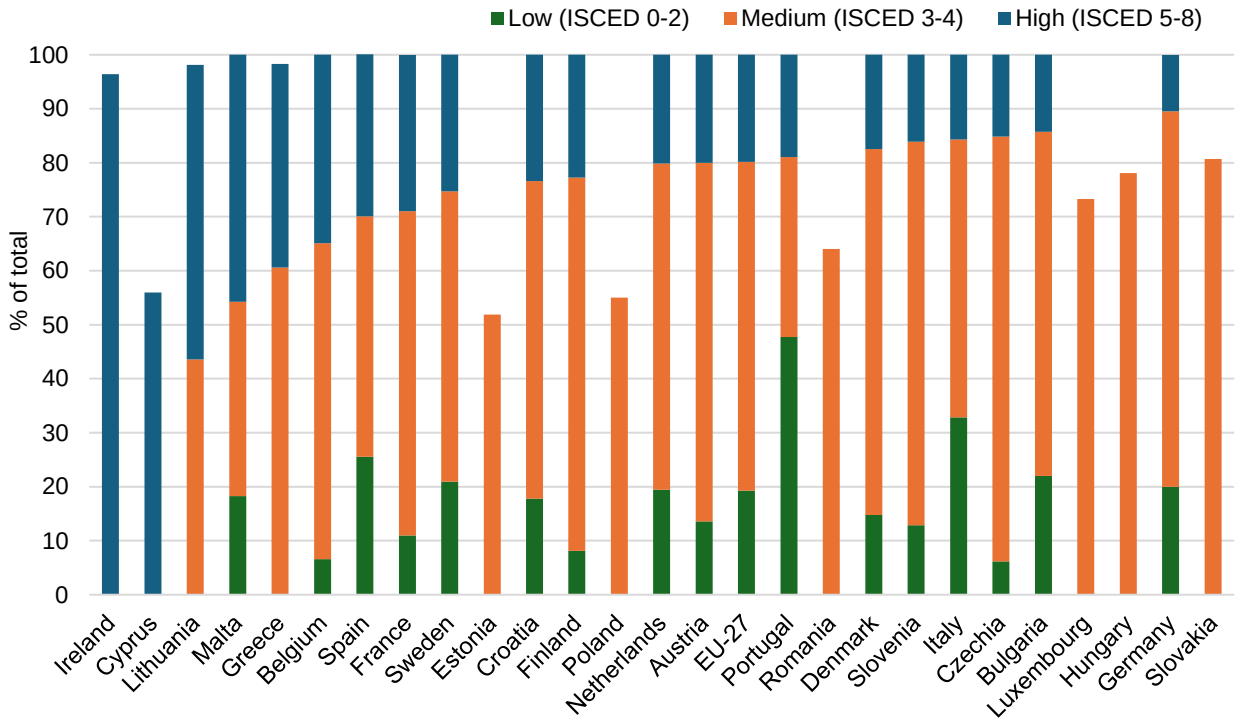
Source: DG EMPL calculation on special extraction from Eurostat, LFS 2023

C21: Share of LTC workers by educational level

Skills requirements in LTC are becoming more complex, including the need for case management, soft and digital skills as well as geriatric and special knowledge (e.g. Alzheimer's and chronic diseases). Despite the relatively high training rate (58% of LTC workers received training paid for or provided by their employer, compared with 38% in all sectors), 24% of LTC workers felt that they "need further training to cope well with duties" (compared with 15% overall). Context information on the educational level of LTC workers can thus be useful in assessing skills gaps and training needs.

Figure 32, based on LFS data, shows that (on average in the EU) most LTC workers have a medium educational level (upper-secondary or post-secondary non-tertiary level). Differences between Member States could lie in the varying national requirements and educational pathways for (health)care staff.

Figure 32: Share of LTC workers by educational level (%), 2023



Note: Due to low reliability, data for LV are not published; the share for high educational level is not published for EE, PL, RO, LU, HU and SK; the share for medium educational level is not published for IE and CY; and the share for low educational level is not published for IE, CY, LT, EL, EE, PL, RO, LU, HU and SK.

Source: DG EMPL calculation on special extraction from Eurostat, LFS 2023

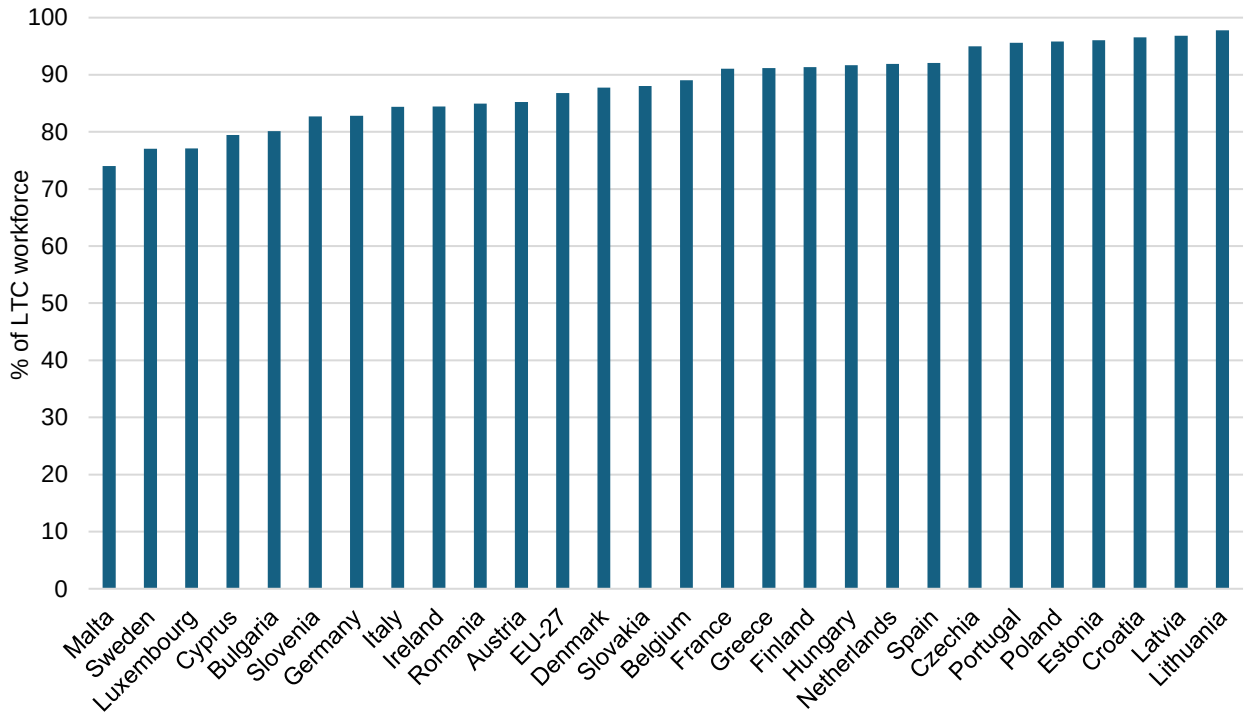
C22: Share of women in the LTC workforce

The LTC Recommendation invites Member States to "implement measures to tackle gender stereotypes and gender segregation and to make the long-term care profession attractive to both men and women".

The care sector is one of the most gender-segregated sectors. Based on LFS data for 2023, 88% of LTC workers in the EU were women (with an even higher rate if only LTC sector workers who provide direct care, and not support workers, are considered). The gender imbalance is somewhat more pronounced in non-residential LTC (83% versus 17%) than in residential LTC (81% versus 19%) (see Figure 33).

Context information using more recent LFS data show that women represent 86.8% of the workforce. Wide variability is observed among Member States.

Figure 33: Share of women in the total LTC workforce (%), 2023



Source: DG EMPL calculation on special extraction from Eurostat, LFS 2023

3.6 Informal carers

"9. It is recommended that Member States establish clear procedures to identify informal carers and support them in their caregiving activities by:

(a) facilitating their cooperation with long-term care workers;

(b) supporting their access to the necessary training, including on occupational health and safety, counselling, healthcare, psychological support and respite care, as well as supporting them in balancing work and care responsibilities;

(c) providing them with access to social protection and/or to adequate financial support, while making sure that such support measures do not deter labour market participation."

Source: LTC Recommendation

The LTC Recommendation sets out guidance to improve the situation for informal carers in Member States, specifically to identify informal carers and support them in their care-giving activities. Informal care has been, and continues to be, essential in the provision of LTC[25], with informal carers, mostly women, traditionally carrying out the bulk of care-giving, often due to a lack of accessible and affordable formal LTC. However, providing informal care can

[25] In some Member States informal care is particularly important as, by law, families have the obligation to care for their relatives, before they can receive formally-provided care. For instance, the constitutions of Hungary and Lithuania place this obligation on families.

negatively affect carers' physical and mental health and well-being and is a significant obstacle to employment, particularly for women. That has an immediate effect on their current income, and also affects their old-age income due to a reduced accrual of pension rights, which can be even more significant for carers with additional childcare responsibilities. A good work-life balance and better reconciliation of work and care responsibilities, together with access to formal LTC services, are therefore necessary for all informal carers, both men and women. In addition, in some cases, informal carers do not have access to adequate social protection and do not receive sufficient direct and/or indirect support for their care-giving activities, including financial support. Measures supporting the validation of their skills can help those interested in transitioning to formal care activities.

In the monitoring framework, the situation of informal carers is contextualised using EHIS data on the share of the population providing informal care overall and of high intensity, broken down by age and between women and men, as well as using EIGE data on the share of informal carers supported by formal services, also broken down between women and men. Progress is measured via three policy levers, drawing on the MISSOC database. The first focuses on the existence of a legal definition or means of identification of informal carers. Further, the nature and extent of financial and non-financial support available to informal carers is assessed: one policy lever evaluates the types of additional support available (such as respite care, training, counselling, and care leave), while another focuses on social protection and financial compensation. The policy levers thereby give an overview of how well informal carers are assisted across Member States.

The LTC Recommendation emphasises the importance of supporting informal carers – predominantly women – who provide essential care due to insufficient formal care services. Informal carers represent nearly 80% of all care-providers in the EU. Member States are encouraged to establish clear procedures for identifying and supporting informal carers to enhance their well-being and mitigate the negative impacts of care-giving on their employment and financial security.

There is a clear prevalence of informal care in the EU, as 17% of the overall EU population provides care or assistance at least once a week. 19.1% of women engage in informal care, compared with 14.8% of men, illustrating a significant gender disparity.

When it comes to age, people aged 45-64 are the most active in providing informal care. Among this age group, the gender gap is 8 percentage points (more women than men) in informal care-provision. Regarding high-intensity care, around 20% of female informal carers and 13% of male informal carers aged 45-64 provide over 20 hours of care per week. In Spain this share exceeds 40%, indicating a particularly high intensity of care-giving.

Concerning support services, 66.8% of informal carers' primary care recipients use formal LTC services weekly, with men receiving more support (73%) than women (61%). Countries such as Malta show no gender disparity in access to formal services.

The existence of a legal definition or means to identify informal carers varies significantly. Whereas many Member States (BE, CZ, FI, FR, DE, IE, IT, LT, LU, MT, PL, PT, RO, SK, ES, SE, NL) have partial to full legal definitions in place, no legal definitions exist in the others (AT, BG, HR, CY, EE, EL, HU, LV, PL, SI).

Support measures, including training and respite care, are in place to varying degrees. High support is available in some Member States (e.g. FI, FR, DE, IE, RO). No support exists in Czechia and Italy, while seven Member States provide a low level of support.

Almost all Member States offer some form of social protection or financial support for informal carers. Estonia, Finland and France provide both social protection and financial support. Cyprus, Denmark, Greece, Italy and Latvia provide neither.

3.6.1 Characteristics of informal carers

C23: Share of people providing informal care or assistance at least once per week on average

Informal carers, mostly women, traditionally carry out the bulk of care-giving, often due to a lack of accessible and affordable formal LTC services. In the EU, informal carers represent close to 80% of all care-providers (in full-time equivalents). While providing informal care should remain a choice and not a necessity due to a lack of adequate services, the LTC Recommendation invites Member States to establish clear procedures to identify informal carers and support them in their care-giving activities.

On the one hand, a high share of informal care often indicates insufficient LTC services. Similarly the OECD highlights that Member States with high numbers of formal carers tend to have low numbers of informal carers, and vice versa. On the other hand, many people also prefer to provide or to receive informal care as a matter of choice. Overall, self-perceptions about informal caring duties and roles may differ across Member States.

EHIS data, by reporting the number of people who declare that they provide informal care or assistance, are helpful in identifying the share of informal carers across the EU and their characteristics. Nevertheless, a study[26] of different methodologies to identify informal carers, suggests that cultural differences surrounding the self-declaration of a care-giving role, especially in Member States where care-giving is seen as part of family life across generations, might influence the results. They also highlight the potential impact of marital status, since married/cohabiting couples may not view certain activities as care-giving and might not declare them as informal care. Taking these factors into account, the data are used as context information.

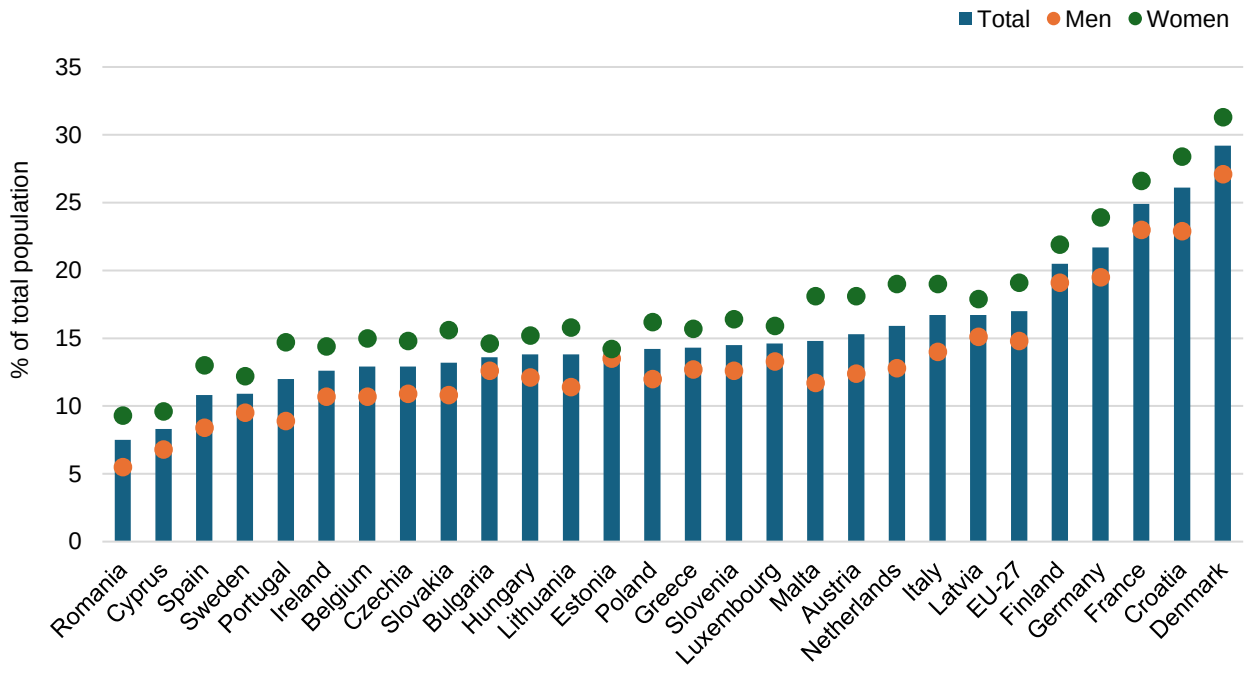
Firstly, EHIS data show that, across the EU, 17% of the population report providing care or assistance to people suffering from some age problem, chronic health condition or infirmity, at least once a week (see Figure 34). This average is higher for women since, on average across the EU, 19.1% of women report providing informal care, as against 14.8% of men.

Secondly, a breakdown by age group shows those aged 45-64 providing the highest share of informal care, confirming previous findings (see Figure 35). This age group also includes the most significant gender differences in providing informal care: at EU level, the difference between men and women stands at 8 percentage points, compared with only 4 percentage

[26] Urwin S., Lau YS., Grande G. et al. A Comparison of Methods for Identifying Informal Carers: Self-Declaration Versus a Time Diary. *PharmacoEconomics* 40, 611–621 (2022).

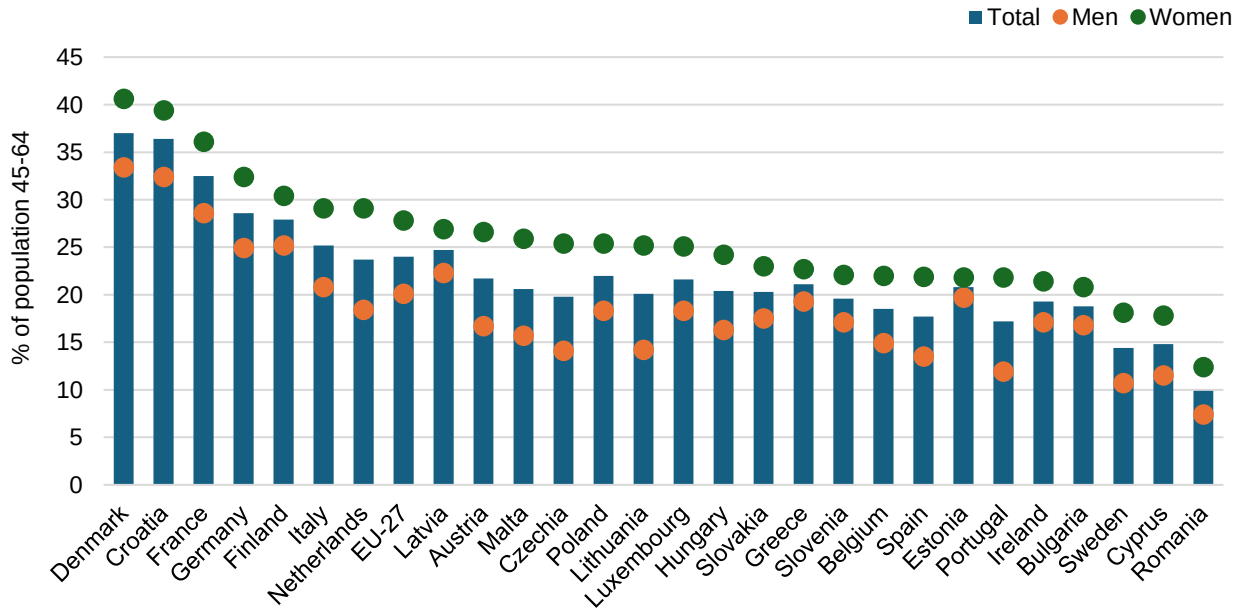
points across the entire age range. This gap could potentially be larger in practice, as women may be under-reporting their care-giving duties.

Figure 34: Share of the population providing informal care or assistance at least once a week on average (%), 2019



Source: Eurostat, EHIS, wave 3, 2019, hlth_ehis_ic1e

Figure 35: Share of the population aged 45-64 providing informal care at least once per week on average (%), 2019



Source: Eurostat, EHIS, wave 3, 2019, hlth_ehis_ic1u

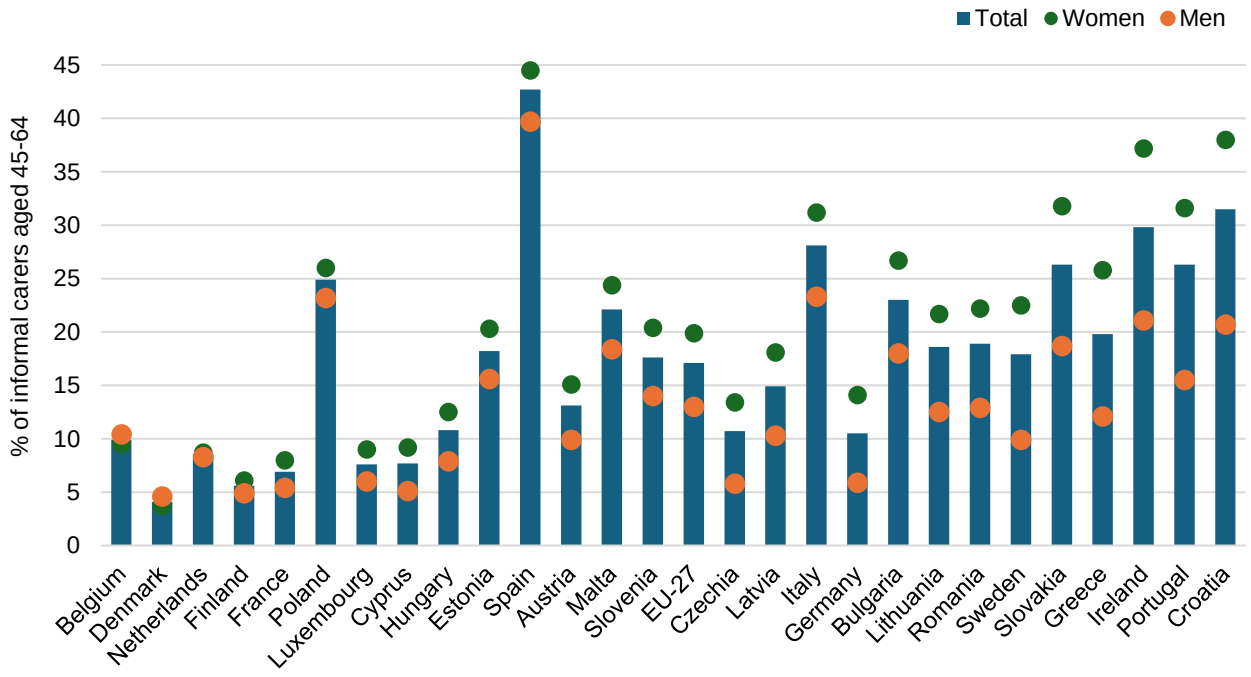
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)

Although many informal carers provide few hours of care, potentially problematic high-intensity care is also prevalent. The analysis of intensity of care is important, as it has strong impacts on the carer (e.g. with regards to health or the ability to combine work with caring activities, and later on also developing LTC needs of their own), particularly for women.

EHIS data measure the intensity of care provided (i.e. hours of care provided per week), providing further context information on the differing situations of informal carers across Member States.

Focusing on the age group with the most significant differences between women and men in overall informal care-provision (45-64) confirms the gender gap in care intensity as well: in most Member States the share of women providing high-intensity informal care is higher than that of men. The data also show an overall high share of high-intensity informal care in some Member States: on average in the EU, 20% of female and 13% of male informal carers aged 45-64 provide more than 20 hours of informal care per week, with the proportion of women exceeding 40% in Spain. Informal care-giving of this intensity further exacerbates the challenges faced by informal care-givers, indicating an increased need for formal support (see Figure 36).

Figure 36: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week), 2019



Source: Eurostat, EHIS, wave 3, 2019, special extraction

3.6.2 Identification of and support for informal carers

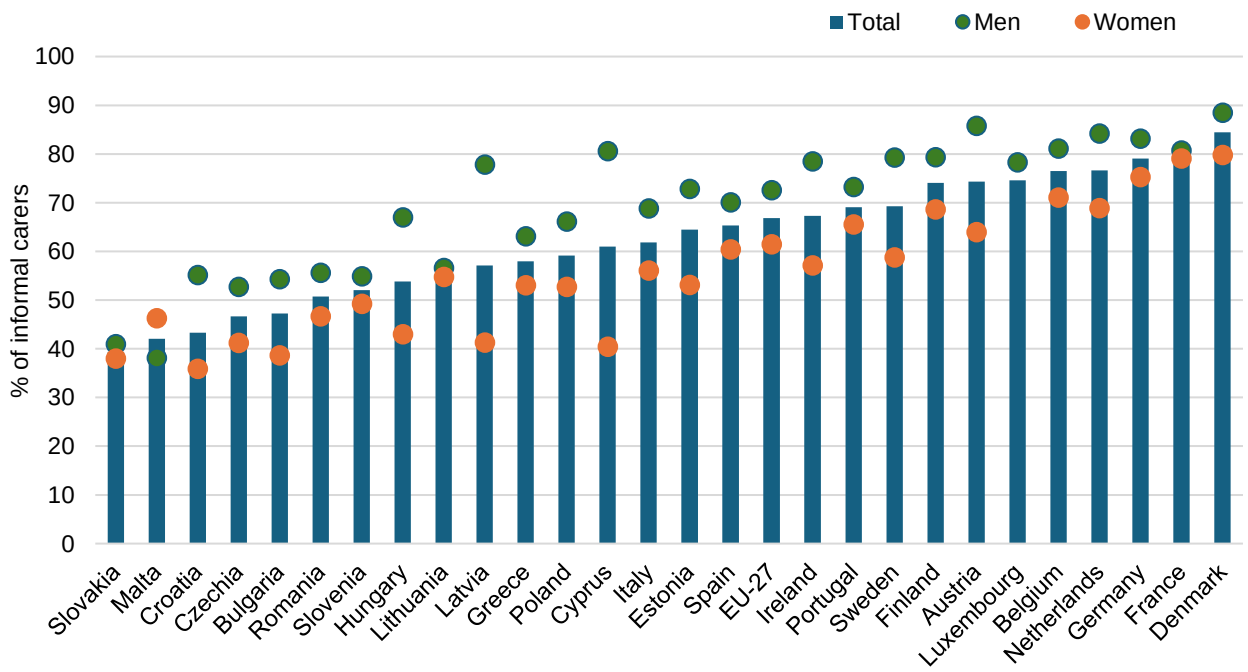
C25: Share of informal carers relying on formal care services

Formal care services are fundamental to respond to the increasing demand for LTC, offering support not only to care recipients but also to informal carers. Formal LTC services help alleviate the burden of care responsibilities, facilitate a healthier work-life balance and provide professional assistance and care.

As Member States are recommended to ensure the availability of LTC services and to support informal carers, including by ensuring respite care, context information on the availability of LTC support services for informal carers is considered. EIGE's CARE survey data are used to describe the frequency of use of formal care services (residential LTC facilities/institutions; daycare centres; home-based personal care workers; nurses and/or healthcare assistants; domestic cleaners and helpers; live-in carers; social workers; and other healthcare professionals) by care recipients who also receive informal care, at least once per week.

EIGE's survey shows that 66.8% of informal carers' main care recipients use formal LTC services at least once a week in the EU. A gender disparity can be observed in all Member States except Malta. A higher proportion of male informal carers are supported at least once a week by formal LTC services used by their main care recipient (73%), while a lower share of female informal carers (61%) is supported by such services for their main care recipient (see Figure 37).

Figure 37: Share of informal carers relying on formal care services at least once per week, 2022



Note: Due to low reliability, data for women are not published for LU.

Source: Computed using microdata from EIGE's 2022 CARE survey.

L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers

For Member States to adequately support informal carers in their care-giving activities, thus mitigating the negative consequences of care responsibilities, information on (and a clear identification of) informal carers is needed. Research on their characteristics and their situation is a prerequisite for tailoring measures to their needs.

Clear procedures for identifying informal carers, and clear regulation of the rights associated with informal care, can help explain the scale and impact of informal care and to define and guarantee the rights of informal carers. Having a legal definition of informal carers helps the recognition of those who provide LTC to a family member or a friend, and consequently facilitates their identification and support. Beyond the existence of a national legal definition, having specific legislation in place to identify informal carers, for example the existence of a registry, is also useful for identification purposes.

As Member States are recommended to identify informal carers, a policy lever assesses the existence of a legal definition of informal carers and/or legislation in place to identify informal carers. Table 11 shows an assessment of the existence of such definitions and procedures, based on data available in the MISSOC database.

To fulfil the criteria of the policy lever, a Member State's legislation needs to include a legal definition of informal carers, and/or informal carers need to be registered or recognised by a relevant public authority. When a benefit exists specifically for informal carers, this is also considered as identifying informal carers. Based on the information available in the MISSOC database, it seems that there are some procedures to identify informal carers in almost half of the Member States. Among those, however, only a few have a registry or legislation in place to identify informal carers.

Table 11: Existence of a legal definition and/or legislation to identify informal carers

Member State	Existence of a legal definition and/or legislation to identify informal carers
Austria	No
Belgium	Yes
Bulgaria	No
Croatia	No
Cyprus	No
Czechia	Yes
Denmark	Yes (partial)*
Estonia	No
Finland	Yes
France	Yes
Germany	Yes
Greece	No
Hungary	No
Ireland	Yes

Member State	Existence of a legal definition and/or legislation to identify informal carers
Italy	Yes
Latvia	No
Lithuania	Yes
Luxembourg	Yes
Malta	Yes
Netherlands	Yes (partial)*
Poland	No
Portugal	Yes
Romania	Yes
Slovakia	Yes
Slovenia	No
Spain	Yes
Sweden	Yes

*Those who conclude an employment contract are defined/identified. However, it needs to be remembered that the concept of informal carer does not cover those family members employed to provide LTC to a person in need of care.

Source: MISSOC database

L11: Existence of support available to informal carers (respite care, training, counselling and care leave)

Providing informal care can negatively affect carers' physical and mental health and well-being. In order to provide good-quality care, informal carers need access to training and counselling. It is important for them to have opportunities to exchange information and learn from professional LTC workers. In addition, measures supporting the validation of their skills can help those interested in transitioning to formal care activities. Psychological support can help prevent and tackle mental health issues among informal carers. Being able to take some time off and having access to respite care that temporarily replaces them, such as temporary residential care or daycare centres, allows informal carers to have some time for themselves and to improve their well-being.

Member States are recommended to support access by informal carers to the necessary training, including on occupational health and safety, counselling, healthcare, psychological support and respite care, as well as supporting them in balancing work and care responsibilities. A policy lever is therefore introduced showing whether non-financial support is available to informal carers. Table 12 shows an assessment of the existence of support to informal carers, based on data available in the MISSOC database. Member States are categorised into providing high, medium, low, or no support, according to whether they have at least three, at least two, only one, or no type of support available, respectively.

From the range of potential support options, the policy lever focuses on respite care, training, counselling and care leave. According to MISSOC data, some forms of support exist in the majority of Member States. Most Member States provide "medium" support, which consists of at least two forms of support. Seven Member States provide "low support", meaning only one form. Among the Member States that provide some sort of support, 13 provide respite

care. Only one Member State was found to have no support available to informal carers in the form discussed under this policy lever.

Table 12: Existence of support available to informal carers

Member State	Existence of support available to informal carers
Austria	High
Belgium	Medium (at regional level)
Bulgaria	Low
Croatia	Medium
Cyprus	Medium
Czechia	Medium
Denmark	Medium
Estonia	Medium (varying between municipalities)
Finland	High
France	High
Germany	High
Greece	Medium
Hungary	Low
Ireland	High
Italy	None
Latvia	High
Lithuania	Low
Luxembourg	Medium
Malta	Medium
Netherlands	Low
Poland	Medium
Portugal	Low
Romania	High
Slovakia	Low
Slovenia	Low
Spain	Medium
Sweden	Medium

Source: MISSOC database

L12: Existence of compensation available for informal carers

Providing informal care can have an impact on current and future income, due to reduced working time and accrued pensions rights, particularly for women. However, in some cases informal carers do not have access to adequate social protection and do not receive sufficient direct and/or indirect support for their care-giving activities, including financial support. The LTC Recommendation invites Member States to provide informal carers with access to social protection (e.g. pensions and healthcare) and/or adequate financial support (e.g. cash benefits) to compensate for possible losses due to care-giving activities. It also clarifies that such support measures should not deter labour market participation.

To assess the financial support available to informal carers across Member States, a policy lever shows the existence of measures available to compensate informal carers, based on information in the MISSOC database. Table 13 shows an assessment of the existence of such compensation.

Almost all Member States provide some compensation to informal carers in the form of social protection and/or financial support. Social protection is more frequent as a form of support and often encompasses pensions entitlements or contributions, and contributions to healthcare and/or unemployment insurance. Only three Member States (EE, DR, LU) provide social protection and financial support, while five provide none (CY, DK, EL, IT, LV).

Table 13: Existence of compensation available to informal carers

Member State	Social protection (e.g. pensions and healthcare)	Financial support (e.g. cash benefits to the informal carer)	Total
Austria	✓	X	Partial
Belgium	✓	✓ at federal level	Yes
Bulgaria	X	✓	Partial
Croatia	✓	X	Partial
Cyprus	X	X	No
Czechia	✓	X	Partial
Denmark	X	X	No
Estonia	✓	✓	Yes
Finland	✓	✓	Yes
France	✓	✓	Yes
Germany	✓	X	Partial
Greece	X	X	No
Hungary	X	✓	Partial
Ireland	X	✓	Partial
Italy	X	X	No
Latvia	X	X	No
Lithuania	✓	X	Partial
Luxembourg	✓	✓	Yes
Malta	X	✓	Partial
Netherlands	X	✓	Partial
Poland	✓	X	Partial
Portugal	X	✓	Partial
Romania	X	✓	Partial
Slovakia	✓	✓	Yes
Slovenia	X	✓	Partial
Spain	✓	X	Partial
Sweden	X	✓	Partial

Source: MISSOC database

Acknowledgments

The monitoring framework has been prepared as part of the mandate set out by the 2022 Council Recommendation on access to affordable high-quality long-term care[27], which welcomed the Commission's intention to work with the Social Protection Committee (SPC) to establish a framework of indicators for monitoring the implementation of the Recommendation. It represents the joint work of the Social Protection Unit of Directorate-General for Employment, Social Affairs and the Indicators Sub-Group (ISG) of the Social Protection Committee.

The framework was developed by colleagues in the Social Protection and Demography Unit of Directorate-General for Employment, Social Affairs and Inclusion (Francesco Giusti, Flaviana Teodosiu, Susanna Ulinski, Valeria Spazzoli, Julia Teresa Amorim, Johanna Harting, Clara Lunden, Jiri Svojse and Dana-Carmen Bachmann) with extensive support from Eurostat, DG ECFIN, SPC ISG Secretariat, and members of the ISG.

[27] 2022/C 476/01.

Annexes

Annex 1: Key data sources

The agreed ISG indicators are based on survey data or administrative data published by Eurostat where possible. These data are complemented by data collected by the Ageing Working Group (AWG), the OECD, and MISSOC.

Administrative data

Administrative data concerning LTC are not collected separately, but some information regarding LTC can be extracted from healthcare expenditure and non-expenditure data collections.

Non-expenditure healthcare statistics[28] are a dataset concerning healthcare resources (such as personnel, beds and medical equipment) and healthcare activities (such as information on surgical operations and procedures and hospital discharges). Data on the availability of beds should cover all hospitals as well as nursing and residential care facilities. Non-expenditure healthcare data are mainly based on national administrative sources and reflect the country-specific way of organising healthcare. A few Member States compile this information from surveys. Common definitions for many non-expenditure healthcare indicators were agreed with the OECD and the WHO in the context of the Eurostat joint questionnaire on non-monetary healthcare statistics.

Expenditure data on LTC come from the System of Health Accounts (SHA) and are collected within the categories “LTC health” and “LTC social”. It is mandatory for Member States to report on the health component (HC.3), but not the social component (HCR.1) of expenditure, which is however reported on voluntary basis by the majority of Member States.

The Ageing Report is a triannual publication from the Directorate-General for Economic and Financial Affairs (DG ECFIN) and the AWG. It presents projections showing the economic and budgetary impact of an ageing population over the long term. The DG ECFIN and AWG collect data directly from Member States on the numbers of recipients of public in-kind or cash benefits for LTC. To obtain a more complete picture of public LTC expenditure than in the SHA, the Ageing Report combines data from the SHA, the European system of integrated social protection statistics (ESSPROS), and data directly provided by Member States.

The OECD developed a framework based on stylised cases of LTC needs that, despite significant differences in terms of how care is organised, allows for social protection for LTC to be compared across Member States. To measure the depth of social protection for LTC in old age and compare it across Member States, the OECD developed a set of eight typical cases of LTC needs. These cases describe an older person in terms of the types and severity of their needs, the professional services they require, and their level of income and

[28] https://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_non-expenditure_statistics_-_methodology#Main_features

assets. The costs of care and public support available are then analysed for each of the typical cases.

The European Statistics on Accidents at Work (ESAW) collects data on accidents at work, requiring Member States to transmit annually to the Commission (Eurostat) microdata on people who had an accident in the course of work during a reference period and the associated metadata.

Survey data

The European Health Interview Survey (EHIS) is designed to measure, on a harmonised basis and with high comparability among Member States, the health status (including disability), healthcare and LTC use, health determinants and limitations in access to health and care services of EU citizens. This instrument is anchored in the European statistical system (ESS). The EHIS may be implemented as a separate national survey or integrated into an existing national survey. It was last conducted in 2019 and is repeated every six years. The 2025 questionnaire will include additional LTC variables, with data available in 2028.

The EU Statistics on Income and Living Conditions (EU-SILC) is the EU reference source for comparative statistics on income distribution and social inclusion. This instrument is anchored in the ESS. Rolling modules (previously ad hoc modules) are collected each year to complement the variables permanently collected. The 2016 ad hoc module “access to services” includes variables on access to healthcare and professional home care and will be repeated in the EU-SILC 2024 six-yearly rolling module on “access to services”, with data available in 2026.

The EU Labour Force Survey (EU-LFS) is the largest European household sample survey. Its main statistical objective is to classify the population by employment status (employed, unemployed, outside the labour force), but it also identifies the occupation and sector of employed people. To ensure that the statistical results are comparable across Member States and over time, the EU-LFS follows ILO guidelines, and uses common classifications (NACE, ISCO, ISCED, NUTS[29]). The EU-LFS provides quarterly and annual data. In 2025 the EU-LFS module on reconciliation of work and family life will also include variables on informal LTC responsibilities.

The methodology for selecting the LTC workforce from EU-LFS data has been one of the most important topics discussed in the TF LTC. While there is currently agreement in the TF LTC on using selected ISCO 4 digits and NACE 3 digits to identify the LTC workforce, the final list is still being discussed, including ways to take into account recent work from the WHO providing a comprehensive list of LTC actors.

For the purposes of the monitoring framework, the following ISCO and NACE categories have been agreed with ISG:

a) sector (NACE) codes 87.1, 87.3, 88.1; and

[29] NACE = nomenclature of economic activities; ISCO = international standard classification of occupations; ISCED = international standard classification of education; NUTS = nomenclature of territorial units for statistics.

b) occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322.

When detailed ISCO/NACE classifications are not available, the use of a less granular ISCO-NACE cross-classification leads to the inclusion of people not belonging to the LTC workforce. The deriving bias will depend on the extent to which these additional (categories of) people are different from the LTC workforce in the characteristic of interest. At the same time, caveats on reliability limits have to be taken into consideration (e.g. data not displayed for certain Member States).

The Structure of Earnings Survey (SES) is designed to provide accurate data on earnings, comparable across Member States and over time. It is a large sample survey of enterprises on the relationships between the level of pay and individual characteristics of employees (sex, age group, occupation, length of service, highest educational level attained, etc.) and those of their employer, including enterprises with at least 10 employees. It is conducted every four years; data from the most recent data collection (2022), with results available in 2024, were used.

The first wave of the European Institute for Gender Equality (EIGE) survey on gender gaps in unpaid care, individual and social activities (CARE) was carried out in all 27 EU Member States, with a total sample size of over 60,000 respondents. In most of them, data were collected through computer-assisted web interviews using established online access panels. In Luxembourg and Malta, respondents were interviewed using computer-assisted telephone interviews due to a lack of robust online access panels. The survey targeted respondents aged 16-74, with the exceptions of Luxembourg (16 or over), Malta (16 or over) and Romania (16-64). The fieldwork took place between August and October 2022, with two additional fieldwork days at the beginning of November 2022. Work on a second wave of the CARE survey is currently ongoing.

Data concerning the policy and legal framework for LTC

The EU's Mutual Information System on Social Protection (MISSOC) was established in 1990 to promote a continuous exchange of information on social protection among the EU Member States. The database provides information on social protection legislation, benefits and conditions, including for LTC. It covers the 27 EU Member States, the European Economic Area and Switzerland, and is updated twice per year. The guidelines regarding the production of Table XII (LTC) were adjusted in 2024 to allow for comprehensive monitoring of the MISSOC-based policy levers included in the monitoring framework.

The Social Protection Committee's (SPC) Indicators' Sub-Group (ISG) complements and validates information pertaining to the policy and legal framework for LTC at national level, in particular underpinning some of the policy levers included in the monitoring framework.

Annex 2: Indicator description tables

Overarching context information items

- C1: People aged 65+ and 75+ as a share of the total population (Eurostat)
- C2: People aged 65+ with severe difficulties in ADL and/or IADL as a share of the population aged 65+ (EHIS)
- C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing (Ageing Report)
- C4: Projected public spending on LTC as a share of GDP in 2030 (Ageing Report)

Adequacy	Availability	Quality	Workforce	Informal carers
L1: Maximum (legal) waiting time for services (MISSOC) L2: Maximum (legal) waiting time for needs-assessment (MISSOC) C5: Monitoring of waiting times (MISSOC) L3: Standardised procedure for LTC needs-assessment (MISSOC) C6: Clear categories of degrees of dependency (MISSOC) L4: Comprehensive evaluation (coverage) of LTC needs (OECD) P1: People in need of LTC not using (more) professional home care services primarily	C8: Share of public LTC expenditure by setting (Ageing Report) C9: Number of LTC beds (Eurostat – Non-monetary healthcare statistics) C10: Existence of choice between care settings for people in need of LTC (MISSOC) C11: Existence of choice between providers for people in need of LTC (MISSOC) P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months (Eurostat – EHIS) P7: Share of people aged 65+ who receive	L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans (MISSOC) L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated (MISSOC) L6A: Existence of quality standards that apply to different care settings and to all types of providers (MISSOC) L6B: Existence of rules regulating quality-assurance in public and non-public providers (MISSOC) L7: Existence of quality-assurance bodies for all elements and types of LTC (MISSOC)	P10: Coverage of collective bargaining for LTC workers (Eurostat – SES) P11: Mean gross hourly wages for LTC workers compared with mean gross hourly wages in all other sectors (Eurostat – SES) C13: Share of LTC workers in full-time employment (Eurostat – EU-LFS) C14: Share of LTC workers with permanent contracts (Eurostat – EU-LFS) C15: Share of LTC workers working shifts (Eurostat – EU-LFS) C16: Non-fatal accidents at work in the care sector (Eurostat – ESAW) L9: Ratification of ILO Domestic	C23: Share of people providing informal care or assistance at least once per week on average (Eurostat – EHIS) C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week) (Eurostat – EHIS) C25: Share of informal carers relying on formal care services at least once per week (EIGE) L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers (MISSOC) L11: Existence of support available to informal carers (respite care, training, counselling and care leave) (MISSOC) L12: Existence of compensation

Adequacy	Availability	Quality	Workforce	Informal carers
due to cost (Eurostat – EU-SILC) P2: Difficulty in affording professional home care service (Eurostat – EU-SILC) P3: Share of costs covered by public social protection (OECD) P4: Out-of-pocket costs of care as a share of income for care recipients aged 65+ (OECD) P5: Share of population aged 65+ who would have below 60% of median income after paying for the out-of-pocket costs of home care (OECD) C7: Income-testing and asset-testing of LTC benefits (OECD)	public home care, residential care or cash benefits (Ageing Report) C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits (Ageing Report, Eurostat – EU-SILC) P8: Share of people aged 65+ with unmet need for help with ADL/IADL, with at least one severe difficulty in ADL/IADL (Eurostat – EHIS) P9: People in need of LTC not using (more) professional home care services primarily due to poor availability (Eurostat – EU-SILC)	L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect (MISSOC)	Workers Convention (No 189) (ILO) P12: Number of LTC workers per 100 people aged 65+ (Eurostat – EU-LFS) C17: Share of LTC workers aged 55+ (Eurostat – EU-LFS) C18: Share of LTC workers who are personal care workers or nurses (Eurostat – EU-LFS) C19: Share of LTC workers in residential and non-residential care (Eurostat – EU-LFS) C20: Share of LTC workers by job tenure (Eurostat – EU-LFS) P13: Share of LTC workers who did not participate in education and training in the last four weeks (Eurostat – EU-LFS) C21: Share of LTC workers by educational level (Eurostat – EU-LFS) C22: Share of women in the LTC workforce (Eurostat – EU-LFS)	available for informal carers (MISSOC)

Annex 2.1 Overarching context information items

Note: labels “EU” and “NAT” indicate whether data quality allows for a comparison at EU level (EU) or whether the data do not allow for such a comparison (NAT).

Definition	C1: People aged 65+ and 75+ as a share of the total population
Data source	National administrative data, demo_pjanind
Member State coverage	27 Member States
Calculation methods	The number of people aged 65+ or 75+, divided by the number of usual residents of a given area on 1 January of the year in question
Major proposed breakdowns	Age and sex
Policy relevance / polarity for interpretation	The indicator puts the performance indicators into context. Age structure is also essential for public LTC planning and scenarios. The indicator has a clear interpretation.
Robustness and statistical validity	Population data are collected by Eurostat from the national statistical offices. National annual population estimates can be based on data from the most recent census, adjusted by the components of population change produced since the last census or based on population registers.
Cross-country comparability	Very high
Underlying data / timely and susceptible to revision	Data are updated annually
Actionable	No
EU/NAT classification	Context (EU)

Definition	C2: Share of people aged 65+ with severe difficulties in ADL/IADL
Data source	EHIS, hlth_ehis_tadle and hlth_ehis_tadli
Member State coverage	27 Member States
Calculation methods	Share of people aged 65+ with limitations in ADL/IADL in total population aged 65+
Major proposed breakdowns	Breakdowns for difficulties in ADL only, difficulties in IADL only, and difficulties in both, by: Sex and age group (65+, 75+); income quintile; and degree of urbanisation
Policy relevance / polarity for interpretation	The indicator shows how many people are in need of LTC, in line with the SPC definition and LTC Recommendation
Robustness and statistical validity	ADL and IADL are widely used instruments for measuring disability in surveys; many studies have shown their validity in this respect
Cross-country comparability	Eurostat ensures comparability via a joint methodology
Underlying data / timely and susceptible to revision	The indicator is built on underlying data

Actionable	The indicator is susceptible to policy intervention by the promotion of healthy and active ageing
EU/NAT classification	Context (EU)

Definition	C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing
Data source	Ageing Report / Ageing Working Group (AWG)
Member State coverage	27 Member States
Calculation methods	Data for the SHA categories HC.3 for nursing care, plus data available on HC.R.1 for LTC social services are combined with ESSPROS data as a proxy for social care spending for the respective Member State. Spending is then divided by the GDP of the respective year to calculate the ratio, or alternatively by the total cost of ageing (including expenditure on pensions, healthcare, LTC and education).
Major proposed breakdowns	No breakdown
Policy relevance / polarity for interpretation	Although spending also has to be analysed qualitatively in relation to the indicators identified for each dimension of the LTC Recommendation, there is a general trend – the more a Member State spends on LTC, the better is its public provision of LTC, in terms of quantity and quality
Robustness and statistical validity	Validated by AWG national delegates for each Member State. For Member States where both HC.3 and HCR.1 are available, the quality is the same as that of Eurostat statistics. For those where Member States had to validate the ESSPROS proxy to substitute for the missing HCR.1, the quality is lower*.
Cross-country comparability	The same definition is used for every Member State and there is careful bilateral work with AWG delegates to ensure comparability. The results are validated by AWG national delegates for each Member State.
Underlying data / timely and susceptible to revision	The underlying sources are the SHA, ESPROSS and data reported directly by Member States. The data are updated every three years.
Actionable	The indicator is actionable, as it is directly influenced by government expenditure
EU/NAT classification	Context (EU)

* There is, however, no better alternative currently available. OECD has a “total LTC expenditure” statistic, but whenever HCR.1 is not available it assumes it is zero. This leads to significant underestimates of the expenditure of some countries.

Definition	C4: Projected public spending on LTC as a share of GDP in 2030
Data source	Ageing Report / AWG
Member State coverage	27 Member States
Calculation methods	The baseline scenario is based on current public LTC expenditure and assumes that half the projected gains in

	life expectancy are spent without disability (i.e. needing care), without any policy change. Additionally, income elasticity is assumed to converge from 1.1 in 2016 to unity in 2070 for those Member States that are below the first quartile in terms of expenditure of LTC as a proportion of GDP. The risk scenario is based on current public LTC expenditure and assumes that half the projected gains in life expectancy are spent without disability (i.e. needing care). In addition, it assumes a convergence of both total average cost and LTC coverage rates to the EU average for those below it. Income elasticity remains at unity for the projection period.
Major proposed breakdowns	Projections for 2030 and 2050 and by type of benefit
Policy relevance / polarity for interpretation	The projection analysis helps policy-makers to understand the impact their policy decisions might have on LTC expenditure in the mid- and long term. The projections are based on different assumptions, which need to be taken into account in their interpretation.
Robustness and statistical validity	These results are co-produced and validated by the Member State through the AWG (EPC)
Cross-country comparability	The same methodology is used for every Member State, and the data and methodology are accepted by Member States through the AWG. Comparability is fairly strong.
Underlying data / timely and susceptible to revision	The underlying sources are the LTC expenditure data from the Ageing Report and the population projections from Eurostat. The indicator is updated every three years.
Actionable	The indicator is actionable in the long term, as it is directly influenced by government policies regarding healthy ageing and the provision of LTC
EU/NAT classification	Context (EU)

Annex 2.2 Adequacy

Definition	L1: Maximum (legal) waiting time for service provision
Data source	MISSOC
Member State coverage	27 Member States (23 replied to ad-hoc survey)
Assessment method	Maximum waiting times for service provision: a Member State is categorised as “yes” if there is legislation in place regarding a maximum waiting time for home care and residential care. It is categorised as “partly” if there is legislation on waiting times only pertaining to one care setting, or if there is no legislation but there are agreed norms on waiting time. It is categorised as “no” if there are no waiting times specified by law or by norms.
Major break-down	Not applicable

Policy relevance / polarity for interpretation	Social protection should ensure timely access to LTC, allowing people in need of LTC to receive the necessary care as soon as needed, preventing further deterioration, and alleviating the burden from family members. This policy lever illustrates legal maximum waiting times for service provision, but not effective waiting times.
Robustness and statistical validity	The data are provided by national correspondents to the MISSOC Secretariat that ensures cross-country comparability through an agreed guidance document.
Cross countries comparability	Yes
Underlying data / timely and susceptible to revision	Collected and updated biannually from Member States by MISSOC. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Definition	L2: Maximum (legal) waiting time for needs-assessment
Data source	MISSOC
Member State coverage	27 Member States
Assessment method	Maximum waiting times for LTC needs-assessments. Member States are categorised as “yes” if there is legislation in place regarding a maximum waiting time; as “partly” if there are agreed norms on waiting times; and as “no” if there are no waiting times specified by law or by norms.
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	Social protection should ensure that people in need of LTC receive it in a timely way – preventing further deterioration and alleviating the burden on family members. This policy lever illustrates legal maximum waiting times for needs-assessments, but not effective waiting times.
Robustness and statistical validity	The data are provided by national correspondents to the MISSOC Secretariat, which ensures cross-country comparability based on an agreed guidance document
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected and updated biannually from Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Definition	C5: Monitoring of waiting times
Data source	MISSOC
Member State coverage	27 Member States
Assessment method	Member States are categorised as “yes” if there is monitoring of waiting times for home care, residential care and needs-assessments; as “partly” if there is monitoring

	for one or two of those; and as “no” if there are no monitoring arrangements in place.
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	Social protection should ensure that people in need of LTC receive it in a timely way – preventing further deterioration, and alleviating the burden on family members. This item illustrates whether Member States supports timely provision by monitoring waiting times.
Robustness and statistical validity	The data are provided by national correspondents to the MISSOC secretariat, which ensures cross-country comparability based on an agreed guidance document
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected and updated biannually from Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Context information (NAT)

Definition	L3: Standardised procedure for LTC needs-assessment
Data source	MISSOC
Member State coverage	27 Member States
Assessment method	Binary indicator. Member States are categorised as “yes” if they have standardised LTC needs-assessment procedures at national or regional level; and as “no” if they have no standardised procedures.
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	Clear criteria for LTC needs-assessment can facilitate not only access to and uptake of LTC services but also their timeliness and comprehensiveness. Having a standardised system is essential to ensure the adequacy of LTC.
Robustness and statistical validity	The data are collected by the MISSOC secretariat via national correspondents (two per Member State) and validated
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected from, and updated biannually by, Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Definition	C6: Clear categories of degrees of dependency
Data source	MISSOC
Member State coverage	27 Member States
Assessment method	Binary indicator. Member States are categorised as “yes” if they have a clear degree of dependency; and as “no” if they do not.
Major proposed breakdowns	Not applicable

Policy relevance / polarity for interpretation	As a part of identifying clear criteria for LTC needs-assessments, this indicator shows whether Member States have clear categories of degree of dependence
Robustness and statistical validity	The data are collected by the MISSOC secretariat via national correspondents (two per Member State) and validated
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected and updated biannually from Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Context (NAT)

Definition	L4: Comprehensive evaluation (coverage) of LTC needs
Data source	OECD social protection questionnaire and secondary national sources
Member State coverage	27 Member States
Assessment method	Member States are categorised as "yes" (comprehensive) if the system is ranked as mid-level to comprehensive, and as "no" if the system is ranked as low-level. The ranking of systems is determined based on the following three categories: Comprehensive: includes all ADL and IADL described in the OECD typical cases, along with additional limitations such as cognitive and behavioural aspects. Mid-level: includes all ADL from the typical cases and a sub-set of IADL. Low level: primarily focuses on ADL.
Major proposed breakdowns	Low level, mid-level, comprehensive
Policy relevance / polarity for interpretation	To compare the comprehensiveness of social protection coverage of LTC needs
Robustness and statistical validity	The indicator is modelled according to the most recent information provided by Member States, and from secondary public national sources
Cross-country comparability	High. A questionnaire with typical cases has been designed.
Underlying data / timely and susceptible to revision	The indicator could be updated every three years based on information collected by the OECD from Member States
Actionable	The indicator is highly actionable, as it is directly influenced by the rules governing needs-assessments and social protection benefits for LTC
EU/NAT classification	Policy lever (EU)

Definition	P1: People in need of LTC not using (more) professional home care services by reason (in private households)
Data source	Eurostat – the EU-SILC ad hoc module on "access to services", ilc_ats15 (rolling module in 2024)
Member State coverage	27 Member States

Calculation methods	The indicator shows the reasons why more professional home care services are not used, among the sample sub-group of respondents who have someone in the household who needs help due to long-term physical or mental ill-health, infirmity or old age. The distribution variables for the main reason are “cannot afford it”, “refused by people needing such services”, “no such services available”, “quality of the services available not satisfactory”, and “other”.
Major proposed breakdowns	Income group, degree of urbanisation (cities, towns and suburbs, rural areas), reason for not using professional home care services, and household type
Policy relevance / polarity for interpretation	It helps identify the reasons why some people in need of LTC do not use home care (be it for financial reasons, availability, or because they choose not to) and helps policy-makers design measures addressing the specific challenges in access
Robustness and statistical validity	The indicator is robust and statistically validated
Cross-country comparability	High
Underlying data / timely and susceptible to revision	The indicator is built on underlying data. No revisions are expected for this indicator in the module.
Actionable	The indicator is highly actionable, as it is directly influenced by the public provision of LTC in terms of availability, affordability and regional balance
EU/NAT classification	Performance (EU)

Definition	P2: Difficulty in affording professional home care services
Data source	Eurostat – the EU-SILC ad hoc module on "access to services", ilc_ats16 (rolling module in 2024)
Member State coverage	26 Member States (DK not available)
Calculation methods	The indicator shows the share of people according to their level of difficulty in paying for professional home care services used by someone in their household
Major proposed breakdowns	Household type, income group and level of difficulty in paying for professional home care services
Policy relevance / polarity for interpretation	It helps to identify the level of difficulty people in need have with OOP payments for professional home care services, and to design targeted policy measures in case of difficulties in doing so
Robustness and statistical validity	The indicator is robust and statistically validated
Cross-country comparability	High
Underlying data / timely and susceptible to revision	The indicator is built on underlying data. No revisions are expected for this indicator in the module.

Actionable	The indicator is highly actionable, as it is directly influenced by social protection coverage for LTC
EU/NAT classification	Performance (EU)

Definition	P3: Share of care costs (home care and residential care) covered by public social protection
Data source	OECD
Member State coverage	20 Member States and four sub-national areas
Calculation methods	The indicator shows the share of total LTC costs covered by social protection in Member States or regions, by income level and severity of LTC needs, for people aged 65+ with no assets
Major proposed breakdowns	Low, moderate and severe LTC needs in home care and severe needs in residential care, for people with a median income. An analysis can be provided by low and high incomes, on request.
Policy relevance / polarity for interpretation	This indicator shows the share of home care and residential care costs covered by social protection in Member States
Robustness and statistical validity	The indicator is modelled according to the most recent information provided by Member States on legislation and the unit costs of care. Sensitivity and uncertainty analyses performed by the OECD can be found in Oliveira Hashiguchi and Llena-Nozal (2020), op. cit.
Cross-country comparability	Very high – all typical cases are the same across Member States
Underlying data / timely and susceptible to revision	The indicator is built on underlying data provided by Member States.
Actionable	The indicator is highly actionable, as it is directly influenced by the social protection provided by Member States for LTC
EU/NAT classification	Performance (EU)
Specific considerations	Background and limitations to this approach to be clearly explained. Not all Member States covered.

Definition	P4: Out-of-pocket (OOP) costs of care (home care and residential care) as a share of income for care recipients aged 65+
Data source	OECD
Member State coverage	20 Member States and four sub-national areas
Calculation methods	Benefits in kind and in cash provided by social protection are subtracted from total care costs, showing the OOP costs of care. These are then divided by the median (or low or high) income for people aged 65+.
Major proposed breakdowns	Low, moderate and severe LTC needs in home care and severe LTC needs in residential care for people with a median income. An analysis can be provided by low and high incomes, on request.

Policy relevance / polarity for interpretation	The share of OOP costs in people's incomes shows whether they are likely to be able to afford to pay for care
Robustness and statistical validity	The indicator is modelled according to the most recent information provided by Member States on legislation and the unit costs of care. Sensitivity and uncertainty analyses performed by the OECD can be found in Oliveira Hashiguchi and Llena-Nozal (2020), op. cit.
Cross-country comparability	Very high – all typical cases are the same across Member States
Underlying data / timely and susceptible to revision	The indicator is built on underlying data provided by Member States. The indicator could be updated every three years.
Actionable	The indicator is highly actionable, as it is directly influenced by the social protection provided by Member States for LTC
EU/NAT classification	Performance (EU)
Specific considerations	Background and limitations to this approach to be clearly explained. Not all Member States covered.

Definition	P5: Share of population aged 65+ who would have below 60% of median income after paying for the out-of-pocket (OOP) costs of home care
Data source	OECD
Member State coverage	20 Member States and four sub-national areas
Calculation methods	The income distribution of the 65+ age group is known from the OECD income distribution database. The assumption is that people in this group have no net wealth. The OOP costs for low, moderate and high LTC needs are then subtracted from people's income. The indicator shows the share of the entire population aged 65+ who would be at risk of poverty (below 60% of median income) after paying for the OOP costs of LTC.
Major proposed breakdowns	Low, moderate and severe LTC needs in home care
Policy relevance / polarity for interpretation	The share of the population aged 65+ with access to social protection who would be at risk of poverty after paying for the OOP costs of home care should be compared with: (a) the share of those aged 65+ who would be at risk of poverty after paying for the full costs of home care; and/or (b) the share of the overall population aged 65+ who are at risk of poverty. Measuring the difference between incomes (after LTC costs and social protection) and the relative income poverty line (i.e. the at-risk-of-poverty threshold) shows to what extent public support should be increased through public social protection systems to bring these older people up to non-poverty levels. One of the assumptions underlying this indicator is that people with LTC needs actively seek, and have access, to public support and the benefits available.

Robustness and statistical validity	The indicator is modelled according to the most recent information provided by Member States on legislation and the unit costs of care. Sensitivity and uncertainty analyses performed by the OECD can be found in Oliveira Hashiguchi and Llena-Nozal (2020), op. cit.
Cross-country comparability	Very high – all typical cases are the same across Member States
Underlying data / timely and susceptible to revision	The indicator is built on underlying data provided by Member States. A timely revision of indicators can be discussed if the indicators are assessed as useful.
Actionable	The indicator is highly actionable, as it is directly influenced by the social protection provided by Member States for LTC
EU/NAT classification	Performance (EU)
Specific considerations	Background and limitations to this approach to be clearly explained. Not all Member States covered.

Definition	C7: Income-testing and asset-testing of LTC benefits
Data source	OECD social protection questionnaire and secondary national sources
Member State coverage	27 Member States (including four sub-national areas)
Assessment method	Member States are divided into two categories: (a) does the system include benefits that apply income-testing? or (b) does the system include benefits that apply asset-testing?
Major proposed breakdowns	Income-testing and asset-testing
Policy relevance / polarity for interpretation	To illustrate the design of social protection for LTC
Robustness and statistical validity	The indicator is based on administrative data
Cross-country comparability	High. The information is collected through a standardised questionnaire and desk research.
Underlying data / timely and susceptible to revision	The indicator could be updated every three years based on information collected by the OECD from Member States
Actionable	The indicator is highly actionable, as it is directly influenced by the organisation of LTC benefits and schemes
EU/NAT classification	Context (EU)

Annex 2.3 Availability

Definition	C8: Public LTC expenditure on home care, residential care and cash benefits as a share of total public LTC spending
Data source	Ageing Report / AWG; permission should be sought from the AWG to use these data
Member State coverage	27 Member States
Calculation methods	Data for the SHA categories HC.3 for nursing care, plus data available on HC.R.1 for LTC social services are combined with ESSPROS data as a proxy for social care spending by Member States. Spending on each benefit is then divided by total LTC expenditure to calculate the ratio.
Major proposed breakdowns	Home care, residential care and cash benefits
Policy relevance / polarity for interpretation	The relative importance of residential care versus home care and cash benefits varies substantially across Member States. The care setting can have a significant influence on the public cost of care-provision, and also on user satisfaction.
Robustness and statistical validity	Validated by AWG national delegates for each Member State. For the Member States where both HC.3 and HCR.1 are available, the quality is the same as that of those Eurostat statistics. For those where Member States had to validate the ESSPROS proxy to substitute for the missing HCR1, the quality is lower.
Cross-country comparability	The same definition is used for every Member State and there is intensive bilateral work with AWG delegates to ensure comparability. The results are validated by Member States and, where possible, their statistical authorities.
Underlying data / timely and susceptible to revision	The underlying sources are the SHA, ESPROSS and data reported directly by Member States. The data are updated every three years.
Actionable	The indicator is actionable, as it is directly influenced by government expenditure on the different categories of LTC provision
EU/NAT classification	Context (EU)

Definition	C9: Number of LTC beds in nursing and residential care facilities
Data source	Eurostat, joint questionnaire on non-monetary healthcare statistics, hlth_rs_bdltc
Member State coverage	25 Member States
Calculation methods	Density rates are derived by measuring the number of LTC beds per 100,000 inhabitants. They are calculated by dividing the absolute number of LTC beds in a given period by the respective population in the same period and then multiplying by 100,000.

Major proposed breakdowns	NUTS-2 regions (for some Member States the breakdown is only available for NUTS 1 regions; for others there is no regional breakdown available)
Policy relevance / polarity for interpretation	The indicator is relevant to policy, as residential homes are usually not covered by surveys. The number of LTC beds shows the resources available for the provision of residential LTC. When assessing this indicator, the provision/resources of home care should be taken into account. In addition, this indicator does not capture the quality of care, which is an essential element in the overall analysis of LTC provision.
Robustness and statistical validity	The administrative data are based on the absolute number of LTC beds reported by Member States
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual administrative data
Actionable	The provision of public LTC beds directly affects this indicator
EU/NAT classification	Context (EU)

Definition	C10: Existence of choice between care settings for people in need of LTC
Data source	MISSOC
Member State coverage	27 Member States
Assessment method	Member States are categorised as “yes” if people receiving public benefits can choose whether to use home, community-based or residential care, in line with their care needs, while accounting for situations where a certain level of needs requires a specific setting
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	The item shows whether the regulatory framework would allow people in need of care to choose their care setting while benefiting from public support, taking into account their respective level of care needs
Robustness and statistical validity	The data are provided by national correspondents to the MISSOC secretariat, which ensures cross-country comparability based on an agreed guidance document
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected from, and updated biannually by, Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Context information (NAT)

Definition	C11: Existence of choice between providers for people in need of LTC
Data source	MISSOC
Member State coverage	27 Member States

Assessment method	Member States are categorised as “yes” if people receiving public benefits have, based on the regulatory system, some options to choose between different (pre-selected / accredited) providers of care services – either by using cash benefits to pay for care or by being able to choose between in-kind service providers
Major proposed breakdown	Not applicable
Policy relevance / polarity for interpretation	The item shows whether the regulatory framework would allow people in need of care to choose their care-provider while benefiting from public support
Robustness and statistical validity	The data are provided by national correspondents to the MISSOC secretariat, which ensures cross-country comparability based on an agreed guidance document
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected from, and updated biannually by, Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Context information (NAT)

Definition	P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months
Data source	EHIS, AM7TA, AM7TH, AM7SA, AM7SH, AM7I
Member State coverage	27 Member States
Calculation methods	Number of people aged 65+ with at least one severe difficulty in ADL and/or IADL using home care services for personal needs in the previous 12 months, divided by the total number of people with at least one severe difficulty in ADL and/or IADL
Major proposed breakdowns	Sex Age group (65+, 75+), degree of urbanisation, income quintile, household type
Policy relevance / polarity for interpretation	The share of people with LTC needs using professional home care services indicates the availability and affordability of such services. Home care services are a key element of the development of LTC systems.
Robustness and statistical validity	The underlying indicators are robust and statistically validated
Cross-country comparability	High
Underlying data / timely and susceptible to revision	The indicator is built on underlying data
Actionable	The indicator is susceptible to policy intervention through the promotion and public provision of home care services
EU/NAT classification	Performance indicator (EU)

Definition	P7: Share of people aged 65+ who receive public home care, residential care or cash benefits
Data source	Ageing Report 2024 / national administrative data; permission from the AWG to use these data should be sought
Member State coverage	27 Member States – 24 reports; others are estimated by the AWG
Calculation methods	National
Major proposed breakdowns	Residential care versus home care Sex Age group (total, 65+, 85+)
Policy relevance / polarity for interpretation	The indicator is highly relevant for policy-making. When using this indicator, it needs to be made clear that the data only refer to care provided through publicly provided or funded LTC services.
Robustness and statistical validity	The administrative data are based on the absolute number of people provided with home care, residential care or cash benefits; thus, they are robust and statistically valid
Cross-country comparability	In order to ensure a common methodology and cross-country comparability, these data could be gathered (and their quality checked) through Eurostat
Underlying data / timely and susceptible to revision	As the data are provided by Member States, timeliness and susceptibility to revision vary by Member State
Actionable	The LTC provisions of Member States have a direct and immediate impact on this indicator
EU/NAT classification	Performance indicator (EU)

Definition	C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits
Data source	Ageing Report 2024 / national administrative data / EU-SILC
Member State coverage	27 Member States
Calculation methods	Recipient data are provided by Member States. The population of potential dependants is based on the 2018-2021 average of EU-SILC data on “self-perceived longstanding limitation in activities because of health problems (for at least the last six months)”, adjusted for the number of people living in residential homes.
Major proposed breakdowns	In residential care and home care By sex and age group (total, 65+, 85+)
Policy relevance / polarity for interpretation	This item can point towards a gap in LTC coverage. A disclaimer has to be applied.
Robustness and statistical validity	The administrative data are based on the absolute number of people who are provided with home care, residential care or cash benefits; thus they are robust and statistically valid. The EU-SILC variable used to define dependency status focuses on (self-reported) “severe” limitations only, whereas some social protection systems

	may also provide coverage for less severe needs, such as people who need help with IADL: this biases the coverage estimate upwards as it under-estimates the dependent population.
Cross-country comparability	Sufficient. In order to ensure a common methodology and cross-country comparability, data on LTC recipients could be gathered (and their quality checked) through Eurostat
Underlying data / timely and susceptible to revision	As the data are provided by Member States, timeliness and susceptibility to revision varies by Member State
Actionable	The LTC provisions of Member States have a direct and immediate impact on this indicator
EU/NAT classification	Context information (EU)

Definition	P8: Share of people aged 65+ with unmet need for help with ADL/IADL, with at least one severe difficulty in ADL/IADL
Data source	Eurostat, EHIS TADLH, TADLHI
Member State coverage	27 Member States (data for one Member State not disseminated because of low reliability)
Calculation methods	The share of people with at least one severe difficulty in ADL and/or IADL and lacking assistance, divided by the total number of respondents with severe difficulties in ADL and/or IADL
Major proposed breakdowns	Sex Age group (65+, 75+) Income quintile
Policy relevance / polarity for interpretation	The share of people lacking assistance with ADL and/or IADL indicates unmet needs in this regard
Robustness and statistical validity	The underlying indicators are robust and statistically validated
Cross-country comparability	High
Underlying data / timely and susceptible to revision	The indicator is built on underlying data
Actionable	The indicator is susceptible to policy intervention by the public provision of LTC services and/or benefits and by support for informal carers
EU/NAT classification	Performance indicator (EU)

Definition	P9: People in need of LTC not using (more) professional home care services by reason
Data source	Eurostat – the EU-SILC ad hoc module on "access to services", ilc_ats15 (the related variables, collected in 2016, will be part of the EU-SILC 2024 six-yearly rolling module on “access to services”)

Member State coverage	27 Member States
Calculation methods	The indicator shows the reasons why more professional home care services are not used, among the sample sub-group of respondents who have someone in the household who needs help due to long-term physical or mental ill-health, infirmity or old age. The distribution variables for the main reason are “cannot afford it”, “refused by people needing such services”, “no such services available”, “quality of the services available not satisfactory”, and “other”.
Major proposed breakdowns	Income group; degree of urbanisation (cities, towns and suburbs, rural areas); reason for not using professional home care services; and household type
Policy relevance / polarity for interpretation	It is crucial for policy-making to know why some people in need of LTC do not use home care, and how this is reflected in territorial disparities
Robustness and statistical validity	The indicator is robust and statistically validated. For reference see: https://circabc.europa.eu/sd/a/6f7191df-c72d-4537-aee4-81972188497d/2016%20EU%20SILC%20ESQRS.zip (EU Quality Report 2016).
Cross-country comparability	High
Underlying data / timely and susceptible to revision	The indicator is built on underlying data. No revisions are expected for this indicator in the module.
Actionable	The indicator is highly actionable, as it is directly influenced by the public provision of LTC in terms of availability, affordability and regional balance
EU/NAT classification	Performance indicator (EU)

Annex 2.4 Quality

Definition	L5A: Existence of rules regulating the use of personal care plans and cooperation of different services in their design and implementation. L5B: Such plans cover all LTC needs of the individual, are drawn up with the participation of the individual or his/her representatives and are regularly updated.
Data source	MISSOC E-XII-11 2. Providers / professional providers and MISSOC ad-hoc survey
Member State coverage	27 Member States
Assessment method	Yes: Clear mention of an individual care plan in the national legislation (names can vary, e.g. personal care plan, individual care plan, personal client plan, case plan, case management) and of the cooperation of different services. Legislation mentions that such plans cover all LTC needs of the individual, are drawn with the participation of the individual or his/her representatives and are regularly updated.

	Yes* for decentralized systems, where there is a central administration regulation/guidance on the issue. No: No indication of a personal care plan and of the cooperation of different services. No indication that such plans cover all LTC needs of the individual, are drawn with the participation of the individual or his/her representatives and are regularly updated. Partial: a. The needs assessment is carried by a multidisciplinary team, but there is no information on what happens after and on the regular update of the care plan. b. The information provided is unclear regarding the existence of both the personal care plan and the cooperation of different services (e.g. when information mentions cooperation between services, but not a personal care plan). c. Issue of regional competence, where there is no regulation / guidance to regions from the central administration aiming to ensure consistent approach. d. The legislation/measure is either incomplete or in preparation.
Major break-down	Not applicable
Policy relevance / polarity for interpretation	The policy lever shows whether Member States have rules regulating the use of personal care plans and cooperation of different services in their design and implementation and whether they cover a number of elements, i.e. addressing all LTC needs of the individual, involving the individual or his/her representatives and being regularly updated.
Robustness and statistical validity	The data are collected by MISSOC secretariat via national correspondents (2 per Member State) and validated.
Cross countries comparability	Yes
Underlying data / timely and susceptible to revision	Collected from and updated biannually by Member States. Legal changes are updated immediately.
Actionable	Yes
EU / NAT classification	Policy lever (EU)

Definition	L6A: Existence of quality standards that apply to different care settings and to all types of providers L6B: Existence of rules regulating quality-assurance in public and non-public providers
Data source	MISSOC E-XII-11 2. Providers / professional providers.
Member State coverage	27 Member States
Assessment method	Member States are categorised as “yes” if there are quality standards that apply to different care settings (at least residential care and home care) and to all types of providers; as “yes*” in the case of decentralised systems, where there is a central administration regulation/guidance on the issue; and as “no” if there are no quality standards. Member States are categorised as “partial” if:

	(a) quality standards do not cover all LTC settings, do not apply to all providers, or compliance with them is not compulsory; (b) the issue is of regional competence, where there is no regulation/guidance to regions from the central administration aimed at ensuring a consistent approach; or (c) the information mentions that the legislation/measure exists but is either incomplete or is in preparation.
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	The policy lever shows whether Member States have quality standards in home, community-based care and residential care that are applicable to all types of providers
Robustness and statistical validity	The data are collected by the MISSOC secretariat via national correspondents (two per Member State) and validated
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected from, and updated biannually by, Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Definition	L7: Existence of quality-assurance bodies for all elements and types of LTC
Data source	MISSOC E-XII-11 2. Providers / professional providers.
Member State coverage	27 Member States
Assessment method	Member States are classified as “yes” if there is an LTC quality-assurance body (or bodies); as “yes* in cases of regional competence, where quality-assurance bodies exist at regional level; and as “no” if there is no national LTC quality-assurance body (or bodies). Member States are classified as “partial” if: quality-assurance bodies do not cover all types of LTC (e.g. residential care is covered, but not home care; or only the social part of LTC is covered, not the healthcare part, and vice versa); or the legislation/measure is either incomplete or in preparation.
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	The policy lever shows the existence of a dedicated LTC quality-assurance body or bodies
Robustness and statistical validity	The data are collected by the MISSOC secretariat via national correspondents (two per Member State) and validated
Cross-country comparability	Yes

Underlying data / timely and susceptible to revision	Collected from, and updated biannually by, Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Definition	L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect
Data source	MISSOC ad hoc survey
Member State coverage	27 Member States
Assessment method	Member States are classified as “yes” if there is a procedure for complaints and legal redress; as “yes*” in the case of decentralised systems, where there is a central administration regulation/guidance on the issue; and as “no” if there is no procedure for complaints and legal redress. Member States are classified as “partial” if: the procedure for making complaints or signalling potential problems exists, but does not include follow-up measures (i.e. how the complaints are being analysed and means of legal redress); or the issue is of regional competence, where there is no regulation/guidance to regions from the central administration aimed at ensuring a consistent approach.
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	The policy lever shows whether Member States have a procedure for complaints and signalling of potential cases of abuse or neglect by LTC providers, and of means of legal redress if breaches occur
Robustness and statistical validity	The data are collected by the MISSOC secretariat via national correspondents (two per Member State) and validated
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected from, and updated biannually by, Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Annex 2.5 Workforce

Definition	P10: Coverage of collective bargaining for LTC workers
Data source	SES
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers for ISCO 222, 322 or 532 (or ISCO-2-digit if ISCO-3-digit was not available) crossed with NACE Q87 or Q88. All types of agreements are aggregated as “yes”.
Major proposed breakdowns	None
Policy relevance / polarity for interpretation	Collective bargaining can play an important role in supporting the development of adequate working conditions, attractive wages, non-discrimination, and professionalisation, along with addressing skills needs and labour shortages in the sector
Robustness and statistical validity	By aggregating the answer options, a sufficient sample size can be achieved
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Four years
Actionable	The indicator is directly influenced by the promotion of collective bargaining at all levels
EU/NAT classification	Performance (EU)

Definition	P11: Mean gross hourly wages for LTC workers compared with mean hourly wages in all other sectors
Data source	SES
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers for ISCO 222, 322 or 532 (or ISCO-2-digit if ISCO-3-digit was not available) crossed with NACE Q87-Q88. Wages provided (in EUR).
Major proposed breakdowns	None
Policy relevance / polarity for interpretation	The level of pay of LTC workers significantly contributes to high-quality employment and thus the attractiveness of the sector.
Robustness and statistical validity	Statistics are based on a minimum of 10 records. Statistics based on (e.g.) fewer than 30 records can be flagged as being of low reliability, and the indicator could be mapped along with other data on income.
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Four years
Actionable	The indicator is directly influenced by an increase in wages for the LTC workforce
EU/NAT classification	Performance (EU)

Definition	C13: Share of LTC workers in full-time employment
Data source	EU-LFS
MS coverage	27 Member States
Calculation methods	Data extraction for the subpopulation of LTC workers, crossing the occupations (ISCO) codes Q87-Q88 and sector (NACE) codes 222, 226, 263, 322, 254, 532.
Major proposed breakdowns	Sex
Policy relevance / polarity for interpretation	Part-time work can be linked to inadequate working arrangements, lower income, lower investment in education and training, lower job satisfaction, etc.
Robustness and statistical validity	Data has been extracted at a level to allow for appropriate robustness and statistical validity.
Cross countries comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator is directly influenced by the promotion of full-time work, in particular for women. To address current labour shortages in the sector, MS could target part-time workers who want to increase their working hours.
EU / NAT classification	Performance (EU)

Definition	C14: Share of LTC workers with permanent contracts
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322. Variable TEMP (permanency of main job), value 2 (fixed-term job) used to select workers with temporary contracts.
Major proposed breakdowns	Sex
Policy relevance / polarity for interpretation	Precarious work can be linked to inadequate working arrangements, lower income, lower investment in education and training including on health and safety, lower job satisfaction and gaps in social protection.
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator is directly influenced by the promotion of indefinite contracts
EU/NAT classification	Performance (EU)

Definition	C15: Share of LTC workers working shifts
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322
Major proposed breakdowns	None
Policy relevance / polarity for interpretation	Shiftwork is common in LTC, and associated with a wide range of health risks, such as anxiety, burn-out and depression
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator is directly influenced by the reduction of shift work in the sector
EU/NAT classification	Context information (EU)

Definition	C16: Non-fatal accidents at work in the care sector
Data source	European Statistics on Accidents at Work (ESAW)
Member State coverage	27 Member States
Calculation methods	Incidence rates are calculated as the number of accidents per 100,000 workers in the care sector (Q87+Q88); to be developed further, based on the LTC definition, when available
Major proposed breakdowns	Sex
Policy relevance / polarity for interpretation	Accidents at work may result in a considerable number of working days being lost and often involve considerable harm for the workers concerned. They can cause people to live with a permanent disability, or force them to leave the labour market, or to change job. Accidents at work can also lower the attractiveness of the sector.
Robustness and statistical validity	Administrative data reported by Member States
Cross-country comparability	Sufficient, but different recognition systems in place for work accidents in the Member States to be acknowledged
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator is directly influenced by the promotion of health and safety at work
EU/NAT classification	Context information (EU)

Definition	L9: Ratification of ILO Domestic Workers Convention (No 189)
Data source	ILO
Member State coverage	27 Member States
Classification	Member States are classified as “yes” if they have ratified the convention; as “partially” if there is a future date of entry into force; and as “no” if the convention has not been ratified
Policy relevance / polarity for interpretation	The LTC Recommendation invites Member States to address the challenges of vulnerable groups of workers (such as domestic, live-in and migrant LTC workers), including by providing for effective regulation and professionalisation of such care work. The ILO convention lays down basic rights and principles, and requires national competent authorities to take a series of measures with a view to ensuring decent working conditions for domestic workers, including domestic workers providing LTC.
Robustness and statistical validity	Administrative data based on the legal situation in each Member State
Cross-country comparability	High
Underlying data / timely and susceptible to revision	The policy lever can be continuously updated as soon as an additional Member State ratifies the convention
Actionable	The policy lever is directly actionable via the ratification of the convention
EU/NAT classification	Policy lever (EU)

Definition	P12: Number of LTC workers per 100 people aged 65+
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322
Major proposed breakdowns	Sex and age group
Policy relevance / polarity for interpretation	Significant staff shortages lead to an inadequate provision of high-quality LTC services
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator can be directly influenced by investing in the LTC workforce and ensuring adequate staff ratios
EU/NAT classification	Performance (EU)

Definition	C17: Share of LTC workers aged 55+
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322
Major proposed breakdowns	Sex
Policy relevance / polarity for interpretation	This context information indicates future outflows of workers, as LTC workers aged 55+ may be retiring in the near future, thus contributing to staff shortages
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator can be influenced by investing in recruitment of the LTC workforce. An increased influx of LTC workers in younger age groups would lower the share of LTC workers aged 55+.
EU/NAT classification	Context information (EU)

Definition	C18: Share of LTC workers who are personal care workers or nurses
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322. Personal care workers are selected with ISCO 2-digit level code 53 (personal care worker), nurses are selected with ISCO 4-digit level codes 2221 (nursing professionals) and 3221 (nursing associate professionals).
Major proposed breakdowns	None
Policy relevance / polarity for interpretation	The indicator illustrates how many workers are personal care workers or nurses
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator can be influenced by investing in recruitment of the LTC workforce
EU/NAT classification	Context information (EU)

Definition	C19: Share of LTC workers in residential and non-residential care
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing the sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322. Residential care workers are selected with NACE codes 87.1 and 87.3, while workers who are in non-residential care are selected with value 88.1.
Major proposed breakdowns	None
Policy relevance / polarity for interpretation	The indicator illustrates how many workers are in residential care, and how many are in non-residential care
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator can be influenced by either investing in residential care infrastructure, or pursuing deinstitutionalisation, depending on the Member State situation
EU/NAT classification	Context information (EU)

Definition	C20: Share of LTC workers by job tenure
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing the sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322. Job tenure is calculated with variables from the EU-LFS topic “job tenure, work biography and previous work experience”.
Major proposed breakdowns	None
Policy relevance / polarity for interpretation	The indicator reports the distribution of workers by job tenure (below one year; one to five years; over five years)
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator can be influenced by investing in the LTC workforce (wages, job security, mental health support)
EU/NAT classification	Context information (EU)

Definition	P13: Share of LTC workers not participating in education and training in the previous four weeks
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing the sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322. Variable EDUC4WEEKS (education or training received during previous four weeks) used to analyse education and training.
Major proposed breakdowns	Sex, part-time/full-time employment, and by employment contract
Policy relevance / polarity for interpretation	Appropriate education and training policies, including on-the-job training, can help people entering the sector and their career progression
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator is directly influenced by the promotion of lifelong learning
EU/NAT classification	Performance (EU)

Definition	C21: Share of LTC workers by educational level
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322. Variable HATLEV1D (highest educational attainment level according to ISCED 2011) used to analyse educational level.
Major proposed breakdowns	None
Policy relevance / polarity for interpretation	The indicator reports the distribution of workers by level of educational attainment (low, medium, high)
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator can be influenced by investing in training of the LTC workforce
EU/NAT classification	Context information (EU)

Definition	C22: Share of women in the LTC workforce
Data source	EU-LFS
Member State coverage	27 Member States
Calculation methods	Data extraction for the sub-population of LTC workers, crossing the sector (NACE) codes 87.1, 87.3, 88.1 and occupations (ISCO) codes 2221, 2264, 2266, 2634, 2635, 3221, 3255, 5321, 5322. Variable SEX used to identify women.
Major proposed breakdowns	None
Policy relevance / polarity for interpretation	LTC is a predominantly female profession. Improving the balance between women and men could reduce staff shortages, increase the attractiveness of the sector and counter gender stereotypes.
Robustness and statistical validity	Data have been extracted at a level to allow for appropriate robustness and statistical validity
Cross-country comparability	High
Underlying data / timely and susceptible to revision	Annual
Actionable	The indicator is directly influenced by attracting more men into the LTC workforce
EU/NAT classification	Context information (EU)

Annex 2.6 Informal carers

Definition	C23: Share of people providing informal care or assistance at least once per week on average
Data source	EHIS, hlth_ehis_ic1e
Member State coverage	27 Member States
Calculation methods	People declaring that they provide informal care or assistance at least once a week, as a share of the overall population
Major proposed breakdowns	Sex, age group
Policy relevance / polarity for interpretation	The indicator illustrates how many people provide informal care and should thus be supported in their care-giving activities
Robustness and statistical validity	The underlying indicators are robust and statistically validated
Cross-country comparability	Eurostat ensures comparability via a joint methodology
Underlying data / timely and susceptible to revision	The indicator is built on underlying data
Actionable	The indicator is susceptible to policy intervention by the promotion of affordable and high-quality formal care services
EU/NAT classification	Context (EU)[1]

Definition	C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)
Data source	EHIS, special extraction
Member State coverage	27 Member States
Calculation methods	The share of informal carers declaring that they provide informal care or assistance for at least 20 hours per week
Major proposed breakdowns	Sex, age groups, time bands
Policy relevance / polarity for interpretation	The indicator illustrates how many informal carers provide high-intensity informal care and should thus be supported in their care-giving activities
Robustness and statistical validity	The underlying indicators are robust and statistically validated
Cross-country comparability	Eurostat ensures comparability via a joint methodology
Underlying data / timely and susceptible to revision	The indicator is built on underlying data
Actionable	The indicator is susceptible to policy intervention by promotion of formal care services
EU/NAT classification	Context information (EU)

Definition	C25: Share of informal carers relying on formal care services at least once per week
Data source	Microdata from EIGE's 2022 CARE survey
Member State coverage	27 Member States
Calculation methods	This dataset shows the percentage of informal carers who rely on formal care services for their main care recipient at least once a week
Major proposed breakdowns	Sex
Policy relevance / polarity for interpretation	The context information shows to what extent informal carers can rely on formal care services for their main care recipient at least once per week. Respondents were asked about nine types of care services: residential LTC facilities/institutions; daycare centres; home-based personal care workers; nurses and/or healthcare assistants; domestic cleaners and helpers; live-in carers (paid professionals living in the household); social workers; volunteers; and other healthcare professionals.
Robustness and statistical validity	The underlying context information is robust and statistically validated
Cross-country comparability	The same methodology was applied across Member States, and as such the data can be considered comparable. The use of population size weights also supports a cross-country comparison of results. In addition, the questionnaire ensured the correct translation of country-specific terminology.
Underlying data / timely and susceptible to revision	The indicator is built on underlying data

Actionable	The indicator is susceptible to policy intervention by the promotion of formal care services
EU/NAT classification	Context information (EU)

Definition	L10: Existence of a legal definition of informal carers, and/or legislation in place to identify them
Data source	MISSOC
Member State coverage	27 Member States
Assessment method	Member States are classified as “yes” if they have a legal definition and/or legislation in place to identify informal carers; and as “no” if they do not
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	The policy lever shows whether Member States have in their national legislation a legal definition of informal carers, and/or informal carers need to be registered or recognised by a relevant public authority. When a specific benefit exists for informal carers, this is also considered as identifying informal carers.
Robustness and statistical validity	The data are collected by the MISSOC secretariat via national correspondents (two per Member State) and validated
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected from, and updated biannually, by Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Definition	L11: Existence of support available to informal carers (respite care, training, counselling and care leave)
Data source	MISSOC
Member State coverage	27 Member States
Assessment method	Member States are classified as “high” if there are at least three types of support available; as “medium” if there are at least two; as “low” if there is only one; and as “none” if no support is available
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	The policy lever shows whether Member States provide some sort of support (excluding social protection and financial support) to informal carers
Robustness and statistical validity	The data are collected by the MISSOC secretariat via national correspondents (two per Member State) and validated
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected from, and updated biannually by, Member States. Legal changes are updated immediately.

Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Definition	L12: Existence of compensation available for informal carers
Data source	MISSOC
Member State coverage	27 Member States
Assessment method	Member States are classified as “yes” if social protection and financial compensation are available; as “partial” if either social protection or financial compensation is available; and as “no” if no form of compensation is available
Major proposed breakdowns	Not applicable
Policy relevance / polarity for interpretation	The policy lever shows whether Member States provide some form of compensation to informal carers to cover possible losses. Forms of compensation can include either social protection, financial support, or both.
Robustness and statistical validity	The data are collected by the MISSOC secretariat via national correspondents (two per Member State) and validated
Cross-country comparability	Yes
Underlying data / timely and susceptible to revision	Collected from, and updated biannually by, Member States. Legal changes are updated immediately.
Actionable	Yes
EU/NAT classification	Policy lever (NAT)

Annex 3: Data tables

Annex 3.1 Adequacy

Member State	Public LTC expenditure as % of total GDP (2022)	Public LTC expenditure as % of total cost of ageing (gross) (2022)	Public LTC expenditure as % of GDP, baseline scenario (2030)	Public LTC expenditure as % of GDP, risk scenario (2030)	People in need of LTC not using professional home care services for financial reasons[30,31] (%) (2016)	Great difficulty in affording professional home care services (%) (2016)
Austria	1.6	5.7	1.8	1.9	25.6	8.1
Belgium	2.3	8.6	2.5	2.7	24.4	8.7
Bulgaria	0.5	2.9	0.6	0.7	65.1	36.7
Croatia	0.5	2.7	0.5	0.6	34.2	15.8
Cyprus	0.2	0.9	0.2	0.3	45.6	45.8
Czechia	1.5	7.2	1.7	1.8	16.1	14.6
Denmark	3.0	12.2	3.9	3.9	N/A	16.3
Estonia	0.4	2.4	0.6	0.9	39.6	0.0
Finland	2.1	8.0	2.5	2.6	12.0	1.6
France	1.9	6.3	2.0	2.2	16.4	3.0
Germany	1.9	7.6	2.2	2.3	19.2	8.3
Greece	0.1	0.6	0.1	0.2	63.3	55.0
Hungary	0.5	3.4	0.6	0.7	27.0	12.7
Ireland	1.2	10.2	1.4	1.4	11.3	27.2
Italy	1.6	6.0	1.6	1.7	36.9	26.6
Latvia	0.5	2.8	0.5	0.6	37.9	40.4
Lithuania	1.0	6.6	1.1	1.4	42.4	1.2

[30] Answer options for question “Main reason for not receiving (more) professional home care services” are: 1. Cannot afford it, 2. Refused by person needing such services, 3. No such care services available, 4. Quality of the services available not satisfactory, 5. Other reasons.

[31] To ensure comparability across countries EU-SILC uses harmonised questionnaires and definitions. However, differences in cultural contexts among Member States should be taken into account while interpreting the data.

Member State	Public LTC expenditure as % of total GDP (2022)	Public LTC expenditure as % of total cost of ageing (gross) (2022)	Public LTC expenditure as % of GDP, baseline scenario (2030)	Public LTC expenditure as % of GDP, risk scenario (2030)	People in need of LTC not using professional home care services for financial reasons[30,31] (%) (2016)	Great difficulty in affording professional home care services (%) (2016)
Luxembourg	1.1	6.4	1.1	1.2	3.3	12.8
Malta	1.2	6.9	1.4	1.4	17.4	17.1
Netherlands	3.8	18.2	4.2	4.4	30.2	3.9
Poland	0.5	2.8	0.6	0.8	51.7	22.7
Portugal	0.5	2.0	0.6	0.8	30.8	20.2
Romania	0.3	2.2	0.4	0.5	70.1	N/A
Slovakia	1.0	5.3	1.3	1.4	28.0	17.31
Slovenia	1.0	4.6	1.2	1.4	27.4	16.4
Spain	0.8	3.4	0.9	1.0	54.1	22.5
Sweden	3.2	13.4	3.5	3.6	6.2	3.5
EU-27	1.7	7.1	1.9	2.0	35.7	12.1
Source	Ageing Report 2024	Ageing Report 2024	Ageing Report 2024	Ageing Report 2024	EU-SILC – ATS15	EU-SILC – ATS16

	Share of costs for home care covered by public social protection systems for care recipients (aged 65+) earning a median income and with no net wealth, by severity level (%) (*)			Share of costs for home and residential care covered by public social protection for care recipients (aged 65+) with severe needs earning a median income and with no net wealth (%) (*)		Out-of-pocket costs of home care as a share of income after public support for care recipients (aged 65+) earning a median income and with no net wealth, by severity level (%) (*)			Out-of-pocket costs of care as a share of old-age income after public support for residential care for care recipients (aged 65+) and with no net wealth, by level of income (%) (*)		
	Low	**Moderate**	**Severe**	**Residential care**	**Home care**	**Low**	**Moderate**	**Severe**	**Low income**	**Median income**	**High income**
Austria (Vienna)	52	73	87	67	87	25	45	45	77	78	79
Belgium (Flanders)	77	79	95	57	95	13	31	10	69	74	59
Croatia	0	8	23	74	23	28	88	137	96	98	99
Czechia	5	8	12	32	12	82	276	482	125	97	73
Denmark	100	100	99	86	99	0	0	3	83	68	49
Estonia (Tallinn)	0	0	0	22	0	34	125	189	95	100	77
Finland	91	99	100	84	100	6	1	0	61	67	72
France	76	57	47	24	47	7	46	103	23	102	69
Germany[32]	38	100	76	87[33]	76	15	0	39[34]	1	30	48
Greece	0	0	46	0	46	14	50	49	151	105	69
Hungary	2	72	85	32	85	25	25	25	77	85	85
Ireland	54	87	93	88	93	18	18	18	51	51	51

[32] In general, the German system is based on different payment pillars; therefore, focusing only on specific expenditures does not provide a complete picture of the German reimbursement scheme.

[33] For this calculation, an average is used, but this share depends on the length of stay, becoming more generous the longer the person stays.

[34] 2.17% of all individuals with care needs receive social security (*Hilfe zur Pflege*), and this is not included in the calculations.

	Share of costs for home care covered by public social protection systems for care recipients (aged 65+) earning a median income and with no net wealth, by severity level (%) (*)			Share of costs for home and residential care covered by public social protection for care recipients (aged 65+) with severe needs earning a median income and with no net wealth (%) (*)		Out-of-pocket costs of home care as a share of income after public support for care recipients (aged 65+) earning a median income and with no net wealth, by severity level (%) (*)			Out-of-pocket costs of care as a share of old-age income after public support for residential care for care recipients (aged 65+) and with no net wealth, by level of income (%) (*)		
	Low	Moderate	Severe	Residential care	Home care	Low	Moderate	Severe	Low income	Median income	High income
Italy (South Tyrol)	71	86	75	81	75	29	49	162	50	50	50
Latvia	0	55	75	71	75	32	50	50	21	45	62
Lithuania	0	46	60	52	60	32	60	81	80	80	80
Luxembourg	100	94	97	79	97	0	9	9	81	60	41
Malta	64	92	95	56	95	6	5	5	60	60	60
Netherlands	99	100	98	88	98	1	1	12	56	59	63
Poland	41	12	6	0	6	14	74	143	205	136	94
Portugal	82	24	23	25	23	3	45	84	156	101	61
Slovakia	46	46	46	14	46	9	30	55	175	135	94
Slovenia	70	62	51	16	51	14	60	102	85	68	47
Spain	30	42	52	20	52	21	62	92	87	92	67
Sweden	90	97	98	97	98	11	11	11	16	11	7
Source[35]	OECD			OECD		OECD			OECD		

(*) Data not available for BG, CY and RO.

[35] For a clear understanding of the underlying assumptions involved, please refer to OECD (2024), *Is Care Affordable for Older People?*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/450ea778-en.

	Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for low needs (%) (*)			Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs (%) (*)			Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for severe needs (%) (*)		
	No LTC use	LTC use and no social protection	LTC use and social protection	No LTC use	LTC use and no social protection	LTC use and social protection	No LTC use	LTC use and no social protection	LTC use and social protection
Austria (Vienna)	17	76	50	17	97	83	17	100	88
Belgium (Flanders)	26	85	53	26	98	75	26	100	62
Croatia	37	65	65	37	99	97	37	100	100
Czechia	18	95	94	18	100	100	18	100	100
Denmark	13	92	23	13	100	29	13	100	36
Estonia (Tallinn)	49	79	79	49	100	100	49	100	100
Finland	19	87	33	19	100	44	19	100	5
France	14	52	20	14	94	82	14	100	100
Germany	19	49	40	19	91	36	19	91	62
Greece	15	34	18	15	64	64	15	85	61
Hungary	21	54	52	21	92	67	21	100	61
Ireland	20	71	49	20	95	55	20	100	57
Italy (South Tyrol)	21	94	65	21	100	92	21	100	100
Latvia	46	75	75	46	94	94	46	100	100
Lithuania	38	73	73	38	99	96	38	95	93
Luxembourg	16	55	21	16	96	18	16	82	25
Malta	16	34	21	16	81	34	16	100	69
Netherlands	15	86	18	15	100	25	15	100	67
Poland	22	50	40	22	98	96	22	100	100

	Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for low needs (%) (*)			Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs (%) (*)			Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for severe needs (%) (*)		
	No LTC use	**LTC use and no social protection**	**LTC use and social protection**	**No LTC use**	**LTC use and no social protection**	**LTC use and social protection**	**No LTC use**	**LTC use and no social protection**	**LTC use and social protection**
Portugal	18	39	25	18	75	71	18	71	71
Slovakia	12	41	15	12	82	66	12	100	88
Slovenia	20	72	43	20	99	86	20	100	96
Spain	20	50	41	20	99	98	20	100	100
Sweden	26	91	49	26	100	56	26	100	56
Source	OECD			OECD			OECD		

(*) Data not available for BG, CY and RO.

Annex 3.2 Availability

Member State	Share of people aged 65+ with severe difficulties in ADL and/or IADL (%) (2019)	65+ age group as share of total population (%) (2023)	Public LTC expenditure by setting, as % of total LTC expenditure (2022)			LTC beds in nursing and residential care facilities per 100,000 inhabitants (2022)	Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in previous 12 months (%) (2019)
			Home care	Residential care	Cash benefits		
Austria	27.0	19.4	9.7	40.5	49.8	872.6	31.5
Belgium	29.9	19.5	28.0	61.3	10.8	1,282.7	53.7
Bulgaria	27.9	21.7	49.8	39.4	10.8	25.3	11.6
Croatia	38.5	22.5	4.7	53.7	41.6	238.9	26.9
Cyprus	34.3	16.5	35.2	4.2	60.6	285.8	19.3
Czechia	30.5	20.6	8.3	60.2	31.5	719.6	16.2
Denmark	14.9	20.3	65.8	34.2	0.0	744.2	52.3
Estonia	26.6	20.4	42.7	52.7	4.6	858.7	10.3
Finland	18.1	23.1	77.1	11.5	11.5	1,134.4	33.0
France	21.5	21.0	37.2	57.2	5.6	977.1	40.1
Germany	17.3	22.1	23.2	40.2	36.7	1,185.1	43.3
Greece	29.1	22.7	16.9	83.1	0.0	25.8	20.1
Hungary	24.7	20.5	14.9	66.5	18.7	877.5	22.5
Ireland	20.9	15.0	34.8	42.1	23.1	613.2	35.4
Italy	28.7	23.8	21.2	25.8	53.0	480.4	28.5
Latvia	38.8	20.9	17.0	53.6	29.3	258.9	14.6
Lithuania	34.8	20.0	6.4	55.7	38.0	772.5	14.2
Luxembourg	11.6	14.8	33.1	59.3	7.6	1,161.1	35.2
Malta	22.6	19.2	8.2	89.5	2.3	1,259.4	23.5
Netherlands	26.9	20.0	16.4	51.0	32.6	1,420.3	50.8

Member State	Share of people aged 65+ with severe difficulties in ADL and/or IADL (%) (2019)	65+ age group as share of total population (%) (2023)	Public LTC expenditure by setting, as % of total LTC expenditure (2022)			LTC beds in nursing and residential care facilities per 100,000 inhabitants (2022)	Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in previous 12 months (%) (2019)
			Home care	Residential care	Cash benefits		
Poland	35.9	19.1	34.0	65.4	0.5	213.5	18.8
Portugal	32.6	23.7	41.8	57.5	0.7	211.9	15.9
Romania	56.5	19.5	47.3	48.6	4.2	228.4	4.7
Slovakia	37.0	17.4	9.6	44.3	46.1	782.9	12.1
Slovenia	29.2	21.1	28.3	47.8	23.9	1,116.6	15.8
Spain	28.8	20.1	20.5	66.1	13.4	854.2	28.9
Sweden	12.3	20.3	43.5	53.8	2.6	1,299.3	29.8
EU-27	26.6	21.1	28.8	46.2	25.0	N/A	28.6
Note:						PT: 2021	
Source	EHIS, hlth_ehis_tadle	ESTAT, demo_pjanind	Ageing Report 2024			ESTAT, hlth_rs_bdltc	EHIS, hlth_ehis_AM7TA

Member State	Share of people aged 65+ who receive public home care, residential care or cash benefits (%) (2022)			Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits (%) (2022)			Share of people aged 65+ with unmet need for help with ADL/IADL, with at least one severe difficulty in ADL/IADL (%) (2019)	People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation (%) (2016)		
	Home care	Residential care	Cash benefits	Home care	Residential care	Cash benefits		Cities	Towns and suburbs	Rural areas
Austria	4.5	3.5	19.8	18.2	13.8	79.4	32.4	20.7	0.0	0.0
Belgium	15.2	5.2	8.5	74.8	25.4	41.5	N/A	0.8	7.3	7.4
Bulgaria	0.7	1.1	2.6	6.5	9.6	23.3	67.5	0.0	3.4	22.8
Croatia	0.3	1.0	8.2	1.3	3.7	31.1	71.0	4.5	4.5	18.6
Cyprus	5.4	4.0	2.2	23.5	17.5	9.3	30.4	0.0	3.1	0.0
Czechia	4.3	3.9	11.5	23.7	21.7	64.0	37.9	1.8	4.1	4.5
Denmark	13.6	3.6	0.0	117.2	31.5	0.0	43.0	N/A	N/A	N/A
Estonia	2.9	4.3	2.7	10.2	15.1	9.5	58.4	11.5	33.3	33.3
Finland	7.6	1.5	13.0	46.4	9.0	79.3	70.4	16.9	11.9	9.8
France	5.8	4.4	0.0	24.3	18.3	0.0	38.7	4.2	2.7	3.6
Germany	3.3	3.7	12.1	20.1	22.7	73.9	49.7	0.0	6.0	4.4
Greece	9.1	0.0	0.0	32.5	0.2	0.0	43.1	2.9	6.8	5.8
Hungary	4.2	2.9	1.0	20.0	14.1	4.6	49.0	1.6	20.7	14.9
Ireland	7.8	3.0	7.6	55.0	20.9	53.5	48.5	17.3	11.1	36.5
Italy	5.4	2.5	10.0	33.1	15.4	61.7	44.2	22.4	38.9	29.5
Latvia	3.6	1.8	3.8	14.2	7.0	14.7	23.4	16.2	13.2	18.5
Lithuania	12.0	12.3	14.0	42.9	43.7	50.0	37.2	2.9	N/A	5.8
Luxembourg	5.4	4.5	4.3	23.3	19.6	18.6	74.6	0.0	1.1	0.0
Malta	18.2	4.5	0.9	161.6	39.9	7.9	56.3	4.9	N/A	N/A
Netherlands	17.8	5.0	1.2	126.4	35.8	8.4	24.5	9.3	7.6	5.1
Poland	2.6	2.0	0.8	13.4	10.4	4.0	46.7	2.5	4.2	11.4
Portugal	0.6	1.1	0.3	2.8	5.3	1.5	38.9	4.4	5.5	12.8
Romania	5.2	3.9	5.4	26.3	19.8	27.0	61.6	4.4	23.7	7.2

Member State	Share of people aged 65+ who receive public home care, residential care or cash benefits (%) (2022)			Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits (%) (2022)			Share of people aged 65+ with unmet need for help with ADL/IADL, with at least one severe difficulty in ADL/IADL (%) (2019)	People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation (%) (2016)		
	Home care	Residential care	Cash benefits	Home care	Residential care	Cash benefits		Cities	Towns and suburbs	Rural areas
Slovakia	5.3	5.8	8.2	17.6	19.1	27.2	50.9	0.0	4.5	13.5
Slovenia	4.1	4.2	7.1	17.9	18.3	30.8	38.8	1.6	8.5	7.2
Spain	3.9	2.8	2.6	28.2	20.3	19.4	48.0	5.2	12.3	7.2
Sweden	10.8	2.5	14.4	109.6	25.2	146.0	53.6	3.2	5.6	4.4
EU-27	5.5	3.3	6.2	29.6	17.7	33.7	46.6	7.4	12.3	10.4
Source	Ageing Report 2024			Ageing Report 2024			EHIS, hlth_ehis_tadlh	EU-SILC, ilc_ats15		

Annex 3.3 Workforce

Member State	Coverage of collective bargaining for LTC workers (%)	Mean gross hourly wages for LTC workers compared with other sectors (%)	Share of full-time LTC workers in total LTC workforce (%)	Share of LTC workers with permanent contracts (%)	Share of LTC workers working shifts (%)	Non-fatal accidents at work per 100,000 workers (care sector)
Austria	89.9	94.9	38.8	94.0	57.4	1807
Belgium	100.0	80.6	45.2	93.1	42.4	1323
Bulgaria	54.3	64.2	86.6	65.5	N/A	64
Croatia	74.8	86.4	96.7	70.6	49.5	510
Cyprus	31.8	74.4	99.2	89.3	N/A	329
Czechia	32.1	89.5	94.3	91.2	57.8	588
Denmark	98.5	78.1	52.6	77.3	20.1	14467
Estonia	0.0	65.3	74.6	94.3	56	360
Finland	100.0	75.8	67.5	83.0	76.9	688
France	99.8	85.6	64.4	84.2	11.8	5720
Germany	74.0	83.6	50.5	87.6	52.2	1379
Greece	53.9	80.7	100	62.1	90.1	182
Hungary	0.4	84.4	97.9	95.4	41.6	719
Ireland	100.0	89.6	84.2	97.0	N/A	1664
Italy	100.0	64.8	65.4	82.5	64.1	3315
Latvia	54.2	68.6	81.6	88.5	N/A	219
Lithuania	24.1	88.7	97.9	96.9	N/A	305
Luxembourg	85.7	103.8	68.9	95.0	77.1	2675
Malta	65.8	67.7	98.5	80.1	76.4	696
Netherlands	98.1	95.5	24.7	79.3	57.2	1035
Poland	19.5	66.0	85.1	68.9	40.5	718
Portugal	88.3	67.3	95.3	84.2	46.5	2428
Romania	100.0	75.5	100.0	85.2	37.4	27
Slovakia	97.0	81.8	93.3	96.1	28.9	210
Slovenia	100.0	90.4	87.3	87.3	70.6	2848
Spain	96.9	69.3	78.7	78.9	43.5	3470
Sweden	99.9	78.5	52.1	74.7	57.5	1583

Member State	Coverage of collective bargaining for LTC workers (%)	Mean gross hourly wages for LTC workers compared with other sectors (%)	Share of full-time LTC workers in total LTC workforce (%)	Share of LTC workers with permanent contracts (%)	Share of LTC workers working shifts (%)	Non-fatal accidents at work per 100,000 workers (care sector)
EU-27	82.4	89.2	58.5	83.8	45.8	2635
Source	SES 2022	SES 2022	LFS 2023	LFS 2023	LFS 2023	ESAW 2022

Member State	Number of LTC workers per 100 people aged 65+ (%)	Share of LTC workers in employment aged 55+ (%)	Share of LTC workers who are personal care workers or nurses (%)		Share of LTC workers in residential care (%)
			Personal care workers	Nurses	
Austria	2.4	22.1	61.3	36.3	91.9
Belgium	4.5	20.7	67.8	23.7	77.1
Bulgaria	2.2	46.5	89.7	N/A	15.2
Croatia	1.3	25.3	79.7	9.8	63.5
Cyprus	0.6	N/A	N/A	N/A	N/A
Czechia	2.0	21.2	78.7	10.9	79.1
Denmark	9.0	29.7	91.9	7.8	58.2
Estonia	1.4	N/A	93.8	N/A	N/A
Finland	5.9	30.3	85.0	10.4	57.3
France	3.0	20.8	74.9	14.4	62.8
Germany	5.4	28.1	34.3	59.9	64.9
Greece	0.2	N/A	N/A	80.9	55.1
Hungary	1.0	19.5	37.9	56.9	76.5
Ireland	1.0	N/A	N/A	78.1	N/A
Italy	1.5	27.9	86.4	9.9	76.8
Latvia	0.7	N/A	84.9	N/A	N/A
Lithuania	1.1	26.8	30.3	N/A	61.2
Luxembourg	3.7	N/A	64.3	N/A	N/A
Malta	6.1	N/A	79.8	20.2	N/A
Netherlands	7.8	29.5	68.9	23.8	66.4
Poland	0.4	N/A	63.2	N/A	39.3
Portugal	3.5	25.0	84.2	6.4	79.3
Romania	0.6	31.1	74.6	N/A	33.1
Slovakia	3.7	40.4	85.1	N/A	31.7
Slovenia	1.8	23.9	70.7	25.8	62.8
Spain	2.9	23.8	86.9	6.4	58.6

Member State	Number of LTC workers per 100 people aged 65+ (%)	Share of LTC workers in employment aged 55+ (%)	Share of LTC workers who are personal care workers or nurses (%)		Share of LTC workers in residential care (%)
			Personal care workers	Nurses	
Sweden	10.4	28.6	89.2	8.9	46.3
EU-27	3.2	26.6	64.5	29.0	63.3
Source	LFS 2023	LFS 2023	LFS 2023		LFS 2023

Member State	LTC workers by job tenure (% above 60 months)	Share of LTC workers not participating in education and training (%)	LTC workers by educational level (%)			Share of women in LTC workforce (%)
			High (ISCED 5-8)	Medium (ISCED 3-4)	Low (ISCED 0-2)	
Austria	53.1	72.9	20.0	66.4	13.6	85.2
Belgium	59.2	85.0	34.9	58.5	6.6	89.1
Bulgaria	31.8	97.2	14.3	63.7	22.0	80.1
Croatia	36.7	95.1	23.4	58.8	17.8	96.5
Cyprus	60.3	100.0	56.0	N/A	N/A	79.4
Czechia	43.7	85.3	15.2	78.7	6.2	95.0
Denmark	32.7	60.7	17.4	67.7	14.7	87.7
Estonia	N/A	74.8	N/A	51.9	N/A	96.1
Finland	36.7	67.2	22.8	69.1	8.2	91.3
France	48.2	82.8	28.9	60.1	11.0	91.1
Germany	43.0	85.5	10.4	69.5	20.0	82.8
Greece	26.1	95.1	37.7	60.6	N/A	91.2
Hungary	64.4	80.2	N/A	78.1	N/A	91.7
Ireland	N/A	80.4	96.4	N/A	N/A	84.4
Italy	48.9	85.5	15.7	51.5	32.8	84.4
Latvia	N/A	88.2	N/A	N/A	N/A	96.8
Lithuania	37.0	76.4	54.5	43.6	N/A	97.8
Luxembourg	67.1	85.6	N/A	73.3	N/A	77.1
Malta	33.9	70.9	45.7	36.0	18.2	74.0
Netherlands	43.5	58.4	20.1	60.3	19.4	91.9
Poland	47.7	93.3	N/A	55.0	N/A	95.8
Portugal	52.2	87.8	19.0	33.3	47.8	95.6
Romania	57.0	92.0	N/A	64.0	N/A	84.9
Slovakia	59.8	94.6	N/A	80.7	N/A	88.0

Member State	LTC workers by job tenure (% above 60 months)	Share of LTC workers not participating in education and training (%)	LTC workers by educational level (%)			Share of women in LTC workforce (%)
			High (ISCED 5-8)	Medium (ISCED 3-4)	Low (ISCED 0-2)	
Slovenia	47.8	73.0	16.1	71.0	12.9	82.7
Spain	43.2	80.3	30.0	44.5	25.6	92.1
Sweden	40.0	58.5	25.2	53.6	20.8	77.0
EU-27	44.9	79.1	19.8	60.8	19.3	86.8
Source	LFS 2023	LFS 2023	LFS 2023			LFS 2023

Annex 3.4 Informal carers

Member State	Share of people providing informal care (%)			Share of people aged 45-64 providing informal care at least once per week on average (%)	
	Men	Women	Total	Men	Women
Austria	12.4	18.1	15.3	16.7	26.6
Belgium	10.7	15.0	12.9	14.9	22.0
Bulgaria	12.6	14.6	13.6	16.8	20.8
Croatia	22.9	28.4	26.1	32.4	39.4
Cyprus	6.8	9.6	8.3	11.5	17.8
Czechia	10.9	14.8	12.9	14.1	25.4
Denmark	27.1	31.3	29.2	33.4	40.6
Estonia	13.5	14.2	13.9	19.7	21.8
Finland	19.1	21.9	20.5	25.2	30.4
France	23.0	26.6	24.9	28.6	36.1
Germany	19.5	23.9	21.7	24.9	32.4
Greece	12.7	15.7	14.3	19.3	22.7
Hungary	12.1	15.2	13.8	16.3	24.2
Ireland	10.7	14.4	12.6	17.1	21.4
Italy	14.0	19.0	16.7	20.8	29.1
Latvia	15.1	17.9	16.7	22.3	26.9
Lithuania	11.4	15.8	13.8	14.2	25.2
Luxembourg	13.3	15.9	14.6	18.3	25.1
Malta	11.7	18.1	14.8	15.7	25.9
Netherlands	12.8	19.0	15.9	18.4	29.1
Poland	12.0	16.2	14.2	18.3	25.4
Portugal	8.9	14.7	12.0	11.9	21.8
Romania	5.5	9.3	7.5	7.4	12.4
Slovakia	10.8	15.6	13.2	17.5	23.0
Slovenia	12.6	16.4	14.5	17.1	22.1
Spain	8.4	13.0	10.8	13.5	21.9
Sweden	9.5	12.2	10.9	10.7	18.1
EU-27	14.8	19.1	17.0	20.1	27.8
Source	EHIS 2019			EHIS 2019	

Member State	Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week) (%)			Use of professional care services by informal carers' care recipients at least once per week (%)	
	Total	Men	Women	Men	Women
Austria	13.1	9.9	15.1	85.7	63.9
Belgium	9.9	10.4	9.5	81.1	71.0
Bulgaria	23.0	18.0	26.7	54.3	38.6
Croatia	31.5	20.7	38.0	55.1	35.9
Cyprus	7.7	5.1	9.2	80.5	40.4
Czechia	10.7	5.8	13.4	52.7	41.2
Denmark	4.1	4.6	3.7	88.5	79.8
Estonia	18.2	15.6	20.3	72.8	53.1
Finland	5.6	4.9	6.1	79.3	68.6
France	6.9	5.4	8.0	80.7	79.0
Germany	10.5	5.9	14.1	83.1	75.2
Greece	19.8	12.1	25.8	63.1	53.0
Hungary	10.8	7.9	12.5	66.9	43.0
Ireland	29.8	21.1	37.2	78.5	57.1
Italy	28.1	23.3	31.2	68.8	56.0
Latvia	14.9	10.3	18.1	77.8	41.3
Lithuania	18.6	12.5	21.7	56.6	54.7
Luxembourg	7.6	6.0	9.0	78.3	N/A
Malta	22.1	18.4	24.4	38.1	46.3
Netherlands	8.6	8.3	8.7	84.2	68.9
Poland	24.9	23.2	26.0	66.1	52.7
Portugal	26.3	15.5	31.6	73.2	65.5
Romania	18.9	12.9	22.2	55.6	46.7
Slovakia	26.3	18.7	31.8	41.0	38.0
Slovenia	17.6	14.0	20.4	54.9	49.2
Spain	42.7	39.7	44.5	70.1	60.4
Sweden	17.9	9.9	22.5	79.2	58.7
EU-27	17.1	13.0	19.9	72.5	61.4
Source	EHIS 2019			EIGE 2022	

Annex 4: Country tables[36]

Indicator (by dimension)	Austria	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 19.6%	65+: 21.3%
	75+: 9.5%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	27.0%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.6% of GDP	1.7%
	5.7% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.8%	1.8%
	Risk scenario: 1.9%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	NO	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	Medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	25.6%	35.7%
P2: Great difficulty in affording professional home care service	8.1%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 52.3%	Not available
	Moderate: 73.0%	
	Severe: 87.1%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 24.7%	Not available
	Moderate: 45.4%	
	Severe: 45.4%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 97.2% without social protection, 82.8% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 9.7%	Home: 28.8%
	Residential: 40.5%	Residential: 46.2%
	Cash: 49.8%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	872.6	Not available

[36] In the 27 country tables below, “MS” means “Member State”.

Indicator (by dimension)	Austria	EU average
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	31.5%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 4.5%	Home: 5.5%
	Residential: 3.5%	Residential: 3.3%
	Cash: 19.8%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 18.2%	Home: 29.6%
	Residential: 13.8%	Residential: 17.7%
	Cash: 79.4%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	32.4%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 20.7%	7.4%
	Towns and suburbs: 0.0%	12.3%
	Rural areas: 0.0%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	Not available	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	89.9%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	94.9%	89.2%
C13: Share of LTC workers in full-time employment	38.8%	58.5%
C14: Share of LTC workers with permanent contracts	94.0%	83.8%

Indicator (by dimension)	Austria	EU average
C15: Share of LTC workers working shifts	57.4%	44.9%
C16: Non-fatal accidents at work in the care sector	1,807.4	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	2.4	3.2
C17: Share of LTC workers aged 55+	22.1%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 61.3%	64.5%
	Nurses: 36.3%	29.0%
C19: Share of LTC workers in residential care	91.9%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 14.4%	18.7%
	Above 60 months: 53.1%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	72.9%	79.1%
C21: Share of LTC workers by educational level	Low: 13.6%	19.3%
	Medium: 66.4%	60.8%
	High: 20.0%	19.8%
C22: Share of women in the LTC workforce	85.2%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	15.3%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 15.1%	Women: 19.9%
	Men: 9.9%	Men: 13.0%
	Total: 13.1%	Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 85.7%	Women: 72.5
	Men: 63.9%	Men: 61.4
	Total: 74.3%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	High	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Belgium	EU average
OVERARCHING		
	65+: 19.7%	65+: 21.3%

Indicator (by dimension)	Belgium	EU average
C1: People aged 65+ and 75+ as a share of the total population	75+: 9.3%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	29.9%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	2.3% of GDP	1.7%
	8.6% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 2.5%	1.8%
	Risk scenario: 2.7%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Partly	YES in 10 MS
C5: Monitoring of waiting times	NO	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	24.4%	35.7%
P2: Great difficulty in affording professional home care service	8.7%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 76.6%	Not available
	Moderate: 79.0%	
	Severe: 95.3%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 12.9%	Not available
	Moderate: 30.6%	
	Severe: 9.8%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 98.0% without social protection, 75.4% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: YES	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 28.0%	Home: 28.8%
	Residential: 61.3%	Residential: 46.2%
	Cash: 10.8%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	1,282.7	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Belgium	EU average
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	53.7%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 15.2%	Home: 5.5%
	Residential: 5.2%	Residential: 3.3%
	Cash: 8.5%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 74.8%	Home: 29.6%
	Residential: 25.4%	Residential: 17.7%
	Cash: 41.5%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	Not available	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 0.8%	7.4%
	Towns and suburbs: 7.3%	12.3%
	Rural areas: 7.4%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	Partial	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	Not available	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	100.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	80.6%	89.2%
C13: Share of LTC workers in full-time employment	45.2%	58.5%
C14: Share of LTC workers with permanent contracts	93.1%	83.8%
C15: Share of LTC workers working shifts	42.4%	44.9%

Indicator (by dimension)	Belgium	EU average
C16: Non-fatal accidents at work in the care sector	1,323.0	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	4.5	3.2
C17: Share of LTC workers aged 55+	20.7%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 67.8%	64.5%
	Nurses: 23.7%	29.0%
C19: Share of LTC workers in residential care	77.1%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 13.0%	18.7%
	Above 60 months: 59.2%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	85.0%	79.1%
C21: Share of LTC workers by educational level	Low: 6.6%	19.3%
	Medium: 58.5%	60.8%
	High: 34.9%	19.8%
C22: Share of women in the LTC workforce	89.1%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	12.9%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 9.5%	Women: 19.9%
	Men: 10.4% Total: 9.9%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 81.1%	Women: 72.5
	Men: 71.0%	Men: 61.4
	Total: 76.5%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium (at regional level)	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	YES	YES for 5 MS

Indicator (by dimension)	Bulgaria	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 23.5%	65+: 21.3%
	75+: 9.9%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	27.9%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.5% of GDP	1.7%
	2.9% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.6%	1.8%
	Risk scenario: 0.7%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	YES	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	YES	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	NO	YES for 20 MS
	Low level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	65.1%	35.7%
P2: Great difficulty in affording professional home care service	36.7%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Not available	Not available
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Not available	Not available
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Not available	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: Not available	YES in 15 MS
	Asset: Not available	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 49.8%	Home: 28.8%
	Residential: 39.4%	Residential: 46.2%
	Cash: 10.8%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	25.3	Not available

Indicator (by dimension)	Bulgaria	EU average
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	11.6%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 0.7%	Home: 5.5%
	Residential: 1.1%	Residential: 3.3%
	Cash: 2.6%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 6.5%	Home: 29.6%
	Residential: 9.6%	Residential: 17.7%
	Cash: 23.3%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	67.5%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 0.0%	7.4%
	Towns and suburbs: 3.4%	12.3%
	Rural areas: 22.8%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	Not available	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	Partial	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	54.3%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	64.2%	89.2%
C13: Share of LTC workers in full-time employment	86.6%	58.5%

Indicator (by dimension)	Bulgaria	EU average
C14: Share of LTC workers with permanent contracts	65.5%	83.8%
C15: Share of LTC workers working shifts	Not available	44.9%
C16: Non-fatal accidents at work in the care sector	64.1	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	2.2	3.2
C17: Share of LTC workers aged 55+	46.5%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 89.7%	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	15.2%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 26.9%	18.7%
	Above 60 months: 31.8%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	97.2%	79.1%
C21: Share of LTC workers by educational level	Low: 22.0%	19.3%
	Medium: 63.7%	60.8%
	High: 14.3%	19.8%
C22: Share of women in the LTC workforce	80.1%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	13.6%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 26.7%	Women: 19.9%
	Men: 18.0% Total: 23.0%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 54.3%	Women: 72.5
	Men: 38.6%	Men: 61.4
	Total: 47.2%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Low	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Croatia	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 22.7%	65+: 21.3%
	75+: 9.4%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	38.5%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.5% of GDP	1.7%
	2.7% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.5%	1.8%
	Risk scenario: 0.6%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Not available	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Not available	YES in 10 MS
C5: Monitoring of waiting times	Not available	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	NO	YES for 20 MS
	Low level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	34.2%	35.7%
P2: Great difficulty in affording professional home care service	15.8%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 0.0%	Not available
	Moderate: 8.4%	
	Severe: 22.8%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 27.9%	Not available
	Moderate: 88.4%	
	Severe: 136.6%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 98.6% without social protection, 96.6% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: YES	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 4.7%	Home: 28.8%
	Residential: 53.7%	Residential: 46.2%
	Cash: 41.6%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	238.9	Not available

Indicator (by dimension)	Croatia	EU average
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	26.9%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 0.3%	Home: 5.5%
	Residential: 1.0%	Residential: 3.3%
	Cash: 8.2%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 1.3%	Home: 29.6%
	Residential: 3.7%	Residential: 17.7%
	Cash: 31.1%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	71.0%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 4.5%	7.4%
	Towns and suburbs: 4.5%	12.3%
	Rural areas: 18.6%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	Partial	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	Partial	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	74.8%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	86.4%	89.2%
C13: Share of LTC workers in full-time employment	96.7%	58.5%
C14: Share of LTC workers with permanent contracts	70.6%	83.8%

Indicator (by dimension)	Croatia	EU average
C15: Share of LTC workers working shifts	49.5%	44.9%
C16: Non-fatal accidents at work in the care sector	509.9	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	1.3	3.2
C17: Share of LTC workers aged 55+	25.3%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 79.7%	64.5%
	Nurses: 9.8%	29.0%
C19: Share of LTC workers in residential care	63.5%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 24.8%	18.7%
	Above 60 months: 36.7%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	95.1%	79.1%
C21: Share of LTC workers by educational level	Low: 17.8%	19.3%
	Medium: 58.8%	60.8%
	High: 23.4%	19.8%
C22: Share of women in the LTC workforce	96.5%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	26.1%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 38.0%	Women: 19.9%
	Men: 20.7% Total: 31.5%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 55.1%	Women: 72.5
	Men: 35.9%	Men: 61.4
	Total: 43.3%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Cyprus	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 16.6%	65+: 21.3%
	75+: 7.2%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	34.3%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.2% of GDP	1.7%
	0.9% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.2%	1.8%
	Risk scenario: 0.3%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	NO	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	Medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	45.6%	35.7%
P2: Great difficulty in affording professional home care service	45.8%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Not available	Not available
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Not available	Not available
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Not available	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: Not available	YES in 15 MS
	Asset: Not available	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 35.2%	Home: 28.8%
	Residential: 4.2%	Residential: 46.2%
	Cash: 60.6%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	285.9	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Cyprus	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	19.3%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 5.4%	Home: 5.5%
	Residential: 4.0%	Residential: 3.3%
	Cash: 2.2%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 23.5%	Home: 29.6%
	Residential: 17.5%	Residential: 17.7%
	Cash: 9.3%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	30.4%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 0.0%	7.4%
	Towns and suburbs: 3.1%	12.3%
	Rural areas: 0.0%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	Partial	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	NO	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	NO	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	NO	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	NO	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	31.8%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	74.4%	89.2%
C13: Share of LTC workers in full-time employment	99.2%	58.5%
C14: Share of LTC workers with permanent contracts	89.3%	83.8%

Indicator (by dimension)	Cyprus	EU average
C15: Share of LTC workers working shifts	Not available	44.9%
C16: Non-fatal accidents at work in the care sector	328.6	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	0.6	3.2
C17: Share of LTC workers aged 55+	Not available	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: Not available	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	Not available	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: 60.3%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	100.0%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: Not available	60.8%
	High: 56.0%	19.8%
C22: Share of women in the LTC workforce	79.4%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	8.3%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 9.2%	Women: 19.9%
	Men: 5.1% Total: 7.7%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 80.5%	Women: 72.5
	Men: 40.4%	Men: 61.4
	Total: 61.0%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	NO	YES for 5 MS

Indicator (by dimension)	Czechia	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 20.4%	65+: 21.3%
	75+: 8.7%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	30.5%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.5% of GDP	1.7%
	7.2% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.7%	1.8%
	Risk scenario: 1.8%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	NO	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	Medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	16.1%	35.7%
P2: Great difficulty in affording professional home care service	14.6%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 5.3%	Not available
	Moderate: 7.6%	
	Severe: 12.1%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 81.8%	Not available
	Moderate: 276.2%	
	Severe: 481.9%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 100.0% without social protection, 100.0% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: NO	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 8.3%	Home: 28.8%
	Residential: 60.2%	Residential: 46.2%
	Cash: 31.5%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	719.6	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Czechia	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	16.2%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 4.3%	Home: 5.5%
	Residential: 3.9%	Residential: 3.3%
	Cash: 11.5%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 23.7%	Home: 29.6%
	Residential: 21.7%	Residential: 17.7%
	Cash: 64.0%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	37.9%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 1.8%	7.4%
	Towns and suburbs: 4.1%	12.3%
	Rural areas: 4.5%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	32.1%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	89.5%	89.2%
C13: Share of LTC workers in full-time employment	94.3%	58.5%
C14: Share of LTC workers with permanent contracts	91.2%	83.8%

Indicator (by dimension)	Czechia	EU average
C15: Share of LTC workers working shifts	57.8%	44.9%
C16: Non-fatal accidents at work in the care sector	587.7	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	2.0	3.2
C17: Share of LTC workers aged 55+	21.2%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 78.7%	64.5%
	Nurses: 10.9%	29.0%
C19: Share of LTC workers in residential care	79.1%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 13.6%	18.7%
	Above 60 months: 43.7%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	85.3%	79.1%
C21: Share of LTC workers by educational level	Low: 6.2%	19.3%
	Medium: 78.7%	60.8%
	High: 15.2%	19.8%
C22: Share of women in the LTC workforce	95.0%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	12.9%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 13.4%	Women: 19.9%
	Men: 5.8% Total: 10.7%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 52.7%	Women: 72.5
	Men: 41.2%	Men: 61.4
	Total: 46.7%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	None	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Denmark	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 20.5%	65+: 21.3%
	75+: 9.9%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	14.9%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	3.0% of GDP	1.7%
	12.2% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 3.9%	1.8%
	Risk scenario: 3.9%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Not available	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Not available	YES in 10 MS
C5: Monitoring of waiting times	Not available	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	Not available	35.7%
P2: Great difficulty in affording professional home care service	16.3%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 100.0%	Not available
	Moderate: 100.0%	
	Severe: 99.3%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 0.0%	Not available
	Moderate: 0.0%	
	Severe: 3.1%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 100.0% without social protection, 28.7% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: NO	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 65.8%	Home: 28.8%
	Residential: 34.2%	Residential: 46.2%
	Cash: 0.0%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	744.2	Not available
C10: Existence of choice between care settings for people in need of LTC	NO	YES in 21 MS

Indicator (by dimension)	Denmark	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	52.3%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 13.6%	Home: 5.5%
	Residential: 3.6%	Residential: 3.3%
	Cash: 0.0%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 117.2%	Home: 29.6%
	Residential: 31.5%	Residential: 17.7%
	Cash: 0.0%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	43.0%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: Not available	7.4%
	Towns and suburbs: Not available	12.3%
	Rural areas: Not available	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	98.5%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	78.1%	89.2%
C13: Share of LTC workers in full-time employment	52.6%	58.5%
C14: Share of LTC workers with permanent contracts	77.3%	83.8%

Indicator (by dimension)	Denmark	EU average
C15: Share of LTC workers working shifts	20.1%	44.9%
C16: Non-fatal accidents at work in the care sector	14,467.2	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	9.0	3.2
C17: Share of LTC workers aged 55+	29.7%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 91.9%	64.5%
	Nurses: 7.8%	29.0%
C19: Share of LTC workers in residential care	58.2%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 27.5%	18.7%
	Above 60 months: 32.7%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	60.7%	79.1%
C21: Share of LTC workers by educational level	Low: 14.7%	19.3%
	Medium: 67.7%	60.8%
	High: 17.4%	19.8%
C22: Share of women in the LTC workforce	87.7%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	29.2%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 3.7%	Women: 19.9%
	Men: 4.6% Total: 4.1%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 88.5%	Women: 72.5
	Men: 79.8%	Men: 61.4
	Total: 84.4%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES (partial)	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	NO	YES for 5 MS

Indicator (by dimension)	Estonia	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 20.2%	65+: 21.3%
	75+: 9.3%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	26.6%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.4% of GDP	1.7%
	2.4% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.6%	1.8%
	Risk scenario: 0.9%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	YES	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	39.6%	35.7%
P2: Great difficulty in affording professional home care service	0.0%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 0.0%	Not available
	Moderate: 0.0%	
	Severe: 0.0%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 33.9%	Not available
	Moderate: 125.1%	
	Severe: 189.4%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 100.0% without social protection, 100.0% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 42.7%	Home: 28.8%
	Residential: 52.7%	Residential: 46.2%
	Cash: 4.6%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	858.7	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Estonia	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	10.3%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 2.9%	Home: 5.5%
	Residential: 4.3%	Residential: 3.3%
	Cash: 2.7%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 10.2%	Home: 29.6%
	Residential: 15.1%	Residential: 17.7%
	Cash: 9.5%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	58.4%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 11.5%	7.4%
	Towns and suburbs: 33.3%	12.3%
	Rural areas: 33.3%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	Partial	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	Partial	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	0.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	65.3%	89.2%
C13: Share of LTC workers in full-time employment	74.6%	58.5%
C14: Share of LTC workers with permanent contracts	94.3%	83.8%

Indicator (by dimension)	Estonia	EU average
C15: Share of LTC workers working shifts	56.0%	44.9%
C16: Non-fatal accidents at work in the care sector	360.3	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	1.4	3.2
C17: Share of LTC workers aged 55+	Not available	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 93.8%	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	Not available	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: Not available	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	74.8%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: 51.9%	60.8%
	High: Not available	19.8%
C22: Share of women in the LTC workforce	96.1%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	13.9%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 20.3%	Women: 19.9%
	Men: 15.6% Total: 18.2%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 72.8%	Women: 72.5
	Men: 53.1%	Men: 61.4
	Total: 64.4%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium (varying between municipalities)	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	YES	YES for 5 MS

Indicator (by dimension)	Finland	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 23.3%	65+: 21.3%
	75+: 10.8%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	18.1%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	2.1% of GDP	1.7%
	8.0% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 2.5%	1.8%
	Risk scenario: 2.6%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	YES	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	12.0%	35.7%
P2: Great difficulty in affording professional home care service	1.6%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 90.9%	Not available
	Moderate: 99.4%	
	Severe: 100.0%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 6.0%	Not available
	Moderate: 1.4%	
	Severe: 0.0%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 100.0% without social protection, 43.9% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 77.1%	Home: 28.8%
	Residential: 11.5%	Residential: 46.2%
	Cash: 11.5%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	1,134.4	Not available
C10: Existence of choice between care settings for people in need of LTC	Not available	YES in 21 MS

Indicator (by dimension)	Finland	EU average
C11: Existence of choice between providers for people in need of LTC	NO	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	33.0%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 7.6%	Home: 5.5%
	Residential: 1.5%	Residential: 3.3%
	Cash: 13.0%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 46.4%	Home: 29.6%
	Residential: 9.0%	Residential: 17.7%
	Cash: 79.3%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	70.4%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 16.9%	7.4%
	Towns and suburbs: 11.9%	12.3%
	Rural areas: 9.8%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	100.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	75.8%	89.2%
C13: Share of LTC workers in full-time employment	67.5%	58.5%
C14: Share of LTC workers with permanent contracts	83.0%	83.8%

Indicator (by dimension)	Finland	EU average
C15: Share of LTC workers working shifts	76.9%	44.9%
C16: Non-fatal accidents at work in the care sector	687.6	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	5.9	3.2
C17: Share of LTC workers aged 55+	30.3%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 85.0%	64.5%
	Nurses: 10.4%	29.0%
C19: Share of LTC workers in residential care	57.3%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 27.2%	18.7%
	Above 60 months: 36.7%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	67.2%	79.1%
C21: Share of LTC workers by educational level	Low: 8.2%	19.3%
	Medium: 69.1%	60.8%
	High: 22.8%	19.8%
C22: Share of women in the LTC workforce	91.3%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	20.5%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 6.1%	Women: 19.9%
	Men: 4.9% Total: 5.6%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 79.3%	Women: 72.5
	Men: 68.6%	Men: 61.4
	Total: 74.1%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	High	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	YES	YES for 5 MS

Indicator (by dimension)	France	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 21.2%	65+: 21.3%
	75+: 10.0%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	21.5%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.9% of GDP	1.7%
	6.3% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 2.0%	1.8%
	Risk scenario: 2.2%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Partly	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High/medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	16.4%	35.7%
P2: Great difficulty in affording professional home care service	3.0%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 76.4%	Not available
	Moderate: 56.8%	
	Severe: 47.2%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 7.3%	Not available
	Moderate: 46.1%	
	Severe: 103.3%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 93.8% without social protection, 82.0% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: YES	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 37.2%	Home: 28.8%
	Residential: 57.2%	Residential: 46.2%
	Cash: 5.6%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	977.1	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	France	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	40.1%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 5.8%	Home: 5.5%
	Residential: 4.4%	Residential: 3.3%
	Cash: 0.0%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 24.3%	Home: 29.6%
	Residential: 18.3%	Residential: 17.7%
	Cash: 0.0%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	38.7%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 4.2%	7.4%
	Towns and suburbs: 2.7%	12.3%
	Rural areas: 3.6%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	99.8%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	85.6%	89.2%
C13: Share of LTC workers in full-time employment	64.4%	58.5%
C14: Share of LTC workers with permanent contracts	84.2%	83.8%

Indicator (by dimension)	France	EU average
C15: Share of LTC workers working shifts	11.8%	44.9%
C16: Non-fatal accidents at work in the care sector	5,719.8	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	3.0	3.2
C17: Share of LTC workers aged 55+	20.8%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 74.9%	64.5%
	Nurses: 14.4%	29.0%
C19: Share of LTC workers in residential care	62.8%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 16.7%	18.7%
	Above 60 months: 48.2%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	82.8%	79.1%
C21: Share of LTC workers by educational level	Low: 11.0%	19.3%
	Medium: 60.1%	60.8%
	High: 28.9%	19.8%
C22: Share of women in the LTC workforce	91.1%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	24.9%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 8.0%	Women: 19.9%
	Men: 5.4% Total: 6.9%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 80.7%	Women: 72.5
	Men: 79.0%	Men: 61.4
	Total: 79.9%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	High	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	YES	YES for 5 MS

Indicator (by dimension)	Germany	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 22.1%	65+: 21.3%
	75+: 11.0%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	17.3%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.9% of GDP	1.7%
	7.6% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 2.2%	1.8%
	Risk scenario: 2.3%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Not available	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	19.2%	35.7%
P2: Great difficulty in affording professional home care service	8.3%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 37.9%	Not available
	Moderate: 100.0%	
	Severe: 75.8%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 14.6%	Not available
	Moderate: 0.0%	
	Severe: 38.7%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 91.1% without social protection, 35.8% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: YES	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 23.2%	Home: 28.8%
	Residential: 40.2%	Residential: 46.2%
	Cash: 36.7%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	1,185.1	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Germany	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	43.3%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 3.3%	Home: 5.5%
	Residential: 3.7%	Residential: 3.3%
	Cash: 12.1%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 20.1%	Home: 29.6%
	Residential: 22.7%	Residential: 17.7%
	Cash: 73.9%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	49.7%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 0.0%	7.4%
	Towns and suburbs: 6.0%	12.3%
	Rural areas: 4.4%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	74.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors??	83.6%	89.2%
C13: Share of LTC workers in full-time employment	50.5%	58.5%
C14: Share of LTC workers with permanent contracts	87.6%	83.8%

Indicator (by dimension)	Germany	EU average
C15: Share of LTC workers working shifts	52.2%	44.9%
C16: Non-fatal accidents at work in the care sector	1,379.1	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	5.4	3.2
C17: Share of LTC workers aged 55+	28.1%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 34.3%	64.5%
	Nurses: 59.9%	29.0%
C19: Share of LTC workers in residential care	64.9%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 18.4%	18.7%
	Above 60 months: 43.0%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	85.5%	79.1%
C21: Share of LTC workers by educational level	Low: 20.0%	19.3%
	Medium: 69.5%	60.8%
	High: 10.4%	19.8%
C22: Share of women in the LTC workforce	82.8%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	21.7%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 14.1%	Women: 19.9%
	Men: 5.9% Total: 10.5%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 83.1%	Women: 72.5
	Men: 75.2%	Men: 61.4
	Total: 79.0%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	High	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Greece	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 23.0%	65+: 21.3%
	75+: 11.6%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	29.1%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.1% of GDP	1.7%
	0.6% of total cost of age-ing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.1%	1.8%
	Risk scenario: 0.2%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-as-sessment	NO	YES in 10 MS
C5: Monitoring of waiting times	NO	YES in 6 MS
L3: Standardised procedure for LTC needs-as-sessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	NO	YES for 20 MS
	Low level	High for 11 MS
P1: People in need of LTC not using (more) pro-fessional homecare services primarily due to cost	63.3%	35.7%
P2: Great difficulty in affording professional home care service	55.0%	12.1%
P3: Share of costs for home care covered by pub-lic social protection by severity level	Low: 0.0%	Not available
	Moderate: 0.0%	
	Severe: 45.9%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 14.2%	Not available
	Moderate: 49.8%	
	Severe: 49.1%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 64.5% without social protection, 64.5% with	Not available
C7: Income-testing and asset-testing of LTC bene-fits	Income: YES	YES in 15 MS
	Asset: YES	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 16.9%	Home: 28.8%
	Residential: 83.1%	Residential: 46.2%
	Cash: 0.0%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	25.9	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Greece	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	20.1%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 9.1%	Home: 5.5%
	Residential: 0.0%	Residential: 3.3%
	Cash: 0.0%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 32.5%	Home: 29.6%
	Residential: 0.2%	Residential: 17.7%
	Cash: 0.0%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	43.1%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 2.9%	7.4%
	Towns and suburbs: 6.8%	12.3%
	Rural areas: 5.8%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	NO	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	NO	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	Partial	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	NO	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	NO	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	53.9%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	80.7%	89.2%
C13: Share of LTC workers in full-time employment	100.0%	58.5%
C14: Share of LTC workers with permanent contracts	62.1%	83.8%

Indicator (by dimension)	Greece	EU average
C15: Share of LTC workers working shifts	90.1%	44.9%
C16: Non-fatal accidents at work in the care sector	181.9	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	0.2	3.2
C17: Share of LTC workers aged 55+	Not available	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: Not available	64.5%
	Nurses: 80.9%	29.0%
C19: Share of LTC workers in residential care	55.1%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: 26.1%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	95.1%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: 60.6%	60.8%
	High: 37.7%	19.8%
C22: Share of women in the LTC workforce	91.2%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	14.3%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 25.8%	Women: 19.9%
	Men: 12.1% Total: 19.8%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 63.1%	Women: 72.5
	Men: 53.0%	Men: 61.4
	Total: 58.0%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	NO	YES for 5 MS

Indicator (by dimension)	Hungary	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 20.5%	65+: 21.3%
	75+: 8.4%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	24.7%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.5% of GDP	1.7%
	3.4% of total cost of age-ing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.6%	1.8%
	Risk scenario: 0.7%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-as-sessment	NO	YES in 10 MS
C5: Monitoring of waiting times	NO	YES in 6 MS
L3: Standardised procedure for LTC needs-as-sessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	NO	YES for 20 MS
	Medium/low level	High for 11 MS
P1: People in need of LTC not using (more) pro-fessional homecare services primarily due to cost	27.0%	35.7%
P2: Great difficulty in affording professional home care service	12.7%	12.1%
P3: Share of costs for home care covered by pub-lic social protection by severity level	Low: 2.2%	Not available
	Moderate: 71.8%	
	Severe: 84.6%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 25.0%	Not available
	Moderate: 25.0%	
	Severe: 25.0%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 92.4% without social protection, 67.1% with	Not available
C7: Income-testing and asset-testing of LTC bene-fits	Income: YES	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 14.9%	Home: 28.8%
	Residential: 66.5%	Residential: 46.2%
	Cash: 18.7%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	877.5	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Hungary	EU average
C11: Existence of choice between providers for people in need of LTC	Not available	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	22.5%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 4.2%	Home: 5.5%
	Residential: 2.9%	Residential: 3.3%
	Cash: 1.0%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 20.0%	Home: 29.6%
	Residential: 14.1%	Residential: 17.7%
	Cash: 4.6%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	49.0%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 1.6%	7.4%
	Towns and suburbs: 20.7%	12.3%
	Rural areas: 14.9%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	0.4%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	84.4%	89.2%
C13: Share of LTC workers in full-time employment	97.9%	58.5%
C14: Share of LTC workers with permanent contracts	95.4%	83.8%

Indicator (by dimension)	Hungary	EU average
C15: Share of LTC workers working shifts	41.6%	44.9%
C16: Non-fatal accidents at work in the care sector	718.9	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	1.0	3.2
C17: Share of LTC workers aged 55+	19.5%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 37.9%	64.5%
	Nurses: 56.9%	29.0%
C19: Share of LTC workers in residential care	76.5%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: 64.4%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	80.2%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: 78.1%	60.8%
	High: Not available	19.8%
C22: Share of women in the LTC workforce	91.7%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	13.8%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 12.5%	Women: 19.9%
	Men: 7.9% Total: 10.8%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 66.9%	Women: 72.5
	Men: 43.0%	Men: 61.4
	Total: 53.8%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Low	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Ireland	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 15.2%	65+: 21.3%
	75+: 6.6%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	20.9%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.2% of GDP	1.7%
	10.2% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.4%	1.8%
	Risk scenario: 1.4%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Not available	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	11.3%	35.7%
P2: Great difficulty in affording professional home care service	27.2%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 53.8%	Not available
	Moderate: 86.7%	
	Severe: 92.7%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 18.5%	Not available
	Moderate: 18.5%	
	Severe: 18.5%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 95.2% without social protection, 55.2% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: NO	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 34.8%	Home: 28.8%
	Residential: 42.1%	Residential: 46.2%
	Cash: 23.1%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	613.2	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Ireland	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	35.4%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 7.8%	Home: 5.5%
	Residential: 3.0%	Residential: 3.3%
	Cash: 7.6%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 55.0%	Home: 29.6%
	Residential: 20.9%	Residential: 17.7%
	Cash: 53.5%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	48.5%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 17.3%	7.4%
	Towns and suburbs: 11.1%	12.3%
	Rural areas: 36.5%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	Partial	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	Partial	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	Partial	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	Partial	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	100.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	89.6%	89.2%
C13: Share of LTC workers in full-time employment	84.2%	58.5%
C14: Share of LTC workers with permanent contracts	97.0%	83.8%

Indicator (by dimension)	Ireland	EU average
C15: Share of LTC workers working shifts	Not available	44.9%
C16: Non-fatal accidents at work in the care sector	1,663.7	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	1.0	3.2
C17: Share of LTC workers aged 55+	Not available	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: Not available	64.5%
	Nurses: 78.1%	29.0%
C19: Share of LTC workers in residential care	Not available	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: Not available	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	80.4%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: Not available	60.8%
	High: 96.4%	19.8%
C22: Share of women in the LTC workforce	84.4%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	12.6%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 37.2%	Women: 19.9%
	Men: 21.1% Total: 29.8%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 78.5%	Women: 72.5
	Men: 57.1%	Men: 61.4
	Total: 67.3%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	High	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Italy	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 24.0%	65+: 21.3%
	75+: 12.3%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	28.7%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.6% of GDP	1.7%
	6.0% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.6%	1.8%
	Risk scenario: 1.7%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Not available	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	Not available	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	NO	YES for 20 MS
	Low level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	36.9%	35.7%
P2: Great difficulty in affording professional home care service	26.6%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 71.0%	Not available
	Moderate: 85.8%	
	Severe: 74.7%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 29.2%	Not available
	Moderate: 49.5%	
	Severe: 161.9%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 100.0% without social protection, 91.5% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: YES	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 21.2%	Home: 28.8%
	Residential: 25.8%	Residential: 46.2%
	Cash: 53.0%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	480.4	Not available
C10: Existence of choice between care settings for people in need of LTC	Not available	YES in 21 MS

Indicator (by dimension)	Italy	EU average
C11: Existence of choice between providers for people in need of LTC	NO	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	28.5%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 5.4%	Home: 5.5%
	Residential: 2.5%	Residential: 3.3%
	Cash: 10.0%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 33.1%	Home: 29.6%
	Residential: 15.4%	Residential: 17.7%
	Cash: 61.7%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	44.2%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 22.4%	7.4%
	Towns and suburbs: 38.9%	12.3%
	Rural areas: 29.5%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	100.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	64.8%	89.2%
C13: Share of LTC workers in full-time employment	65.4%	58.5%
C14: Share of LTC workers with permanent contracts	82.5%	83.8%

Indicator (by dimension)	Italy	EU average
C15: Share of LTC workers working shifts	64.1%	44.9%
C16: Non-fatal accidents at work in the care sector	3,314.5	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	1.5	3.2
C17: Share of LTC workers aged 55+	27.9%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 86.4%	64.5%
	Nurses: 9.9%	29.0%
C19: Share of LTC workers in residential care	76.8%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 16.6%	18.7%
	Above 60 months: 48.9%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	85.5%	79.1%
C21: Share of LTC workers by educational level	Low: 32.8%	19.3%
	Medium: 51.5%	60.8%
	High: 15.7%	19.8%
C22: Share of women in the LTC workforce	84.4%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	16.7%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 31.2%	Women: 19.9%
	Men: 23.3% Total: 28.1%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 68.8%	Women: 72.5
	Men: 56.0%	Men: 61.4
	Total: 61.9%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	None	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	NO	YES for 5 MS

Indicator (by dimension)	Latvia	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 21.0%	65+: 21.3%
	75+: 9.7%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	38.8%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.5% of GDP	1.7%
	2.8% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.5%	1.8%
	Risk scenario: 0.6%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	NO	YES for 20 MS
	Low level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	37.9%	35.7%
P2: Great difficulty in affording professional home care service	40.4%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 0.0%	Not available
	Moderate: 55.1%	
	Severe: 75.5%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 32.3%	Not available
	Moderate: 50.2%	
	Severe: 50.2%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 93.6% without social protection, 93.6% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 17.0%	Home: 28.8%
	Residential: 53.6%	Residential: 46.2%
	Cash: 29.3%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	258.9	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Latvia	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	14.6%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 3.6%	Home: 5.5%
	Residential: 1.8%	Residential: 3.3%
	Cash: 3.8%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 14.2%	Home: 29.6%
	Residential: 7.0%	Residential: 17.7%
	Cash: 14.7%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	23.4%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 16.2%	7.4%
	Towns and suburbs: 13.2%	12.3%
	Rural areas: 18.5%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	Partial	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	Partial	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	Partial	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	54.2%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	68.6%	89.2%
C13: Share of LTC workers in full-time employment	81.6%	58.5%
C14: Share of LTC workers with permanent contracts	88.5%	83.8%

Indicator (by dimension)	Latvia	EU average
C15: Share of LTC workers working shifts	Not available	44.9%
C16: Non-fatal accidents at work in the care sector	218.5	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	0.7	3.2
C17: Share of LTC workers aged 55+	Not available	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 84.9%	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	Not available	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: Not available	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	88.2%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: Not available	60.8%
	High: Not available	19.8%
C22: Share of women in the LTC workforce	96.8%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	16.7%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 18.1%	Women: 19.9%
	Men: 10.3% Total: 14.9%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 77.8%	Women: 72.5
	Men: 41.3%	Men: 61.4
	Total: 57.1%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	High	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	NO	YES for 5 MS

Indicator (by dimension)	Lithuania	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 20.0%	65+: 21.3%
	75+: 9.2%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	34.8%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.0% of GDP	1.7%
	6.6% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.1%	1.8%
	Risk scenario: 1.4%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	Medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	42.4%	35.7%
P2: Great difficulty in affording professional home care service	1.2%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 0.0%	Not available
	Moderate: 46.0%	
	Severe: 60.2%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 31.8%	Not available
	Moderate: 59.8%	
	Severe: 80.5%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 99.2% without social protection, 96.0% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 6.4%	Home: 28.8%
	Residential: 55.7%	Residential: 46.2%
	Cash: 38.0%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	772.5	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Lithuania	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	14.2%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 12.0%	Home: 5.5%
	Residential: 12.3%	Residential: 3.3%
	Cash: 14.0%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 42.9%	Home: 29.6%
	Residential: 43.7%	Residential: 17.7%
	Cash: 50.0%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	37.2%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 2.9%	7.4%
	Towns and suburbs: Not available	12.3%
	Rural areas: 5.8%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	Partial	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	Partial	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	24.1%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	88.7%	89.2%
C13: Share of LTC workers in full-time employment	97.9%	58.5%
C14: Share of LTC workers with permanent contracts	96.9%	83.8%

Indicator (by dimension)	Lithuania	EU average
C15: Share of LTC workers working shifts	Not available	44.9%
C16: Non-fatal accidents at work in the care sector	305.1	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	1.1	3.2
C17: Share of LTC workers aged 55+	26.8%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 30.3%	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	61.2%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 19.3%	18.7%
	Above 60 months: 37.0%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	76.4%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: 43.6%	60.8%
	High: 54.5%	19.8%
C22: Share of women in the LTC workforce	97.8%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	13.8%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 21.7%	Women: 19.9%
	Men: 12.5% Total: 18.6%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 56.6%	Women: 72.5
	Men: 54.7%	Men: 61.4
	Total: 55.6%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Low	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Luxembourg	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 14.9%	65+: 21.3%
	75+: 6.6%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	11.6%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.1% of GDP	1.7%
	6.4% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.1%	1.8%
	Risk scenario: 1.2%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Partly	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Not available	YES in 10 MS
C5: Monitoring of waiting times	YES	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	Medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	3.3%	35.7%
P2: Great difficulty in affording professional home care service	12.8%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 100.0%	Not available
	Moderate: 94.2%	
	Severe: 97.2%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 0.0%	Not available
	Moderate: 9.2%	
	Severe: 9.2%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 96.3% without social protection, 18.5% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: NO	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 33.1%	Home: 28.8%
	Residential: 59.3%	Residential: 46.2%
	Cash: 7.6%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	1,161.1	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Luxembourg	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	35.2%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 5.4%	Home: 5.5%
	Residential: 4.5%	Residential: 3.3%
	Cash: 4.3%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 23.3%	Home: 29.6%
	Residential: 19.6%	Residential: 17.7%
	Cash: 18.6%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	74.6%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 0.0%	7.4%
	Towns and suburbs: 1.1%	12.3%
	Rural areas: 0.0%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	85.7%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	103.8%	89.2%
C13: Share of LTC workers in full-time employment	68.9%	58.5%
C14: Share of LTC workers with permanent contracts	95.0%	83.8%

Indicator (by dimension)	Luxembourg	EU average
C15: Share of LTC workers working shifts	77.1%	44.9%
C16: Non-fatal accidents at work in the care sector	2,674.8	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	3.7	3.2
C17: Share of LTC workers aged 55+	Not available	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 64.3%	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	Not available	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: 67.1%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	85.6%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: 73.3%	60.8%
	High: Not available	19.8%
C22: Share of women in the LTC workforce	77.1%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	14.6%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 9.0%	Women: 19.9%
	Men: 6.0% Total: 7.6%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 78.3%	Women: 72.5
	Men: Not available	Men: 61.4
	Total: 74.6%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	YES	YES for 5 MS

Indicator (by dimension)	Malta	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 18.6%	65+: 21.3%
	75+: 8.2%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	22.6%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.2% of GDP	1.7%
	6.9% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.4%	1.8%
	Risk scenario: 1.4%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Not available	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Partly	YES in 10 MS
C5: Monitoring of waiting times	Not available	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	Medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	17.4%	35.7%
P2: Great difficulty in affording professional home care service	17.1%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 64.0%	Not available
	Moderate: 91.5%	
	Severe: 95.2%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 6.3%	Not available
	Moderate: 5.1%	
	Severe: 5.1%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 81.3% without social protection, 34.4% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: NO	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 8.2%	Home: 28.8%
	Residential: 89.5%	Residential: 46.2%
	Cash: 2.3%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	1,259.4	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Malta	EU average
C11: Existence of choice between providers for people in need of LTC	Not available	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	23.5%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 18.2%	Home: 5.5%
	Residential: 4.5%	Residential: 3.3%
	Cash: 0.9%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 161.6%	Home: 29.6%
	Residential: 39.9%	Residential: 17.7%
	Cash: 7.9%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	56.3%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 4.9%	7.4%
	Towns and suburbs: Not available	12.3%
	Rural areas: Not available	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	Partial	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	Partial	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	65.8%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	67.7%	89.2%
C13: Share of LTC workers in full-time employment	98.5%	58.5%
C14: Share of LTC workers with permanent contracts	80.1%	83.8%

Indicator (by dimension)	Malta	EU average
C15: Share of LTC workers working shifts	76.4%	44.9%
C16: Non-fatal accidents at work in the care sector	695.8	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	6.1	3.2
C17: Share of LTC workers aged 55+	Not available	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 79.8%	64.5%
	Nurses: 20.2%	29.0%
C19: Share of LTC workers in residential care	Not available	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: 33.9%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	70.9%	79.1%
C21: Share of LTC workers by educational level	Low: 18.2%	19.3%
	Medium: 36.0%	60.8%
	High: 45.7%	19.8%
C22: Share of women in the LTC workforce	74.0%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	14.8%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 24.4%	Women: 19.9%
	Men: 18.4% Total: 22.1%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 38.1%	Women: 72.5
	Men: 46.3%	Men: 61.4
	Total: 42.0%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Netherlands	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 20.2%	65+: 21.3%
	75+: 9.2%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	26.9%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	3.8% of GDP	1.7%
	18.2% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 4.2%	1.8%
	Risk scenario: 4.4%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Partly	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	Partly	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	30.3%	35.7%
P2: Great difficulty in affording professional home care service	3.9%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 98.7%	Not available
	Moderate: 99.6%	
	Severe: 97.7%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 1.0%	Not available
	Moderate: 1.0%	
	Severe: 11.8%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 100.0% without social protection, 25.3% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: Not available	YES in 15 MS
	Asset: Not available	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 16.4%	Home: 28.8%
	Residential: 51.0%	Residential: 46.2%
	Cash: 32.6%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	1,420.3	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Netherlands	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	50.8%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 17.8%	Home: 5.5%
	Residential: 5.0%	Residential: 3.3%
	Cash: 1.2%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 126.4%	Home: 29.6%
	Residential: 35.8%	Residential: 17.7%
	Cash: 8.4%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	24.5%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 9.3%	7.4%
	Towns and suburbs: 7.6%	12.3%
	Rural areas: 5.1%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	Not available	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	98.1%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	95.5%	89.2%
C13: Share of LTC workers in full-time employment	24.7%	58.5%
C14: Share of LTC workers with permanent contracts	79.3%	83.8%

Indicator (by dimension)	Netherlands	EU average
C15: Share of LTC workers working shifts	57.2%	44.9%
C16: Non-fatal accidents at work in the care sector	1,035.0	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	7.8	3.2
C17: Share of LTC workers aged 55+	29.5%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 68.9%	64.5%
	Nurses: 23.8%	29.0%
C19: Share of LTC workers in residential care	66.4%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 19.4%	18.7%
	Above 60 months: 43.5%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	58.4%	79.1%
C21: Share of LTC workers by educational level	Low: 19.4%	19.3%
	Medium: 60.3%	60.8%
	High: 20.1%	19.8%
C22: Share of women in the LTC workforce	91.9%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	15.9%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 8.7%	Women: 19.9%
	Men: 8.3% Total: 8.6%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 84.2%	Women: 72.5
	Men: 68.9%	Men: 61.4
	Total: 76.6%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES (partial)	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Low	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Poland	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 19.9%	65+: 21.3%
	75+: 7.6%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	35.9%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.5% of GDP	1.7%
	2.8% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.6%	1.8%
	Risk scenario: 0.8%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	NO	YES in 10 MS
C5: Monitoring of waiting times	YES	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	Medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	51.7%	35.7%
P2: Great difficulty in affording professional home care service	22.7%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 41.2%	Not available
	Moderate: 11.9%	
	Severe: 6.5%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 14.2%	Not available
	Moderate: 73.7%	
	Severe: 143.3%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 98.2% without social protection, 95.8% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: Not available	YES in 15 MS
	Asset: Not available	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 34.0%	Home: 28.8%
	Residential: 65.4%	Residential: 46.2%
	Cash: 0.5%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	213.6	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Poland	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	18.8%	28.60%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 2.6%	Home: 5.5%
	Residential: 2.0%	Residential: 3.3%
	Cash: 0.8%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 13.4%	Home: 29.6%
	Residential: 10.4%	Residential: 17.7%
	Cash: 4.0%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	46.7%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 2.5%	7.4%
	Towns and suburbs: 4.2%	12.3%
	Rural areas: 11.4%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	Partial	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	Partial	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	Partial	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	Partial	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	Partial	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	19.5%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	66.0%	89.2%
C13: Share of LTC workers in full-time employment	85.1%	58.5%
C14: Share of LTC workers with permanent contracts	68.9%	83.8%

Indicator (by dimension)	Poland	EU average
C15: Share of LTC workers working shifts	40.5%	44.9%
C16: Non-fatal accidents at work in the care sector	718.2	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	0.4	3.2
C17: Share of LTC workers aged 55+	Not available	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 63.2%	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	39.3%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: 47.7%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	93.3%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: 55.0%	60.8%
	High: Not available	19.8%
C22: Share of women in the LTC workforce	95.8%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	14.2%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 26.0%	Women: 19.9%
	Men: 23.2% Total: 24.9%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 66.1%	Women: 72.5
	Men: 52.7%	Men: 61.4
	Total: 59.1%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Portugal	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 23.9%	65+: 21.3%
	75+: 11.6%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	32.6%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.5% of GDP	1.7%
	2.0% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.6%	1.8%
	Risk scenario: 0.8%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Partly	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Partly	YES in 10 MS
C5: Monitoring of waiting times	YES	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	NO	YES for 20 MS
	Low level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	30.8%	35.7%
P2: Great difficulty in affording professional home care service	20.2%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 82.0%	Not available
	Moderate: 23.7%	
	Severe: 23.3%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 3.1%	Not available
	Moderate: 45.5%	
	Severe: 83.8%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 75.4% without social protection, 70.6% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: NO	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 41.8%	Home: 28.8%
	Residential: 57.5%	Residential: 46.2%
	Cash: 0.7%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	Not available	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Portugal	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	15.9%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 0.6%	Home: 5.5%
	Residential: 1.1%	Residential: 3.3%
	Cash: 0.3%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 2.8%	Home: 29.6%
	Residential: 5.3%	Residential: 17.7%
	Cash: 1.5%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	38.9%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 4.4%	7.4%
	Towns and suburbs: 5.5%	12.3%
	Rural areas: 12.8%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	88.3%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	67.3%	89.2%
C13: Share of LTC workers in full-time employment	95.3%	58.5%
C14: Share of LTC workers with permanent contracts	84.2%	83.8%

Indicator (by dimension)	Portugal	EU average
C15: Share of LTC workers working shifts	46.5%	44.9%
C16: Non-fatal accidents at work in the care sector	2,427.5	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	3.5	3.2
C17: Share of LTC workers aged 55+	25.0%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 84.2%	64.5%
	Nurses: 6.4%	29.0%
C19: Share of LTC workers in residential care	79.3%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 13.3%	18.7%
	Above 60 months: 52.2%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	87.8%	79.1%
C21: Share of LTC workers by educational level	Low: 47.8%	19.3%
	Medium: 33.3%	60.8%
	High: 19.0%	19.8%
C22: Share of women in the LTC workforce	95.6%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	12.0%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 31.6%	Women: 19.9%
	Men: 15.5% Total: 26.3%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 73.2%	Women: 72.5
	Men: 65.5%	Men: 61.4
	Total: 69.1%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Low	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Romania	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 19.7%	65+: 21.3%
	75+: 7.7%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	56.5%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.3% of GDP	1.7%
	2.2% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.4%	1.8%
	Risk scenario: 0.5%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	NO	YES in 10 MS
C5: Monitoring of waiting times	NO	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	70.1%	35.7%
P2: Great difficulty in affording professional home care service	Not available	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: Not available	Not available
	Moderate: Not available	
	High: Not available	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: Not available	Not available
	Moderate : Not available	
	Severe: Not available	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Not available	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: Not available	YES in 15 MS
	Asset: Not available	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 47.3%	Home: 28.8%
	Residential: 48.6%	Residential: 46.2%
	Cash: 4.2%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	228.4	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Romania	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	4.7%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 5.2%	Home: 5.5%
	Residential: 3.9%	Residential: 3.3%
	Cash: 5.4%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 26.3%	Home: 29.6%
	Residential: 19.8%	Residential: 17.7%
	Cash: 27.0%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	61.6%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 4.4%	7.4%
	Towns and suburbs: 23.7%	12.3%
	Rural areas: 7.2%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	100.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	75.5%	89.2%
C13: Share of LTC workers in full-time employment	100.0%	58.5%
C14: Share of LTC workers with permanent contracts	85.2%	83.8%

Indicator (by dimension)	Romania	EU average
C15: Share of LTC workers working shifts	37.4%	44.9%
C16: Non-fatal accidents at work in the care sector	26.8	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	0.6	3.2
C17: Share of LTC workers aged 55+	31.1%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 74.6%	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	33.1%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: 57.0%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	92.0%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: 64.0%	60.8%
	High: Not available	19.8%
C22: Share of women in the LTC workforce	84.9%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	7.5%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 22.2%	Women: 19.9%
	Men: 12.9% Total: 18.9%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 55.6%	Women: 72.5
	Men: 46.7%	Men: 61.4
	Total: 50.8%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	High	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Slovakia	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 17.9%	65+: 21.3%
	75+: 6.6%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	37.0%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.0% of GDP	1.7%
	5.3% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.3%	1.8%
	Risk scenario: 1.4%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	NO	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	NO	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	Medium level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	28.0%	35.7%
P2: Great difficulty in affording professional home care service	17.3%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 45.5%	Not available
	Moderate: 45.5%	
	Severe: 45.5%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 8.7%	Not available
	Moderate: 30.0%	
	Severe: 55.0%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 81.7% without social protection, 65.6% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: NO	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 9.6%	Home: 28.8%
	Residential: 44.3%	Residential: 46.2%
	Cash: 46.1%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	783.0	Not available
C10: Existence of choice between care settings for people in need of LTC	Not available	YES in 21 MS

Indicator (by dimension)	Slovakia	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	12.1%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 5.3%	Home: 5.5%
	Residential: 5.8%	Residential: 3.3%
	Cash: 8.2%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 17.6%	Home: 29.6%
	Residential: 19.1%	Residential: 17.7%
	Cash: 27.2%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	50.9%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 0.0%	7.4%
	Towns and suburbs: 4.5%	12.3%
	Rural areas: 13.5%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	97.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	81.8%	89.2%
C13: Share of LTC workers in full-time employment	93.3%	58.5%
C14: Share of LTC workers with permanent contracts	96.1%	83.8%

Indicator (by dimension)	Slovakia	EU average
C15: Share of LTC workers working shifts	28.9%	44.9%
C16: Non-fatal accidents at work in the care sector	210.2	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	3.7	3.2
C17: Share of LTC workers aged 55+	40.4%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 85.1%	64.5%
	Nurses: Not available	29.0%
C19: Share of LTC workers in residential care	31.7%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: Not available	18.7%
	Above 60 months: 59.8%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	94.6%	79.1%
C21: Share of LTC workers by educational level	Low: Not available	19.3%
	Medium: 80.7%	60.8%
	High: Not available	19.8%
C22: Share of women in the LTC workforce	88.0%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	13.2%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 31.8%	Women: 19.9%
	Men: 18.7% Total: 26.3%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 41.0%	Women: 72.5
	Men: 38.0%	Men: 61.4
	Total: 39.3%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Low	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	YES	YES for 5 MS

Indicator (by dimension)	Slovenia	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 21.4%	65+: 21.3%
	75+: 9.4%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	29.2%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	1.0% of GDP	1.7%
	4.6% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 1.2%	1.8%
	Risk scenario: 1.4%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Not available	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	Not available	YES in 10 MS
C5: Monitoring of waiting times	Not available	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	27.4%	35.7%
P2: Great difficulty in affording professional home care service	16.4%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 70.1%	Not available
	Moderate: 61.5%	
	Severe: 51.4%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 14.4%	Not available
	Moderate: 60.0%	
	Severe: 101.7%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 99.3% without social protection, 85.7% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: YES	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 28.3%	Home: 28.8%
	Residential: 47.8%	Residential: 46.2%
	Cash: 23.9%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	1,116.6	Not available
C10: Existence of choice between care settings for people in need of LTC	YES	YES in 21 MS

Indicator (by dimension)	Slovenia	EU average
C11: Existence of choice between providers for people in need of LTC	YES	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	15.8%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 4.1%	Home: 5.5%
	Residential: 4.2%	Residential: 3.3%
	Cash: 7.1%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 17.9%	Home: 29.6%
	Residential: 18.3%	Residential: 17.7%
	Cash: 30.8%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	38.8%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 1.6%	7.4%
	Towns and suburbs: 8.5%	12.3%
	Rural areas: 7.2%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	Partial	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	Partial	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	Partial	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	Not available	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	Partial	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	100.0%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	90.4%	89.2%
C13: Share of LTC workers in full-time employment	87.3%	58.5%
C14: Share of LTC workers with permanent contracts	87.3%	83.8%

Indicator (by dimension)	Slovenia	EU average
C15: Share of LTC workers working shifts	70.6%	44.9%
C16: Non-fatal accidents at work in the care sector	2,847.7	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	NO	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	1.8	3.2
C17: Share of LTC workers aged 55+	23.9%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 70.7%	64.5%
	Nurses: 25.8%	29.0%
C19: Share of LTC workers in residential care	62.8%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 13.7%	18.7%
	Above 60 months: 47.8%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	73.0%	79.1%
C21: Share of LTC workers by educational level	Low: 12.9%	19.3%
	Medium: 71.0%	60.8%
	High: 16.1%	19.8%
C22: Share of women in the LTC workforce	82.7%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	14.5%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 20.4%	Women: 19.9%
	Men: 14.0% Total: 17.6%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 54.9%	Women: 72.5
	Men: 49.2%	Men: 61.4
	Total: 52.0%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	NO	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Low	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Spain	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 20.1%	65+: 21.3%
	75+: 10.0%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	28.8%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	0.8% of GDP	1.7%
	3.4% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 0.9%	1.8%
	Risk scenario: 1.0%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	Not available	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	YES	YES in 10 MS
C5: Monitoring of waiting times	YES	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	YES	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	54.1%	35.7%
P2: Great difficulty in affording professional home care service	22.5%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 29.9%	Not available
	Moderate: 41.6%	
	Severe: 52.2%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 21.3%	Not available
	Moderate: 61.5%	
	Severe: 92.4%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 99.3% without social protection, 97.6% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: YES	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 20.5%	Home: 28.8%
	Residential: 66.1%	Residential: 46.2%
	Cash: 13.4%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	854.2	Not available
C10: Existence of choice between care settings for people in need of LTC	Not available	YES in 21 MS

Indicator (by dimension)	Spain	EU average
C11: Existence of choice between providers for people in need of LTC	NO	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	28.9%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 3.9%	Home: 5.5%
	Residential: 2.8%	Residential: 3.3%
	Cash: 2.6%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 28.2%	Home: 29.6%
	Residential: 20.3%	Residential: 17.7%
	Cash: 19.4%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	48.0%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 5.2%	7.4%
	Towns and suburbs: 12.3%	12.3%
	Rural areas: 7.2%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	96.9%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	69.3%	89.2%
C13: Share of LTC workers in full-time employment	78.7%	58.5%
C14: Share of LTC workers with permanent contracts	78.9%	83.8%

Indicator (by dimension)	Spain	EU average
C15: Share of LTC workers working shifts	43.5%	44.9%
C16: Non-fatal accidents at work in the care sector	3,469.6	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	2.9	3.2
C17: Share of LTC workers aged 55+	23.8%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 86.9%	64.5%
	Nurses: 6.4%	29.0%
C19: Share of LTC workers in residential care	58.6%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 19.6%	18.7%
	Above 60 months: 43.2%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	80.3%	79.1%
C21: Share of LTC workers by educational level	Low: 25.6%	19.3%
	Medium: 44.5%	60.8%
	High: 30.0%	19.8%
C22: Share of women in the LTC workforce	92.1%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	10.8%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 44.5%	Women: 19.9%
	Men: 39.7% Total: 42.7%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 70.1%	Women: 72.5
	Men: 60.4%	Men: 61.4
	Total: 65.3%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

Indicator (by dimension)	Sweden	EU average
OVERARCHING		
C1: People aged 65+ and 75+ as a share of the total population	65+: 20.4%	65+: 21.3%
	75+: 10.3%	75+: 10.0%
C2: People 65+ with severe difficulties in ADL/IADLs as a share of the population aged 65+	12.3%	26.6%
C3: Total public expenditure on LTC as a share of GDP and of the total cost of ageing	3.2% of GDP	1.7%
	13.4% of total cost of ageing	7.1%
C4: Projected public spending on LTC as share of GDP in 2030	Baseline scenario: 3.5%	1.8%
	Risk scenario: 3.6%	2.0%
ADEQUACY		
L1: Maximum (legal) waiting time for services	YES	YES in 5 MS
L2: Maximum (legal) waiting time for needs-assessment	NO	YES in 10 MS
C5: Monitoring of waiting times	YES	YES in 6 MS
L3: Standardised procedure for LTC needs-assessment	YES	YES in all MS
C6: Clear categories of degrees of dependency	NO	YES in 15 MS
L4: Comprehensive evaluation (coverage) of LTC needs	YES	YES for 20 MS
	High level	High for 11 MS
P1: People in need of LTC not using (more) professional homecare services primarily due to cost	6.2%	35.7%
P2: Great difficulty in affording professional home care service	3.5%	12.1%
P3: Share of costs for home care covered by public social protection by severity level	Low: 89.7%	Not available
	Moderate: 97.0%	
	Severe: 98.4%	
P4: Out-of-pocket costs of home care as a share of income for care recipients aged 65+ by severity level	Low: 10.9%	Not available
	Moderate: 10.9%	
	Severe: 10.9%	
P5: Share of population aged 65+ who would be at risk of poverty after paying for out-of-pocket costs of home care for moderate needs	Moderate: 100.0% without social protection, 56.0% with	Not available
C7: Income-testing and asset-testing of LTC benefits	Income: YES	YES in 15 MS
	Asset: NO	YES in 8 MS
AVAILABILITY		
C8: Share of public LTC expenditure by setting	Home: 43.5%	Home: 28.8%
	Residential: 53.8%	Residential: 46.2%
	Cash: 2.6%	Cash: 25.0%
C9: Number of LTC beds (per 100,000)	1,299.3	Not available
C10: Existence of choice between care settings for people in need of LTC	NO	YES in 21 MS

Indicator (by dimension)	Sweden	EU average
C11: Existence of choice between providers for people in need of LTC	NO	YES in 21 MS
P6: Share of people aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months	29.8%	28.6%
P7: Share of population aged 65+ who receive public home care, residential care or cash benefits	Home: 10.8%	Home: 5.5%
	Residential: 2.5%	Residential: 3.3%
	Cash: 14.4%	Cash: 6.2%
C12: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits	Home: 109.6%	Home: 29.6%
	Residential: 25.2%	Residential: 17.7%
	Cash: 146.0%	Cash: 33.7%
P8: Share of people aged 65+ with unmet need for help with ADL/IADL with at least one severe difficulty in ADL/IADL	53.6%	46.6%
P9: People in need of LTC not using (more) professional home care services primarily due to poor availability, by degree of urbanisation	Cities: 3.2%	7.4%
	Towns and suburbs: 5.6%	12.3%
	Rural areas: 4.4%	10.4%
QUALITY		
L5A: Existence of rules regulating the use of (comprehensive, integrated, evolving and participatory) personal care plans	YES	YES for 20 MS
L5B: Such plans cover all LTC needs, are drawn up with the participation of the individual (or representatives) and are regularly updated	YES	YES for 17 MS
L6A: Existence of quality standards that apply to different care settings and to all types of providers	YES	YES for 19 MS
L6B: Existence of rules regulating quality-assurance in public and non-public providers	YES	YES for 18 MS
L7: Existence of quality-assurance bodies for all elements and types of LTC	YES	YES for 23 MS
L8: Existence of a procedure for complaints and the signalling of potential cases of abuse or neglect	YES	YES for 24 MS
WORKFORCE		
P10: Coverage of collective bargaining for LTC workers	99.9%	82.4%
P11: Mean gross hourly wages for LTC workers compared with other sectors	78.5%	89.2%
C13: Share of LTC workers in full-time employment	52.1%	58.5%
C14: Share of LTC workers with permanent contracts	74.7%	83.8%

Indicator (by dimension)	Sweden	EU average
C15: Share of LTC workers working shifts	57.5%	44.9%
C16: Non-fatal accidents at work in the care sector	1,582.7	2,635.0
L9: Ratification of ILO Domestic Workers Convention (No. 189)	YES	YES for 9 MS
P12: Number of LTC workers per 100 people aged 65+	10.4	3.2
C17: Share of LTC workers aged 55+	28.6%	26.7%
C18: Share of LTC workers who are personal care workers or nurses	Personal care workers: 89.2%	64.5%
	Nurses: 8.9%	29.0%
C19: Share of LTC workers in residential care	46.3%	63.3%
C20: Share of LTC workers by job tenure	Below 12 months: 22.7%	18.7%
	Above 60 months: 40.0%	44.9%
P13: Share of LTC workers who did not participate in education and training in the last four weeks	58.5%	79.1%
C21: Share of LTC workers by educational level	Low: 20.8%	19.3%
	Medium: 53.6%	60.8%
	High: 25.2%	19.8%
C22: Share of women in the LTC workforce	77.0%	86.8%
INFORMAL CARERS		
C23: Share of people providing informal care or assistance at least once per week on average	10.9%	17.0%
C24: Share of informal carers aged 45-64 providing high-intensity informal care (20h+ per week)	Women: 22.5%	Women: 19.9%
	Men: 9.9% Total: 17.9%	Men: 13.0% Total: 17.1%
C25: Share of informal carers relying on formal care services at least once per week	Women: 79.2%	Women: 72.5
	Men: 58.7%	Men: 61.4
	Total: 69.3%	Total: 66.8
L10: Existence of a legal definition of informal carer and/or legislation in place to identify informal carers	YES	YES for 17 MS
L11: Existence of support available to informal carers (respite care, training, counselling and care leave)	Medium	High for 6 MS
L12: Existence of compensation available for informal carers (social protection and/or adequate financial support)	Partial	YES for 5 MS

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