

Chapter 6

Living conditions in later life

This chapter analyses living conditions later in life. The first section focuses on regional differences and shows that there are both large regional differences within countries in the share of the older population and in access to health and transport services for the elderly. The second section deals with living conditions and well-being among the over-80s. Current generations are better off than previous generations in several dimensions of well-being. At the same time a larger share of the over-80s live alone or with a frail partner, which heightens the risks of poverty and depression. Finally, the third section focuses on long-term care (LTC). As people age, the likelihood of being in need of LTC increases. Inequalities which have accumulated over the life course are magnified in countries where the costs of LTC borne by poorer individuals are not well covered by social protection systems. This implies that in some countries people who have LTC needs might have those needs unmet or in addition fall into poverty.

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

Key findings

- Large inequalities are observed in access to health and transport services, with strong regional variations within countries.
- Living a very long life will become the norm. The probability of surviving to age 85 will increase from 50% today to 75% by 2100 for men (born today), and from 64% to 83% for women.
- The share of people living alone after age 80 has increased in most countries. Women older than 80 years are at least twice as likely to live alone as men, while living alone is associated with higher poverty risks. Women are more likely than men to report struggling with the instrumental activities of daily living, weighing on their capacity to lead independent lives.
- Long-term care needs risk exacerbating inequalities that start earlier in life. People on low income are more likely to need long-term care. Formal home care services remain unaffordable for people with low income in several countries. High “out-of-pocket” costs may create an incentive for them to go into institutional care, as with severe needs they generally access institutional care.
- Women bear most of the costs of providing informal long-term care. In countries with better social protection for long-term care services, rates of informal care are lower, and gender inequality in caring is smaller. Higher female labour force participation may not mean lower informal caregiving rates.

Introduction

This chapter focuses on living conditions later in life. In particular it focuses on regional differences, general living conditions of the population older than 80 and long-term care (LTC). Regional differences in the share of the older population are very large within many OECD countries. Combined with a wide disparity in availability of health services across regions, this reveals that access to health services for the elderly is problematic in some of them. Recently, rural areas have aged faster than urban areas, which is likely to stretch health services and public transport to their limit and amplify the risks of isolation. Given that health and social inclusion is crucial to older people’s well-being, the regional differences in ageing and access to health services and public transport poses serious challenges.

The share of the population aged 80 and over is expected to more than double by 2050 on average across OECD countries. While more people reach that age, the over-80s are in better health than previous generations. However, a large fraction of the elderly report depressive symptoms, while caring for a frail partner at older ages is likely to become more frequent, thereby putting a strain on mental and physical well-being. Moreover, a high proportion of women aged 80 and over live alone, which combined with a persisting gender pension gap (Chapter 5), increases the risk of falling below the poverty line.

As people age the likelihood that they need long-term care (LTC) increases. Inequalities that have cumulated over the life course are magnified if the costs of LTC borne by poorer individuals are not well covered by social protection systems. Indeed, these costs – either financial or non-financial or both – can be high. The proportion of home care costs covered by social protection systems differs widely across countries. This implies that in some countries people who have LTC needs might in addition fall into poverty, choose not to have those needs met or opt for institutional care. Going into institutional care is typically not people’s first choice, but in many OECD countries the costs of institutional care are better covered than costs of home care. This chapter also highlights substantial inequalities in the provision of informal care across genders. While the specific design of health

services for the old might differ by country, by region and over time, the increasing share of the elderly and the wide disparity of living standards among them increase the need for accessible health services and a well-designed LTC system.

1. Spatial inequalities in ageing populations

Around the globe societies are ageing. This affects sustainable development at national and regional levels. By 2050, 25% of the world's population will be over 65 years old, compared to less than 8% in 1950. Demographic changes have profound implications for the fiscal, economic and social health of societies as a whole. Yet, they also affect regions within countries in widely differing ways. Understanding the regional dynamics of population ageing helps identify complementary policies that can help prevent unequal ageing.

Ageing trends and services critical to well-being of older people differ widely from region to region within countries. Differences in old age shares in countries' lower-tier regions (Territorial Level 3 [TL3]; Box 6.1) were actually larger than differences between country averages of old age dependency ratios in 2014. Additionally, access to health services and public transport differs widely by region. This leaves some regions with high shares of older people but limited services to guarantee a high quality of life.¹

Box 6.1. Description of OECD territorial levels

The OECD divides subnational regions in its 35 member countries into two territorial levels that match administrative jurisdictions. Territorial Level 2 (TL2) denotes the upper administrative tier of subnational government, and Territorial Level 3 (TL3) the lower tier. Or, put differently Territorial Level 2 consists of macro-regions, while Territorial Level 3 is composed of micro-regions. Across the OECD, there are 391 large TL2 regions, e.g. Ontario Province in Canada, which contain the 2 197 TL3, or small, regions. For example, the TL2 region of Aquitaine in France contains five TL3 regions: Dordogne, Gironde, Landes, Lot-et-Garonne and Pyrénées-Atlantique. TL3 regions match administrative jurisdictions in all OECD countries, with the exception of Australia, Canada, and the United States. TL2 and TL3 apply only to regions that lie within national borders.

This regional typology – which, for European countries, is broadly consistent with the Eurostat NUTS 2010 classification – makes it easier to compare geographic units at the same territorial level. The two levels are officially established and relatively stable in all OECD member countries, and most use them as a framework for implementing regional policies.

Source: OECD (2016), *OECD Regions at a Glance 2016*, OECD Publishing, Paris, http://dx.doi.org/10.1787/reg_glance-2016-en.

Ageing trends at the regional level

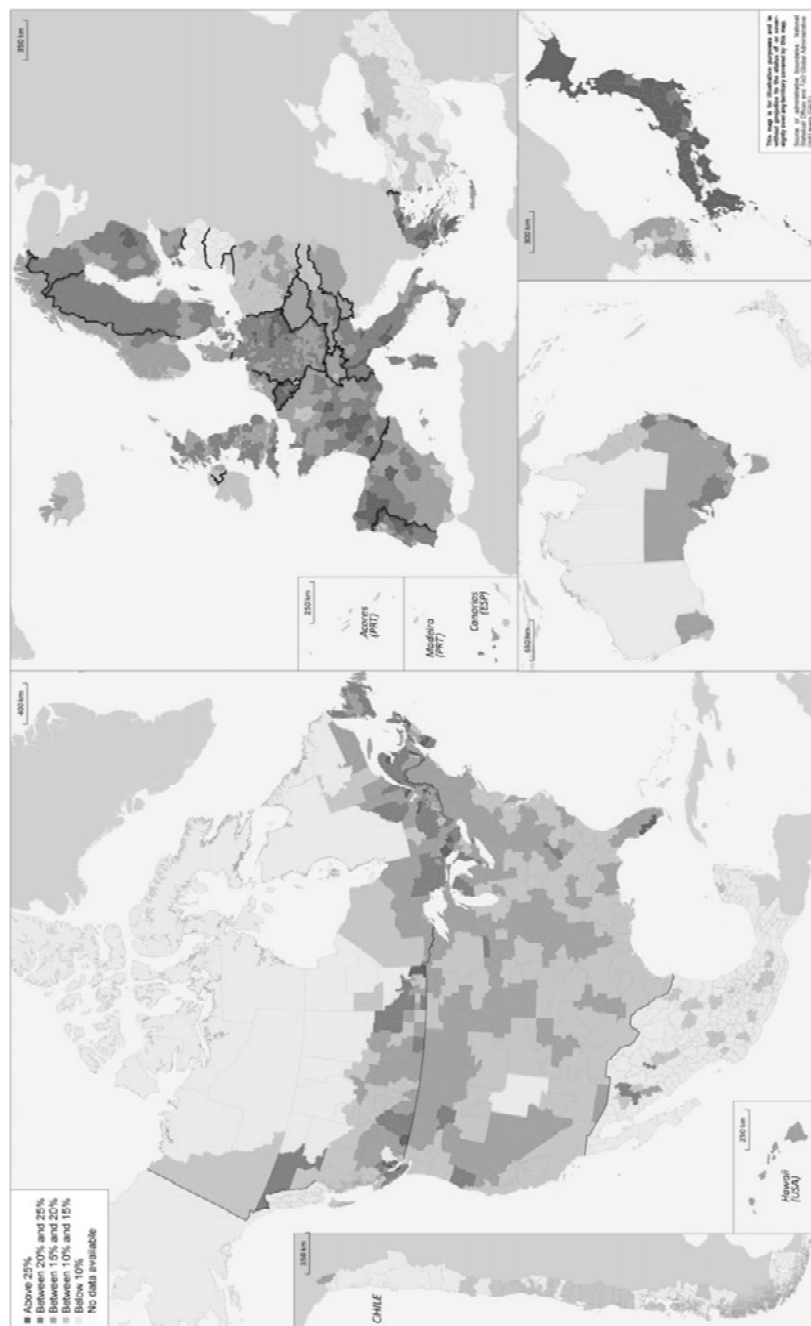
OECD analysis of ageing at the TL3 national level reveals substantial differences in the population shares of older people in regions and in the rates at which populations age. For example, the elderly account for higher proportions of predominantly rural regions, while mainly urban ones aged faster between 2000 and 2014. Spatial variations have major implications for differences in elderly people's quality of life and for economic development, inclusiveness and, ultimately, equity in the distribution and accessibility of services critical to well-being.

Regional shares of the older population in OECD TL3 regions

The average share of the old-age population in OECD countries and their regions is 16%.² Behind that average, though, lie wide variations, ranging from 6% in Mexico to 26% in Japan. The share of the old-age population also exceeds 20% in Italy, Germany and Greece, while Chile and Turkey are comparatively younger with 10% and 7%, respectively. At both national and regional levels, populations are noticeably younger in Central and Eastern Europe, the Americas and Oceania (Figure 6.1).

Figure 6.1. The share of older people varies widely between regions and countries

Shares of populations aged 65 and above in OECD Territorial Level 3 regions, 2014



Source: Calculations based on the *OECD Regional Database*.

In 2014, differences were actually greater at the TL3 regional level within OECD countries than between them (Figure 6.2). The populations of some subnational regions had very low shares of older people (e.g. 2% in the Chilean region of Antártica Chilena), while as many as one in three people was aged 65 and over in others (e.g. 33% in Greece's Evrytania region). The percentage-point difference between regions with the

lowest and highest shares of older people in their populations was widest in Spain, Mexico, Australia, the United States, the United Kingdom, Portugal and Canada – about 20 points (Figure 6.2).³ In Spain, the share of the old-age population ranged between 9% in the region of Fuerteventura and 30% in Orense.

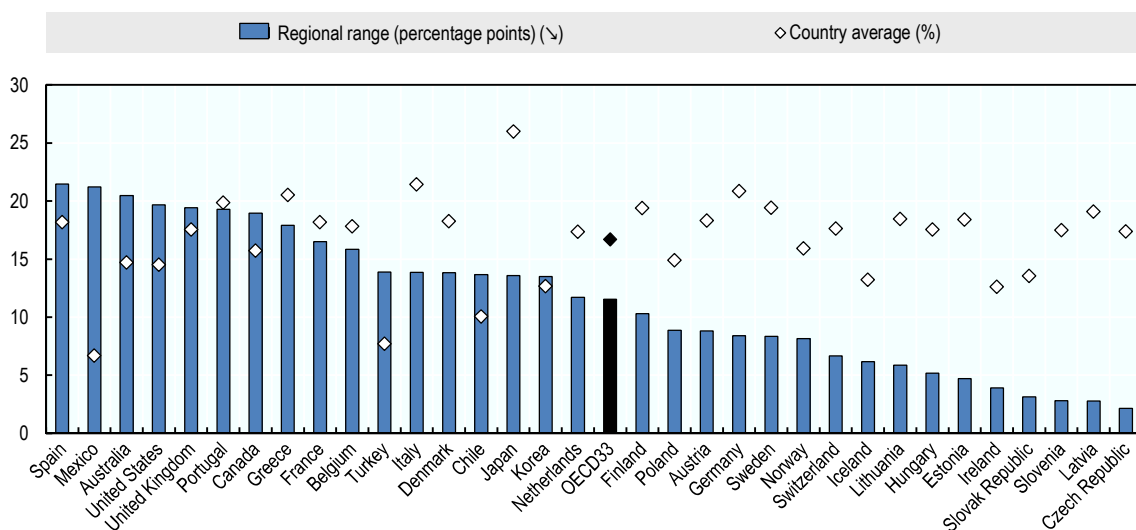
The regions in OECD countries with the highest shares of older people and which substantially exceeded national averages were (in descending order):

- Evrytania in Greece, 33%
- Akita in Japan, 32 %
- Halliburton (Ontario) in Canada, 31%
- Orense in Spain, 30%
- Beira Baixa in Portugal, 29%
- Savona in Italy, 28%.

Generally, regional variations in elderly shares of the population are narrowest in Central and Eastern European countries. Ireland’s old-age population is also relatively evenly distributed, with regional variations not exceeding 5 percentage points.

Figure 6.2. The share of older people varies a lot between regions within countries

Differences between the regions with the highest and lowest shares of older people (65 years and above) in their populations, 2014



Note: “Regional range” (y axis) measures the difference between the region with the highest and the region with the lowest share of the older population within each country.

Source: Calculations based on *OECD Regional Database* (2016).

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Growth in old-age populations

Over the 2000-14 period, OECD countries experienced an average 2.7 percentage-point growth in the population shares of older people. There were, however, wide regional variations in the pace of growth, especially in Canada, Belgium, the United States, and Spain. In Canada, for example, the elderly share declined by 3 percentage points in the Division 2 region in Saskatchewan, while increasing by 17 percentage points in Stikine, British Columbia. By contrast Central and Eastern European countries – particularly Latvia, Lithuania and the Slovak Republic – showed very narrow interregional differences. In the Slovak Republic, for example, the increase in the elderly share of its population ranged from 1.6 percentage points in the Prešov Region to 3.2 in Trenčín.

Overall, 14 OECD countries have regions where the shares of older people declined between 2000 and 2014. The trend was particularly marked in Germany, Norway, Spain, and the United States, with the steepest decline – 5 percentage points – coming in the Spanish region of Guadalajara.⁴ Most regions where the elderly share declined by more than 1 percentage point were predominantly urban (see Box 6.2 for the typology of TL3 regions).

Box 6.2. Typology of OECD Territorial Level 3 regions

Traditionally the OECD classifies Territorial Level 3 (TL3) regions as “predominantly urban” (PU), “intermediate” (IN), or “predominantly rural” (PR). The typology is based on the percentage of a regional population living in rural communities, combined with the existence of urban centres where at least one-quarter of the regional population resides. An extended regional typology distinguishes between rural regions that are located close to larger urban centres and those that are not. The result is a four-fold classification of TL3 regions:

- predominantly urban (PU)
- intermediate regions (IN)
- predominantly rural regions close to a city (PRC)
- predominantly rural remote regions (PRR).

The distance from urban centres is measured by the time it takes a certain share of the regional population to travel by road to an urban centre with at least 50 000 inhabitants. Due to lack of information on road networks and service (or catchment) areas, the extended typology has not been applied to Australia, Chile or Korea.

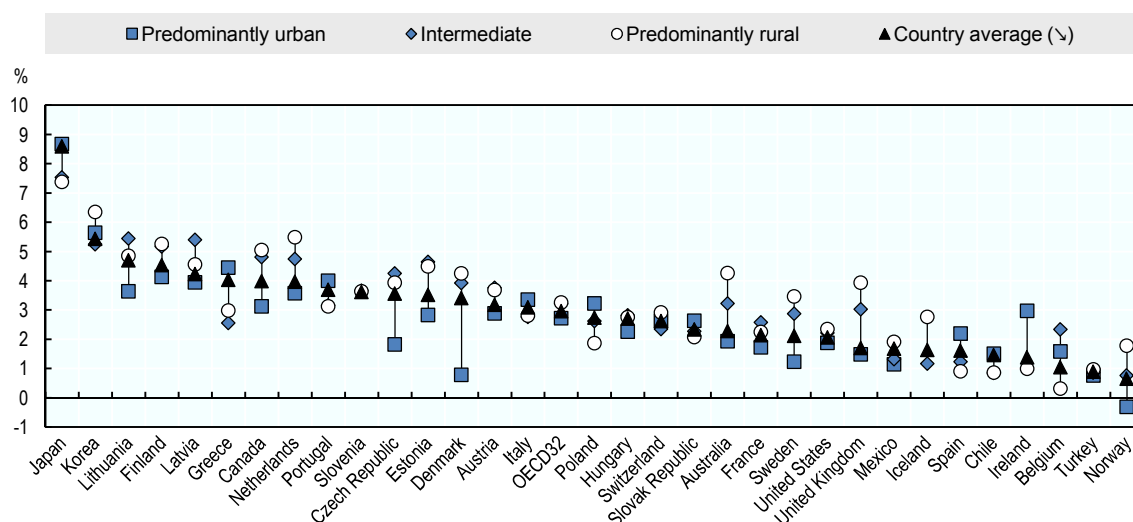
Source: Brezzi, M., L. Dijkstra and V. Ruiz (2011), “OECD Extended Regional Typology: The Economic Performance of Remote Rural Regions”, *OECD Regional Development Working Papers*, No. 2011/06, OECD Publishing, Paris, <http://dx.doi.org/10.1787/5kg6z83tw7f4-en>.

Older population growth by type of region

Growth in the share of the older population by type of TL3 region between 2000 and 2014 reveals that populations aged at a slightly faster pace in predominantly rural regions (Figure 6.3). In Korea, the Netherlands, Denmark, Australia, Sweden, the United Kingdom, and Norway, the share of older people grew more steeply in predominantly rural regions than in urban ones. However, in a number of countries – e.g. Greece, Poland, Spain and Ireland – the share of older people in total population grew faster in predominantly urban regions.

Figure 6.3. Predominantly rural regions are ageing slightly faster

Changes in the share of the older population, 2000-14, by regional type, percentage



Source: Calculations based on *OECD Regional Database* (2016).

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Concentrations of older populations in the TL3 regions of OECD countries

Is the older population concentrated in a small group of regions? According to the Normalised Herfindahl-Hirschman Index (NHHI) – a commonly used measure of concentration ranging from 0 (homogenous distribution) to 1 (extremely concentrated) (Box 6.3) – the spatial concentration of older people in TL3 regions in the year 2014 remained moderate across the OECD (Figure 6.4), with the NHHI below 0.12 everywhere except Iceland (see the note to Figure 6.4). Moreover, there was no substantial divergence between spatial concentration of older people and the under-65s. The overall levels of concentration of both older and younger populations had remained almost unchanged since 2000 and broadly similar in terms of gender in 2000 and 2014.

Box 6.3. Definition of the Normalised Herfindahl-Hirschman Index

The Herfindahl-Hirschman Index (HHI) is commonly used to measure the market concentration of firms, but may also be used to assess the regional concentrations of other variables in a country. The HHI ranges from 0 (homogeneous distribution) to 1 (concentrated in a single region). To account for differences in the number of regions in each country the Normalised Herfindahl Hirschman Index (H^*) is applied. With H^* it is possible to compare countries which have different numbers of regions. It is computed as follows:

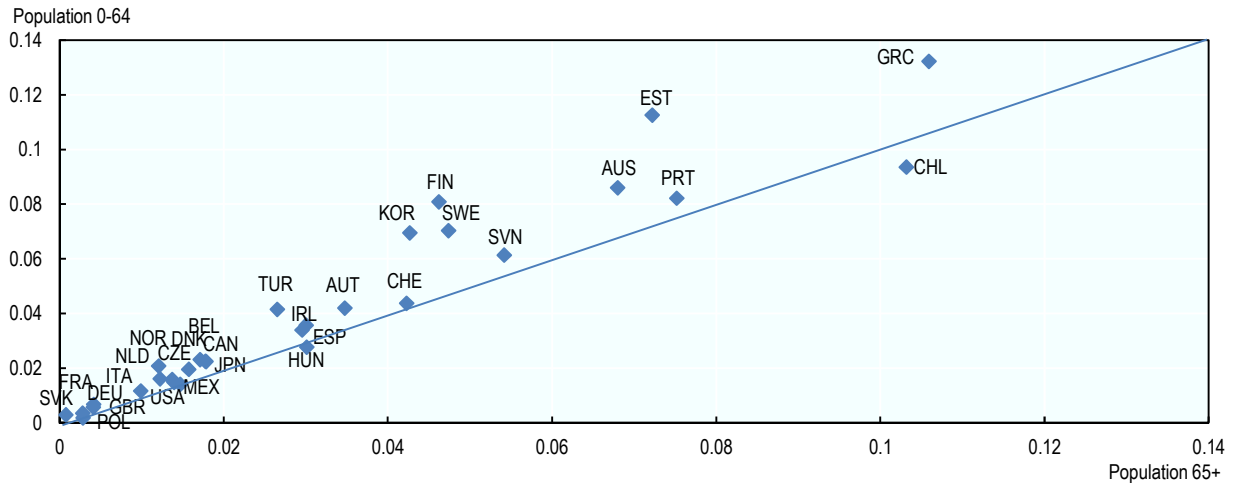
$$H^* = \frac{H - \left(\frac{1}{N}\right)}{1 - 1/N}$$

where H is the sum of the squared share of the older population in each region relative to the older population in the country concerned, and N refers to the total number of regions in a country.

Source: Cracau, D. and J. Lima (2016), “On the Normalized Herfindahl-Hirschman Index: A Technical Note”, *International Journal on Food System Dynamics*, Vol. 7, No. 4, pp. 382-386.

Figure 6.4. The regional concentration of older people is moderate

Concentration in TL3 regions of 65-and-overs and under-65s, 2014, normalised Herfindahl Index



Note: Iceland is not included in the figure for reasons of visibility. With the Normalised Herfindahl-Hirschman Index, Iceland shows strong spatial concentrations of 0.32 among people aged 65 and over and 0.35 for those aged under 65.

Source: Calculations based on the *OECD Regional Database* (2016).

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Uneven access to health services

Accessibility to services is a critical component of well-being and equality, and health services are particularly important when it comes to older people's well-being. The accessibility of health services shows strong spatial patterns, hence the need for a sub-national approach when using it as an indicator of unequal ageing. Physical obstacles to accessing health care services not only translate into higher user costs, they may even contribute to higher rates of morbidity. Because very old people are most affected by poor accessibility, they pay the price of higher costs, possibly with their lives.

Removing impediments that hinder access to health care providers and addressing capacity shortages could enable older people to lead self-determined lives (OECD, 2014). The accessibility of a doctor or hospital is determined not only by physical proximity, but by adequate ratios of physicians and health care facilities to numbers of older people. Regional disparities in ratios increase inequality when the elderly in some regions can no longer see a doctor or receive stationary medical treatment in a timely manner.

The availability of physicians is positively related to a region's life expectancy at birth – an effect that remains significant even when controlling for GDP per capita (OECD, 2014). While the number of active physicians per 1 000 older people is a measure of capacity rather than accessibility, it is nevertheless a relevant proxy for access to adequate health care services as an indicator of interregional old-age inequality.

From a territorial perspective, one of the first questions to address is whether a region's older people are served by adequate health care services in the locality where they live. Information on how low numbers of physicians or poor hospital capacity restrict elderly access to health care services could then be a key input for use by local authorities as they design and implement policies that address disparities in access to

basic public services. For instance, preventive health care or the use of nurse practitioners can help alleviate strained health care services in difficult to service regions. However, they cannot fully replace doctors and hospitals and a more comprehensive approach is needed to improve health care service access.

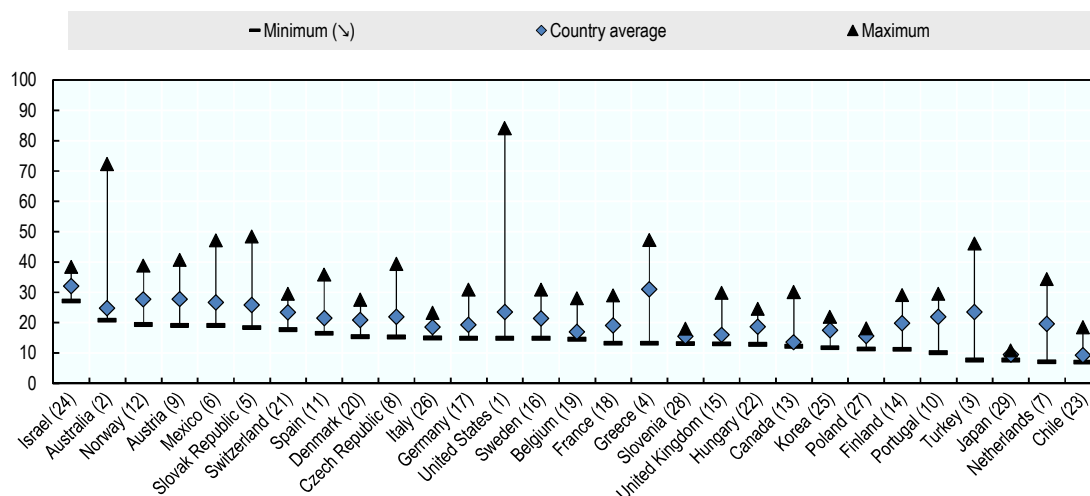
Ratios of active physicians and hospital beds to older people vary widely by TL2 regions

In TL2 regions where older people account for high shares of the population, an adequate provision of physicians is important, as health generally deteriorates with age, so increasing demand for medical care.⁵ However, regional distributions of hospital beds and doctors do not match the localities where older people live in most OECD countries. Accordingly, ensuring they can access health care services and improving their health outcomes is becoming a growing concern in many regions.

The widest gaps between the lowest and highest ratios of active physicians to 1 000 older people in TL2 regions are found in the United States, Australia and Turkey (Figure 6.5). In the United States in 2013, the gap ranged from 14 physicians per 1 000 older people in the state of Iowa to 82 in the District of Columbia. In Australia, the region with the highest ratio was the Northern Territory with 72, while the lowest was Tasmania with 20 doctors per 1 000 elders. As for Turkey, Ankara boasted a ratio of 46/1 000, against just 7/1 000 in the Western Black Sea – Middle and East. Very low ratios of far below ten physicians per 1 000 older people were also found in the Chilean region of O'Higgins, Iwate in Japan, and Zeeland in the Netherlands.

Figure 6.5. Large regional disparities in the ratio of active physicians to older people

Ratio of active physicians to 1 000 older people, Territorial Level 2 regions, 2013



Note: Latest available years: Chile and United States 2009; Belgium, Canada, Japan and Luxembourg 2010; Greece and Mexico 2011; Australia, Israel, Italy and Sweden 2012. Number in brackets indicates ranking according to range. For example the United States is the country with the largest regional difference, measured by the gap between the regions with the maximum and the minimum ratio of active physicians.

Source: Calculations based on the *OECD Regional Database*.

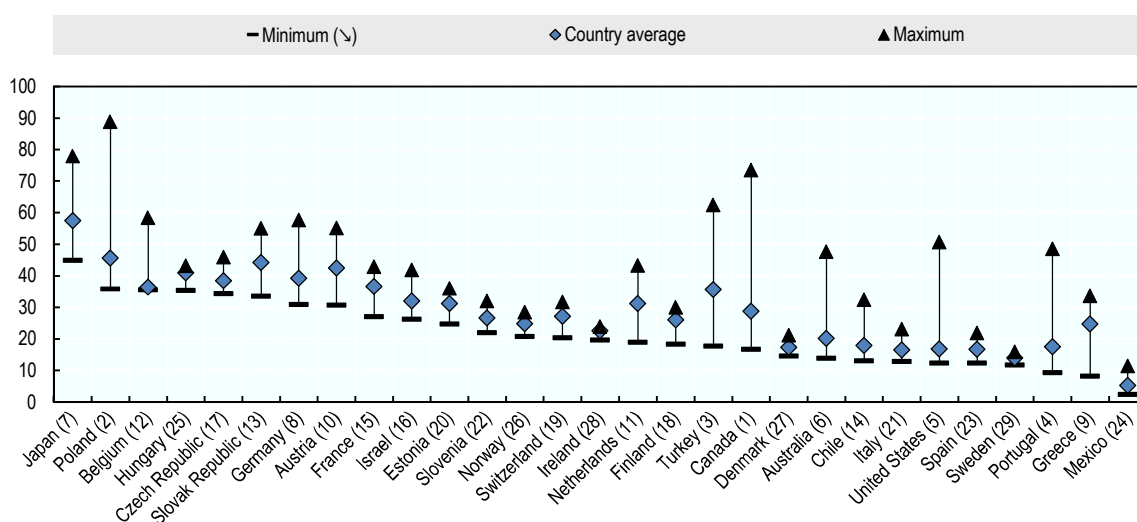
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The greatest regional disparities in the number of hospital beds per 1 000 older people in 2014 came in Canada, Poland, Turkey, Portugal and the United States (Figure 6.6). In Canada, for example, the number of beds ranged from 16 in the Yukon region to 73 in the Northwest Territories. The narrowest was in Sweden, albeit at low levels, with 11 beds in North Middle Sweden to 16 in Upper Norrland.

When it comes to regions where the hospital bed and active physician indicators were high, Australia's Northern Territory stood out for its high ranking on both counts – it boasted 47 hospital beds and 72 active physicians. Portugal's Alentejo region, by contrast, had very few hospital beds or physicians – respectively, 9 and 10 per 1 000 older people.

Figure 6.6. Large regional disparities in the ratio of hospital beds to older people

Number of hospital beds per 1 000 older people, Territorial Level 2 regions, 2014



Note: Number in brackets indicates ranking according to range; e.g. Canada has the largest range across regions.

Source: Calculations based on the *OECD Regional Database*.

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Physical proximity to health care services

A second stage in the territorial approach to assessing unequal access to health care services is to look at how physically near or far health care services are to older people's places of residence. How fast they can get to a hospital is determined by a combination of local factors such as topography, population density, levels of congestion and the regional road infrastructure. The location of the closest hospital and how to reach it are of prime importance, as are regional transport networks. In this analysis, the physical accessibility of health care facilities is measured by the percentage of the older population who may access a hospital within 20 minutes by road.⁶

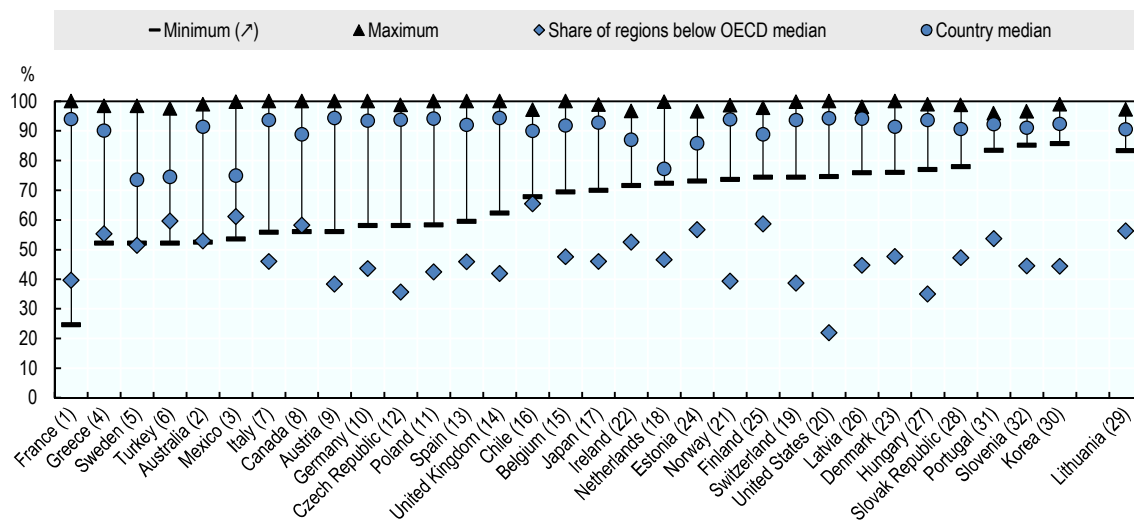
Examination of physical proximity to the nearest hospital reveals stark differences between TL3 regions. The difference between regions is widest in France at 74 percentage points and narrowest in Slovenia with 11 (Figure 6.7). In regions where hospitals are most easily accessible, almost all older people can reach one within 20 minutes by road. This is typically the case in regions of high population density. In

France's Paris region, for example, everyone lives within a 20-minute drive of a hospital, and 98% of the older population do in the United States' Miami-Fort Lauderdale-Miami Beach region.

Unsurprisingly, remoteness from hospitals is observed mostly in rural regions. In the Corrèze region of France, for instance, only 25% of the elderly can get to a hospital by road within 20 minutes. The United States is the OECD country which boasts, at 21%, the lowest percentage of regions where the physical accessibility of hospitals is below that of the OECD median region, in which 88% of older people live within a 20-minute drive of a hospital. At 65%, Chile has the highest percentage.

Figure 6.7. Physical access to a hospital is difficult for older people in some regions

Disparities between Territorial Level 3 regions in the share of older people who can reach a hospital within 20 minutes by road, 2014



Note: Public and private hospitals are considered. Number in brackets indicates ranking according to range; e.g. France has the largest range across regions.

Source: Open Street Map Contributors (2016); *OECD Regional Database* (2016); authors' own calculations.

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Access to public transport

Accessible public transport services⁷ are a critical component of any strategy to reduce spatial inequalities and increase quality of life for all members of society. Improving the proximity, availability and affordability of public transport services, for example, makes it easier to find and keep jobs and reduces travel costs (OECD, 2014). For older people, accessibility is critical to their integration in society. It is of particular importance with regard to health care, social services, housing and involvement in the local community (Frye, 2011). Difficulty in accessing transport services may cause social exclusion of certain groups (OECD, 2014), particularly older people. As their ability to drive fades with age, their autonomy may be further impaired (OECD, 2015a).

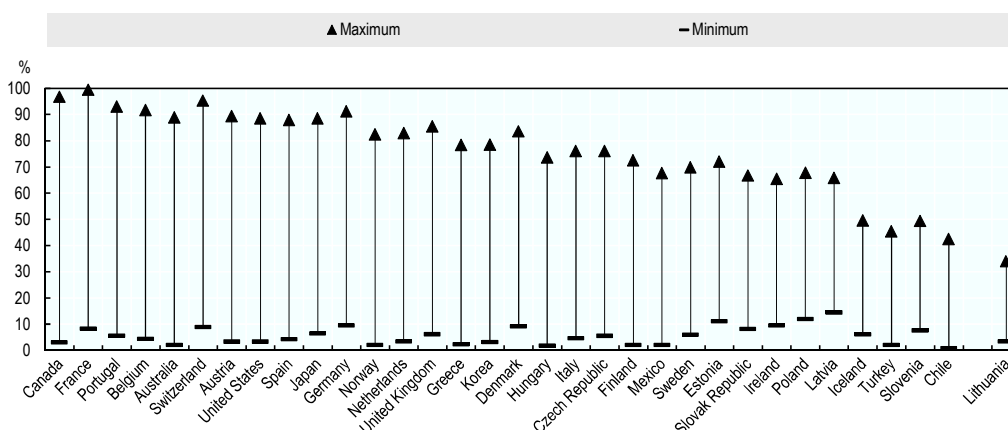
There are wide differences between TL3 regions in shares of older people residing within walking distance of public transport stations and stops in OECD countries. Disparities are particularly pronounced between, on one hand, regions that are home to

major urban centres or capital cities and, on the other, very rural remote regions. As a result, interregional differences between the highest and lowest public transport accessibility rates vary widely (Figure 6.8). In Germany, for example, the share of the older population living within walking distance of a public transit stop – where walking distance is the average distance an older person can walk in ten minutes – ranges between 82% in the München Kreisfreie Stadt region to as little as 4.5% in the region of Ostprignitz-Ruppin. In other countries, such as Lithuania, interregional differences are somewhat less pronounced. However, the overall regional share of Lithuania's older population who enjoy walkable access to public transport stops is among the lowest in the OECD and does not exceed 35%.

Not surprisingly, the highest shares of older people who can walk to public transport stops are in regions with high population densities, where agglomeration economies make public transport more cost-efficient. However, even between regions that host large urban agglomerations, sharp differences in the accessibility of public transport may be observed. For example, while in Barcelona (Spain) 85% of older people live within walking distance of a public transport stop, that share is only 67% in the Stockholm region of Sweden.

Figure 6.8. Large regional disparities in the access of older people to public transport

Shares of living within walking distance of public transit stops, Territorial Level 3, 2014



Note: Countries are ranked according to the difference between the regions with maximum and minimum access.

Source: Open Street Map Contributors (2016); *OECD Regional Database* (2016); authors' own calculations.

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In some rural TL3 regions, the share of the elderly population living within a ten-minute walk of the closest public transport stop is extremely low. For example, it is only 2% in Chile's Petorca region and Canada's Mount Waddington. Both are very sparsely inhabited, with population densities of less than ten people per km². Technological changes such as self-driving cars may help ease some mobility constraints faced by older people in low-density areas. Nevertheless, access to transport services remains a critical issue for the elderly, particularly in remote rural areas, as they grow less autonomous with age and increasingly prone to isolation. Restricted access to services is also a major challenge in urban areas (OECD, 2014).

2. Living conditions and well-being among the over-80s

The over-80s are better off than previous generations in many, though not all, dimensions of well-being. First they represent a greater share of a given cohort reaching that age, and those who reach 80 now live longer than a few decades ago and few suffer from severe activity limitations (see below). They are also more likely to live independently and sustain their autonomy for longer.

However, more over-80's also live alone or with a frail partner, which heightens the risks of poverty and depression. Older women are especially vulnerable. Women live longer on average and frequently survive the death of a partner. At the same time women's careers are typically shorter (see for instance Chapter 5), female wages are lower and a larger share of care activities are carried out by women (Section 4 and OECD, 2017), leading to lower pensions and a higher incidence of poverty among older women. They are also more prone to physical challenges and more likely to report depressive symptoms, live alone, and experience poverty.

There is considerable uncertainty over the future of the over-80s' living conditions and well-being. On the one hand, women are increasingly working throughout the course of their lives and earning personal income, which increases their eligibility for old-age pensions and reduces the risk of living below the poverty line. On the other hand, a significant fraction of men and women in their late-50s report middling or bad health (Chapter 2) and may continue to suffer from poor health as they age.

Changes in families and living arrangements have affected the living conditions and well-being of the elderly, both positively and negatively. And the rapid change in the age structure of populations is exerting more pressure on fewer children to care for their elderly parents. Working adults will need work in proximity of their ageing parents, flexible working schemes if they are to be able to look after ageing parents on top of their childcare commitments. Frail elderly people, either living alone or with a frail partner for longer than they do today, will also require greater support.

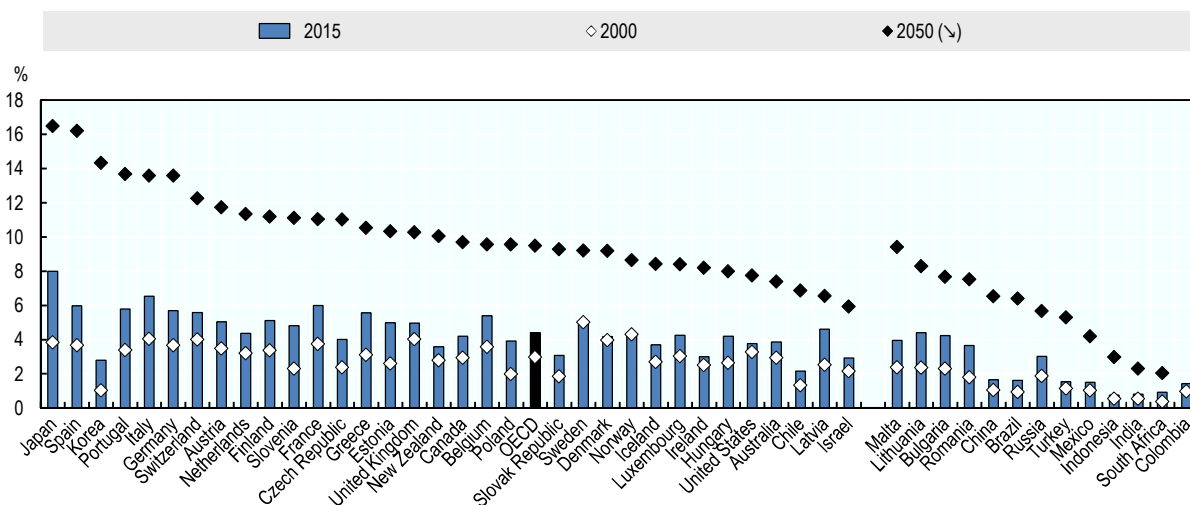
The share of the over-80s in the total population is growing ever faster

Gains in life expectancy are the key factor behind population aging, of which one of the most important consequences has been the spectacular increase over recent decades in the proportion of people aged 80 and over in the populations of OECD countries. The share of over-80s is projected to more than double by 2050, when it will account for an average of 9.5% of the OECD's total population – and up to 16% in Japan and Spain (Figure 6.9). In 2015, by contrast, the over-80s accounted for less than 1% of the population in Indonesia, India and South Africa.

Gains in life expectancy beyond the age of 80 in the 1970s were attributable chiefly to progress in the prevention of cardiovascular diseases which furthered the decline in mortality rates in old age (Meslé and Vallin, 2002). Over the past 15 years, and possibly longer, 80-year-olds' average life expectancy has continued to climb steadily in OECD countries (all of which lie above the diagonal in Figure 6.10, Panel A). Moreover, healthy life expectancy at birth is closely correlated with life expectancy at 80 years old (Panel B), which suggests that better living conditions from birth are conducive to longer lives (Oeppen and Vaupel, 2002; Vallin and Meslé, 2010; Chernew et al., 2016).

Figure 6.9. The share of people older than 80 years will continue to grow

Percentage of the population aged 80+



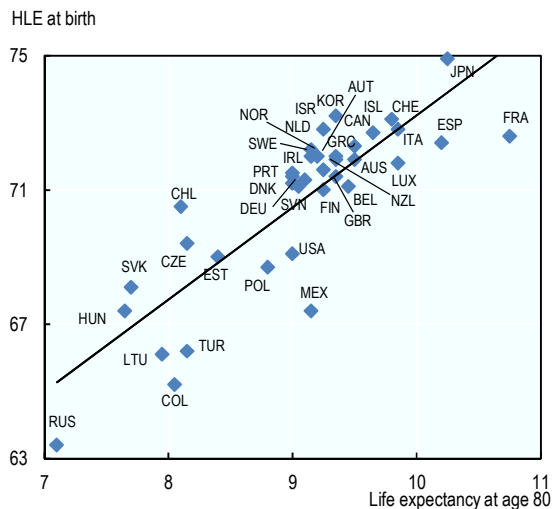
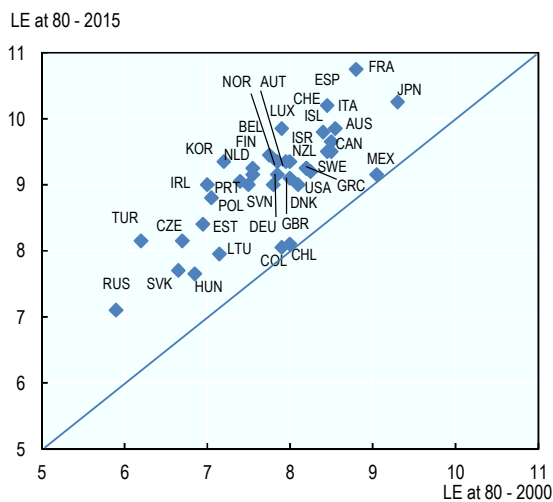
Source: OECD historical population data and projections.

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Figure 6.10. Life expectancy at the age of 80 has risen steadily

Panel A. Life expectancy (LE) at the age of 80 has risen steadily, 2000-15

Panel B. Healthy life expectancy (HLE) at birth is closely correlated with life expectancy at 80 years old, 2015



Source: OECD Health Data and WHO data on healthy life expectancy.

StatLink <http://dx.doi.org/10.1787/888933568262>

Health and the ability to function are determinants of well-being among the over-80s

Heart disease, obesity and depression impair health and well-being

Health status is a fundamental dimension of elderly well-being, though it deteriorates with age, even among the healthiest of those who survive beyond their 80s. The over-80s are more prone than any other age group to chronic disease or disabilities that curtail activities of daily living (ADL) (Box 6.4). At country level, higher incidences of strokes and lung diseases contribute to lower rates of survival to the age of 80 (Solé-Auro and Crimmins, 2013; Solé-Auro, 2016). However, there is no linear association in OECD countries between life expectancy at 80 years old and the general prevalence of chronic diseases, as both their incidence by age and the treatments they receive vary across countries (Solé-Auro and Crimmins, 2013).

Excess weight and obesity are health risk factors in all age groups, including the over-80s, as they heighten the likelihood of cardio-vascular problems and can limit the ability to perform ADLs. Prevalence among the over-80s varies markedly from country to country and, in some, by gender (Figure 6.11). A significant minority are obese in many countries – more than one in five men and women aged 80 and over in England, for example. Women are more likely to be obese than men in Spain, Estonia, the Czech Republic and Denmark.

Box 6.4. Assessing limitations on the ability to function

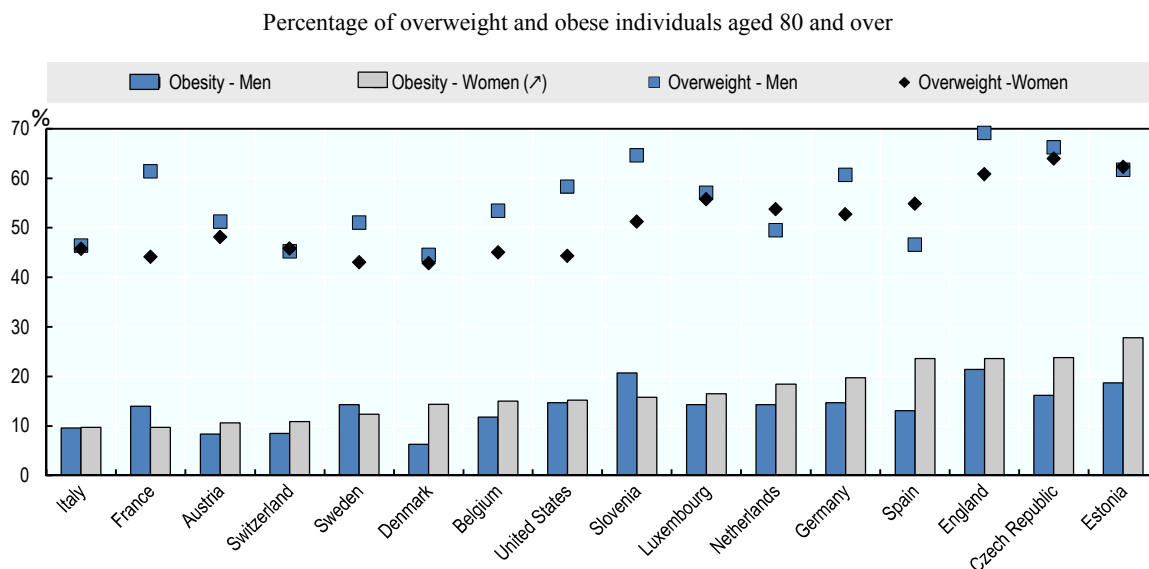
Self-reports of problems with the ability to function are assessed through responses to questions on activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

- There are six ADLs: bathing and showering, dressing, using the toilet, getting in and out of bed, walking across a room, and eating. The ability to perform all six ADLs equates to the ability to self-care. The extent of an individual's inability to function is measured by how many ADLs he or she has trouble performing.
- There are seven IADLs: handling transportation, making phone calls, shopping, preparing meals, taking medication, housework and basic maintenance, and managing finances. The ability to perform all seven equates to the ability to live independently. The extent of an individual's inability dependence is determined by how many IADLs he or she struggles to perform.

The Mobility Index measures mild and severe forms of functional limitations related to walking and climbing stairs, e.g. walking across a room, walking 100 meters, climbing one or several flight of stairs without stopping to rest, and climbing.

The Global Activity Limitation Index (GALI) assesses an individual's long-standing limitations in everyday activities due to a health problem. The individual is asked to rate to what his or her health problem is a limitation. GALI encompasses both severe and mild restrictions on activities.

Smoking is another major risk factor, though only a small proportion of over-80s report smoking – an average of 5% of women and 8% of men, though the figure is as high as 18% of men in Denmark and Spain. However, a high share of men (58%) and women (22%) in the 80+ age group have been smokers, which may affect their health in old age.

Figure 6.11. Prevalence of excess weight and obesity among the 80+ varies markedly across countries

Source: Börsch-Supan (2016); 2006 English Longitudinal Study of Aging; United States Health and Retirement Study 2006 as cited in Sole-Auro (2016); Solé-Auro and Crimmins (2013).

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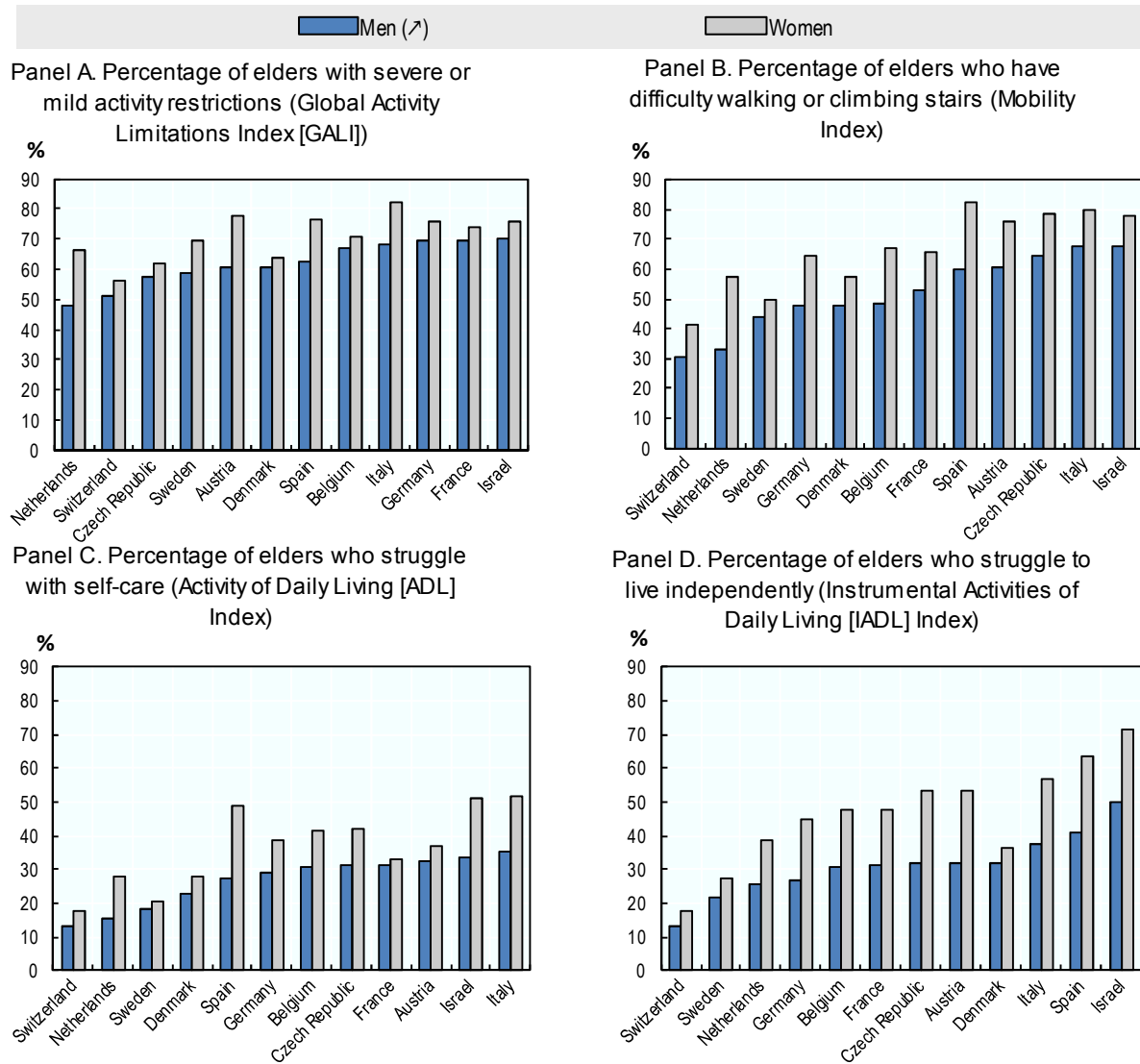
Women are more likely than men to experience physical limitations

Although most people of 80 and over grow old without suffering from any severe disability, the probability of physical and mental dependency increases with age, often making assistance on a daily basis essential. The incidence of functional limitations among the over-80s is lowest in the Netherlands, Sweden and Switzerland, and highest in Spain, Italy, Greece and France despite their comparatively high life expectancies.

The proportions of over-80s affected by some physical limitations (Figure 6.12, Panel A) or reduced mobility (Panel B) are high in all countries considered in Figure 6.12, as they encompass a wide range of possible problems (Box 6.4). However, people who report struggling with self-care (i.e. the ability to perform activities of daily living, ADLs) account for much lower shares of the over-80s (Panel C). In Israel and Italy, however, more than one-third of men and over 50% of women suffer from limitations that impair their self-care ability. Women are also more likely than men to report struggling with the instrumental activities of daily living (IADLs), which indicates that they have trouble leading independent lives (see Panel D).⁸ By contrast, the proportion of men and women with IADL-related difficulties is comparatively low in the Netherlands, Sweden and Switzerland.

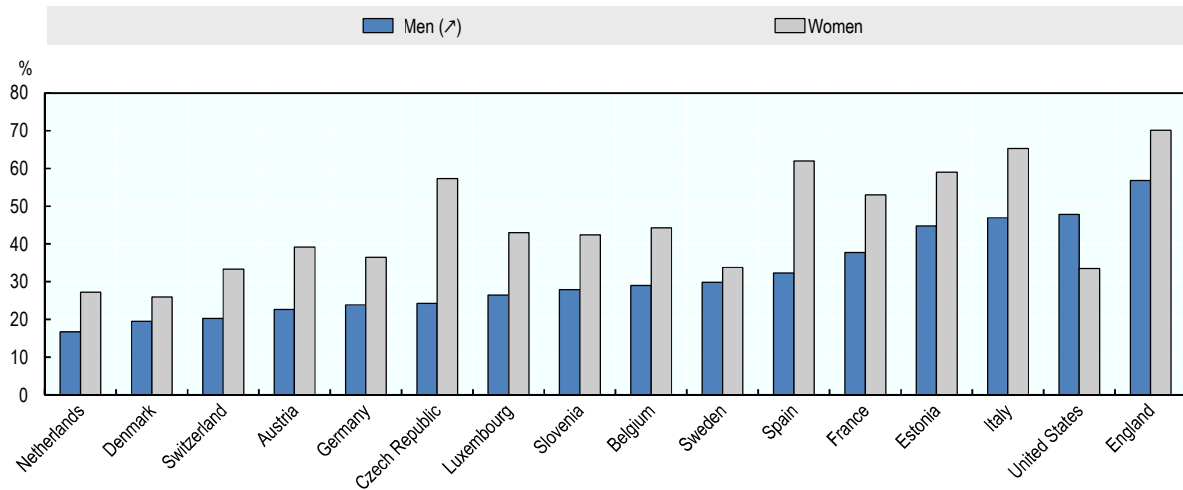
Getting older is not without consequences for mental health, either. The prevalence of depressive symptoms is high in England, with 57% of men over 80 and 70% of women affected. It is high in Italy, too, among both males (47%) and females (65%), in the United States among males (48%), and in Spain among women (60%) (Figure 6.13). By contrast, prevalence is relatively low in Denmark, the Netherlands and Sweden and, among older women, in Switzerland, the Netherlands and the United States.

Figure 6.12. Women report higher rates of functional limitation



Source: Börsch-Supan, A. (2016), “Survey of Health, Ageing and Retirement in Europe (SHARE) Wave 5”, release version 5.0.0.

StatLink  <http://dx.doi.org/10.1787/888933568300>

Figure 6.13. Proportion of 80+ showing depressive symptoms is very high in some countries

Source: Börsch-Supan (2016); United States Health and Retirement Study 2006 as cited in Sole-Auro and Crimmins (2013).

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Living arrangements are critical to elder well-being

A high proportion of women aged 80 and over live alone

Family living arrangements are a key component of the material and subjective well-being of the elderly. They shape the material resources and home environment that family members may share with the elderly to ease their everyday life. The physical proximity of family members facilitates interaction and the provision of care when needed, and tempers the widespread feeling among the elderly that they have been left alone (Fokkema et al., 2012). When family members are absent or unavailable to provide care, demand for professional caregiving increases. Having no surviving children lessens the over-80s' residential autonomy and heightens the likelihood of being placed in an institution (Gaymu et al., 2007; OECD, 2011).

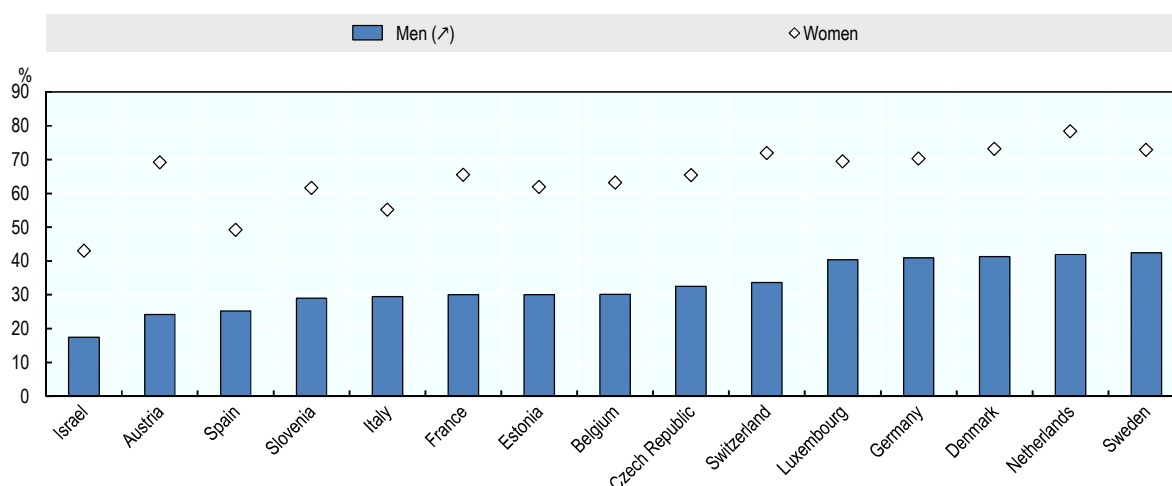
The proportion of over-80s who live in a separate household has risen in most OECD countries over recent decades. There are a number of reasons:

- better health;
- better financial conditions;
- the decline in intergenerational co-residence (Jacobzone et al., 2000; Marshall et al., 2015; Dykstra et al., 2013);
- policies to maintain the very old in their own homes and support family carers (OECD, 2011).

However, family living arrangements differ sharply with gender. In all countries in Figure 6.14, many more women than men live alone, partly because they are more likely to be widowed. Nevertheless, old women are also more likely to live with their children or other adults after the death of their partner in Estonia, Italy, Slovenia and Spain (Gaymu et al., 2008; Dykstra and Fokkema, 2011).

Figure 6.14. Women older than 80 years live alone much more than men in the same age group

Proportion of persons aged 80 and over who live alone



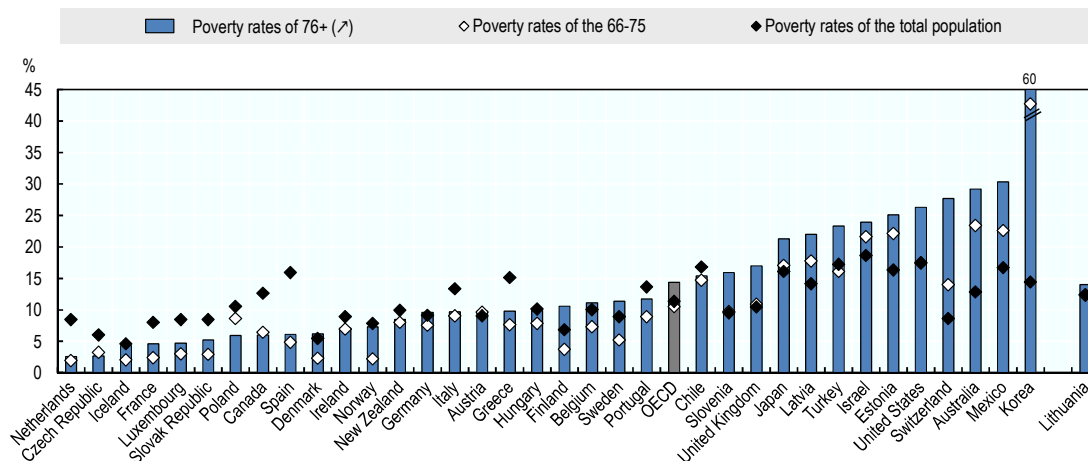
Source: Börsch-Supan, A. (2016), “Survey of Health, Ageing and Retirement in Europe (SHARE) Wave 5”, release version 5.0.0.

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The over-80s who live alone are at a high risk of poverty

Material and care needs sharply increase with age, which reinforces the importance of income for a decent standard of living in old age. An average of one in seven people aged 76 and over is poor OECD-wide against one in nine for the total population (Figure 6.15). In many countries, the over-76s are the age group most at risk of living in poverty. Poverty rates of the over-76s are low in the Netherlands and the Czech Republic, but more than twice the OECD average in Australia and Mexico, and four times higher in Korea.⁹

The situation in Korea is the consequence of two interrelated factors. First, a powerful Confucian social contract has for centuries dictated that children should care for their ageing parents. But filial obligations are weakening as younger generations increasingly migrate to cities and a growing share of the elderly find themselves alone. Second, the national pension system was set up only in 1988, too late for the generations born in the early 1950s, before or during the Korean War, to benefit. Many of the elderly are therefore not entitled to a pension unless they can prove their offspring are unwilling or unable to provide support, which is difficult.

Figure 6.15. Poverty risks are higher among people aged 76 and over on average in the OECD

Note: The poverty rate is defined as the share of people with income below 50% of the median household income of the total population.

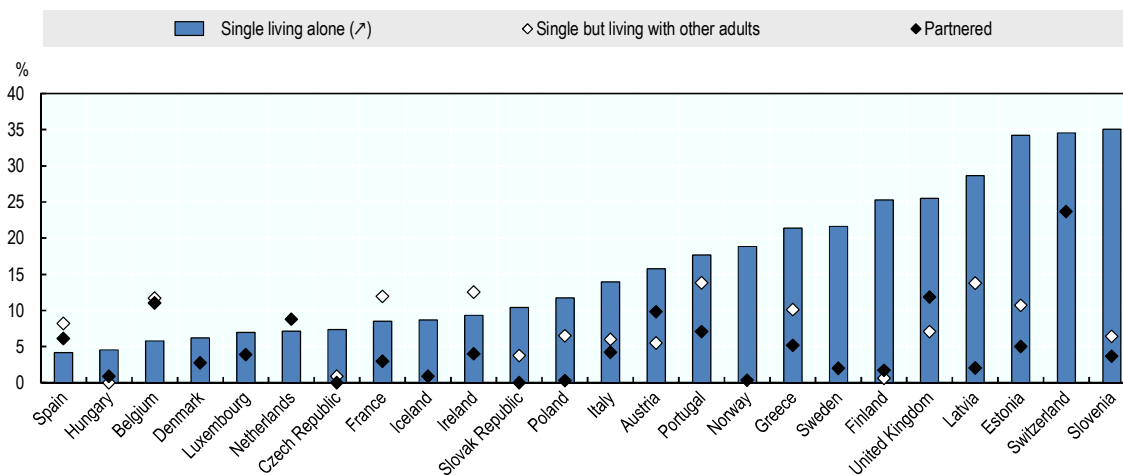
Source: OECD Income Distribution Database.

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In the vast majority of countries, the over-80s who live alone are much more prone to poverty than those who live with people with whom they share incomes – either because they are partnered or, though single, living with other adults in a private household (Figure 6.16). Indeed, many of the poor over-80s have no family to support them. Nor do they have the personal resources to avert poverty and pay for formal care in an institution (Gaymu et al., 2008). Cross-national differences in poverty rates among the over-80s who live alone are very wide. More than 1 in 3 in three are poor in Estonia, Slovenia and Switzerland, for example, but less than 1 in 20 in Hungary and Spain.

Figure 6.16. Poverty rates among the over-80s are much higher for those living alone

Percentage of the over-80s with an equivalised income below 50% of the median



Source: European Union Statistics on Income and Living Conditions (EU-SILC), 2014 edition.

StatLink <http://dx.doi.org/10.1787/888933568376>

As elderly women are more likely than men to live alone, they are at greater risk of poverty at a very old age: about 17% of women aged 80 and over who live alone are in relative poverty in Europe, compared to only 10% of their male peers. The gap is partly attributable to the fact that a significant proportion of women has no personal income or receive low pension benefits because they participated little in paid work and/or earned low wages in earlier years. While higher poverty rates among women aged 80 and over compared to men is of great concern today, it may be less so in the future, as the increase in female labour force participation across cohorts combined with the narrowing of the life expectancy gender gap is likely to narrow the poverty gap as well (OECD, 2015b).

Prospects for the living conditions of the over-80s

Several factors make the outlook for the lives of the over-80s uncertain. Demographic patterns are the main determinants, but various other trends may come into play in contrasting ways. First, given the continuing decline in mortality up to the age of 80, future generations will generally live longer. However, the elderly with functional limitations may also need to learn to cope with such limitations for longer (Gaymu, 2006; OECD, 2011; Grundy et al., 2006). Second, the projected narrowing of the life-expectancy gender gap in most countries will mean more over-80s (especially women) cohabiting with a partner who may be able to care for them. However, the rising divorce rate in all cohorts may weaken that positive development although it, in turn, may be partly offset by people's growing propensity to re-partner or remarry after their first union comes to an end.¹⁰

Whether partners are able to look after each other when the need arises will depend on greater life expectancy not troubled by disability (Chapter 2). While both partners might live longer, they may also experience times in life when both are affected by limitations in their ability to function (Gaymu et al., 2008; OECD, 2011). Indeed, a rise is expected in the number of couples affected by frailty despite progress in monitoring health and treating illness that may help to postpone limitations until later in old age.

How care needs evolve will depend heavily on the health status of the over-80s. There is mixed evidence of an increase in restricted activity and functional limitations among people currently in mid-life (Chapter 2). However, the mounting prevalence of excess weight and obesity across cohorts, and the growing number of women smoking (WHO, 2015) also raise concerns about the health of the elderly in the future.

A further factor, the steep drop in fertility, is likely to result in elder parents having fewer children who are able to act as their possible carers. And those whose parents have long-term care needs may well have to shoulder a heavier caregiving burden. They may thus increasingly become their parents' carers, so reinforcing a trend already observed in many countries (Dykstra et al., 2013). Indeed, more children may have to look after their elderly parents while still in employment and raising their own children.

Longer working lives – partly the result of later retirement – will also heighten the likelihood of workers having to care for a dependent parent. It will therefore become increasingly important to enable workers to take time-off for caregiving (as discussed in greater detail in the following section). To that end, employees in most OECD countries are in fact entitled to flexible working hours or family-caregiver leave, though such arrangements are often short-lived or intended only for cases of very serious illness (OECD, 2016b). Ensuring that workers can use them for a wider spectrum of caregiving situations and at short notice is crucial, as the needs they are designed to meet are often unpredictable. The practical implementation of these policies needs to be thoroughly

thought through. Operational solutions need to be found to ensure that employers' and governments' administration cost and planning are well managed under these increasingly flexible arrangements. Moreover, companies need to make sure that caregiving policies are not only implemented on paper but also in practice, which requires commitment from all layers of management.

Greater flexitime is of course important from workers' own perspective as it helps them ease the strain on the work-life balance. But it is equally important for elderly parents, as being cared for by their own children considerably reduces feelings of loneliness and symptoms of depression (Fokkema et al., 2012). Not all elderly parents will have children living in the same neighbourhood and being able to assist them on a regular basis, in which case formal care assistance will be needed (Dykstra et al., 2013). Whether the children of elderly parents prioritise formal home-based or institutional care will depend on:

- attitudes to keeping their parents in the family environment,
- the financial resources that countries are willing to channel into improving the living conditions of the elderly.

3. Long-term care

Long-term care (LTC) is essential to ensuring many older people's quality of life. As people age, they are increasingly likely to suffer from ill health or disability. For example, 1.3% of 60-64 year-olds suffer from dementia OECD-wide, a figure that rises to nearly 45% among the over-90s (OECD, 2015c). As a result, some of the things that the elderly previously took for granted become more difficult. They may find it more difficult to wash and dress every day, to cook meals and do the housework, and to keep up a social life and relationships. Many older people can, however, continue to live fulfilling, largely independent lives, provided they get the long-term care and support that they need from others.

The costs of meeting long-term care needs can worsen inequalities that start earlier in life. LTC may be provided by professionals or informally by family and friends. Either way there is a cost. Professional care can be very expensive when needs are severe. When no public provisions are available to cover these needs and if the elderly cannot afford it, their needs go unmet. While family and friends are not usually paid for providing informal care, there are nonetheless costs – in terms of the time spent giving care, their health, and their employment prospects.

The costs of LTC are not distributed evenly across the population. People on low incomes are the most likely to become disabled and the least likely to be able to afford professional care – even with support from social protection systems – leaving them at risk of unmet needs. As for informal care, costs fall disproportionately on women.

This section explores evidence of the degree to which the costs and impacts of dependence and LTC needs are unequally distributed across the populations of OECD countries, and to what extent unequal distribution drives and exacerbates inequalities.

The financial cost of LTC and the effectiveness of social protection

The cost of LTC can be high and difficult to afford, especially for lower-income groups

Professional caregiving has a financial cost. For people receiving care in the community, the main cost is that of paying someone to come to their home and help them with everyday tasks that include personal care like washing and dressing, help around the home with chores like cleaning and shopping, or support with social interaction and leisure, e.g. going to a social club or for a walk. The cost of institutional care covers this type of support plus bed and board.

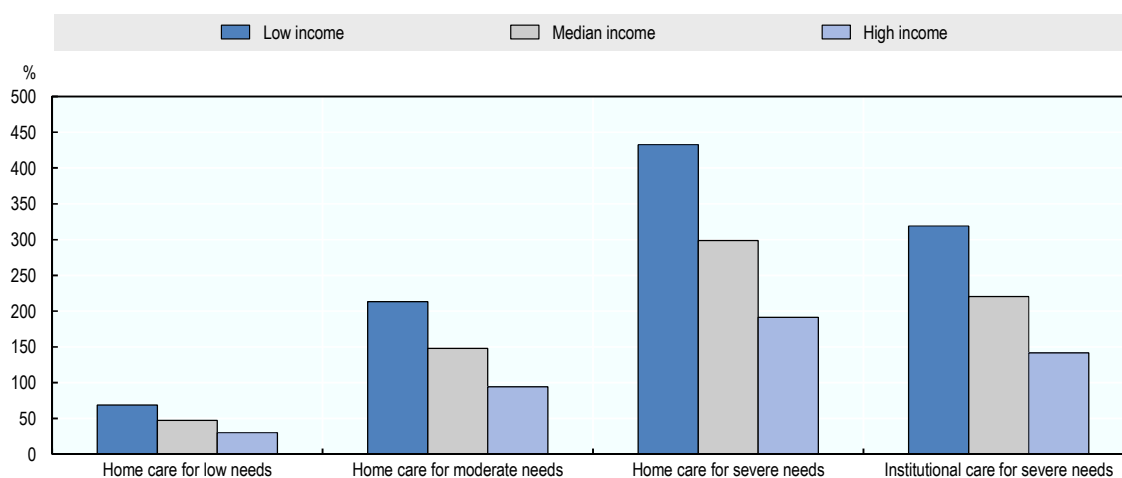
The cost of providing care, even for people with lower-level needs, can be high when set against a pensioner's disposable income (Figure 6.17).¹¹ In the 13 OECD countries for which data are available, 6.5 hours of professional LTC per week costs, on average, half of the median disposable income of a person over aged 65 and over.

Costs are higher for more intensive care needs. Someone with severe needs may require over 40 hours of care in the community. If it were all provided by a professional carer, it would cost on average three times the median disposable income of an older person. In the absence of informal arrangements, institutional care may be a cheaper way to meet acute needs – but even that still costs more than twice an elderly person's median disposable income.

Only the richest older people can cover high costs for moderate needs from their income. The cost of home care for moderate 22.5 hours per week of professional care is equal to 96% of the disposable income for someone in the 80th percentile of the income distribution and more than twice the disposable income of someone in the 20th.

Figure 6.17. Home care costs are high compared to a pensioner's disposable income

Cost of long-term care in different care settings, percentage of the over-65s' disposable income



Note: Percentages are averages of 13 OECD countries. Low income refers to the 20th percentile and high income to the 80th. Low, moderate and severe needs correspond to 6½, 22½ and 41¼ hours of care per week, respectively. The costs of institutional care include the provision of food and accommodation, so are overestimated relative to home care.

Source: Muir, T. (2017), “Measuring Social Protection for Long-term Care”, *OECD Health Working Papers*, No. 93, OECD Publishing, Paris, <http://dx.doi.org/10.1787/a411500a-en>.

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High and unpredictable costs provide a strong rationale for social protection

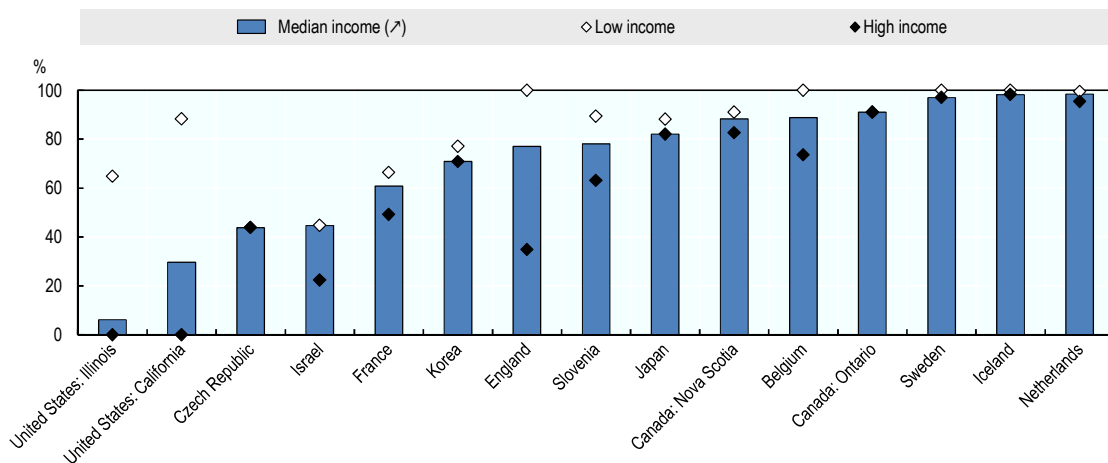
Although growing older heightens the likelihood of needing LTC, it is not easy to predict if or when someone might develop the need. The unpredictable nature of LTC costs and the fact that most people cannot afford them out of their own pockets mean that the elderly stand to benefit from pooling LTC risks. In most OECD countries, private insurance plays only a minor role in LTC (Colombo et al., 2011) and risk pooling is provided largely by public social security systems.

As Figure 6.17 shows, lower-income groups have greater trouble affording LTC. This is reflected in the design of OECD countries' social protection systems, most of which apply some form of means testing. The only exceptions among the 13 countries studied are the Czech Republic, where benefits are universal (though not comprehensive), and some parts of Canada, such as Ontario, where home care is provided free of charge, up to a limited number of hours per week.

Figure 6.18 illustrates how social protection targets lower income groups. Focusing on a scenario where home care is provided to meet moderate needs, it shows the proportion of the cost met by the public purse and how that proportion varies with a person's income. While benefits are means-tested in almost all countries, approaches vary. In the United States and England, social protection is heavily means-tested. People on very low incomes have most or all of their costs met publicly, while people on high incomes pay nearly all of the costs out of their own pockets. At the other end of the spectrum, Sweden, Iceland and the Netherlands have highly comprehensive systems that cover nearly the full cost of care, with users making only small co-payments – although the better-off are asked to make slightly larger contributions.

Figure 6.18. Proportion of LTC costs covered by social protection systems differs widely among countries and income groups

Proportion of LTC costs covered by social protection systems for someone receiving home care for moderate needs, by level of income for people with low assets



Note: Low income refers to the 20th percentile, high income to the 80th. The term “moderate needs” in the figure heading denotes 22½ hours of care weekly. It is assumed that the person does not have assets that they can use to pay for care.

Source: Muir, T. (2017), “Measuring Social Protection for Long-term Care”, *OECD Health Working Papers*, No. 93, OECD Publishing, Paris, <http://dx.doi.org/10.1787/a411500a-en>.

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Though means-tested, home care is unaffordable for low-income groups in several countries

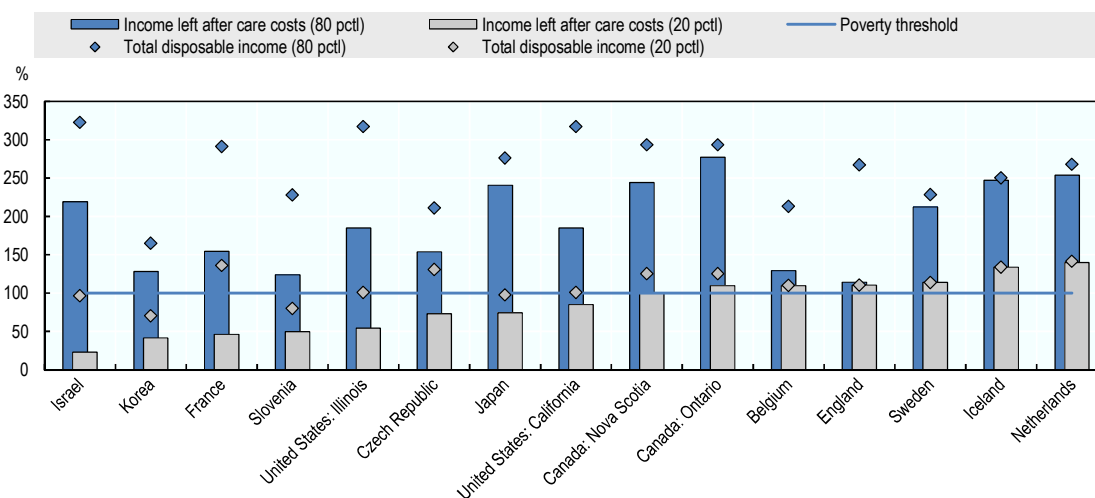
While social protection systems often pay for a high share of the cost of LTC (Figure 6.18), people cannot necessarily pay for the rest out of their own pocket. Out-of-pocket costs for recipients of care in the home must be low enough to leave them with the money they need for other living expenses, such as food, accommodation and heating. If out-of-pocket costs are too high, and family and friends cannot provide unpaid support, older people have to choose between leaving their LTC needs unmet or slipping into poverty.

Figure 6.19 illustrates one way of assessing the affordability of the out-of-pocket share of the cost of home-based LTC for moderate needs. It shows how the disposable income of the over-65s in the 20th and 80th percentiles of the income distribution compares to the poverty threshold and how it changes when their out-of-pocket LTC costs are subtracted from their income. Where the costs would drive them below the poverty line, they may not be able to afford the LTC they need plus other living costs.

People on high incomes can afford LTC for moderate needs in all 13 countries studied. They are able to pay the out-of-the-pocket costs without falling below the poverty threshold, even in the countries where those costs are significant. However, in over half of the countries studied, home care for moderate needs is beyond the means of low-income groups. As needs become more severe, out-of-pocket costs often increase and home care becomes even less affordable to those with low incomes (Muir, 2017).

Figure 6.19. Home care for moderate needs is beyond the means of low-income groups in over half the countries

Disposable income as percentage of the relative poverty threshold, selected OECD countries



Note: Disposable income of home care recipients with moderate needs before and after their out-of-pocket contribution to care costs. “Moderate needs” denotes 22½ hours of care per week. The relative poverty threshold is half the median disposable income for the whole population. 20 pctl refers to 20th income percentile; 80 pctl refers to 80th income percentile. Percentiles refer to the distribution of disposable income among the over-65s in each country. Analysis assumes that people do not have savings which they can use to pay for care.

Source: Muir, T. (2017), “Measuring Social Protection for Long-term Care”, *OECD Health Working Papers*, No. 93, OECD Publishing, Paris, <http://dx.doi.org/10.1787/a411500a-en>.

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Comprehensive or well-targeted social protection makes LTC affordable to low-income groups

Most social protection systems in countries where people on low incomes can afford home care for moderate needs fall into one of two groups. The Netherlands, Iceland and Sweden have comprehensive coverage. People with low incomes pay nothing towards the cost of care and, although the better-off do pay a little, out-of-pocket costs are low for everyone and LTC is always affordable. England and Belgium, on the other hand, have much more closely targeted systems. While people with low incomes pay little or nothing towards the cost of care, those on high incomes pay a significant share of LTC costs. However, although their disposable income is significantly reduced, which has an effect on their standard of living, the costs are not high enough to push them into poverty.

Out-of-pocket costs would push low-income people into poverty in some countries

In countries where benefits are neither comprehensive nor well targeted, old people on low incomes are left with out-of-pocket costs which they cannot afford. Such shortfalls in social protection may be ascribed to different causes in different countries.

- LTC insurance in Japan and Korea covers most of the cost of LTC and, to a certain degree, targets lower-income brackets. In Japan, for example, most people pay only 10% of the cost of home care (up to a maximum monthly amount), but those with high incomes pay 20%. In Korea, people with low incomes pay only 7.5% of the cost of the services covered by LTC insurance, while others pay 15% (although caps on total coverage mean that people would, in practice, need to pay more to meet their needs in full). However, while people often pay only a small proportion of the cost of LTC, even this may be difficult for some to afford, since low-income older people in Japan already live on the poverty threshold and in Korea significantly below it.
- The United States has a targeted system whose structure is similar to England's, which requires that people must be left with no less than a protected level of income after any out-of-pocket LTC costs. In the United States, that amount, set at state level, is known as the Maintenance Needs Allowance (MNA). Of the two states considered in the current analysis, California and Illinois, California has, by far, the higher MNA. Yet in 2014, it still guaranteed a disposable income of only 85% of the poverty threshold. As for Illinois, the MNA in 2014 was just over half of the poverty threshold. In contrast, the level of protected income in the English system is higher than the relative poverty threshold.
- Older people in France and the Czech Republic are better off than in many other countries: even the 20th percentile of the income distribution is well above the poverty threshold. However, benefits in neither country are comprehensive, nor particularly well targeted. The Czech Republic does not practice targeting at all and grants the same allowance regardless of income. However, that amount is less than half of what it would cost to meet moderate needs through professional home care. France's main LTC scheme (the *Allocation Personnalisée d'Autonomie* – APA) pays out more to those with lower incomes, but tax deductions are more valuable to those with higher incomes. However, LTC benefits in France cover only between half and two-thirds of the cost of care.¹² In both the Czech Republic and France, people with high incomes can afford the out-of-pocket costs they are left with, but those with low incomes cannot.

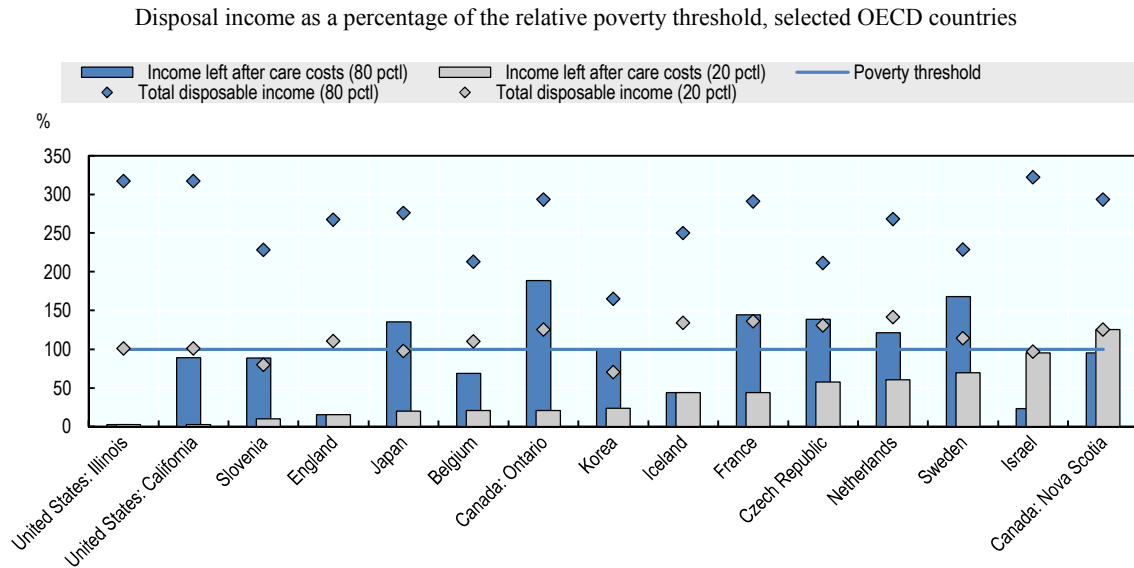
- Israel’s LTC benefit scheme covers only personal care. Yet, to lead independent lives in their own homes, many older people also need help with shopping, cooking or laundry. Unless family and friends can provide that support, people with LTC needs have to pay for it out of their own pockets. For those on low incomes – already on the poverty line – the cost of home help services for moderate LTC needs is around three-quarters of their disposable income.
- In Slovenia, all municipalities are required by law to meet 50% of the costs of home care services. Some, though, go higher than 50% and the average level of allowances is around two-thirds of the cost of LTC. People with lower incomes are entitled to further support and typically pay only around 10% of the cost of home care for moderate needs. However, low-income older people already live below the poverty threshold and paying as little as 10% would reduce their disposable income by one-third.

High out-of-pocket costs may be an incentive to go into institutional care

The out-of-pocket costs of institutional care are generally higher than for home care. However, this covers food and accommodation as well as care. As a result, older people in care institutions no longer need their income to meet the basic costs of living – although it can help them to maintain their independence and live better lives.

Figure 6.20 shows the disposable income of the over-65s in the 20th and 80th percentiles of the income distribution in selected OECD countries and how what they have left varies from country to country when out-of-pocket costs for institutional care are subtracted. Low-income older people in some countries, such as the United States, are left with only a very small amount of “pocket money”. Nevertheless, social protection systems in all countries do ensure that even the low-income elderly are not denied institutional care on affordability grounds.

Some people with severe needs may prefer to remain at home and LTC policies often aim to help them to do so. These policies have been successful and, in recent years, the proportion of LTC recipients living in the community has increased in most countries (OECD, 2015c). However, the design of social protection systems can also influence where people receive care. Some countries restrict public funding for institutional care to people with needs above a minimum threshold, while others cap the number of hours of publicly-funded home care. Even without such policies, differences in out-of-pocket costs can provide a financial incentive for people to choose home or institutional care. In countries where people with low incomes cannot afford home care without being pushed into poverty, they may have incentives to go into institutional care where their care needs will be met and their food and board provided, even if home care might in some cases meet their needs more effectively and give them a better quality of life. Low-income groups may therefore have seen less benefit from the deinstitutionalisation of LTC.

Figure 6.20. Income left after care cost of institutional care recipients varies greatly among countries

Note: Disposable income of institutional care recipients with acute needs before and after their out-of-pocket contribution to care costs. 20 pctl refers to 20th income percentile; 80 pctl refers to 80th income percentile. Percentiles refer to the distribution of disposable income among the over-65s in each country. Analysis assumes that people do not have savings which they can use to pay for care.

Source: Muir, T. (2017), “Measuring Social Protection for Long-term Care”, *OECD Health Working Papers*, No. 93, OECD Publishing, Paris, <http://dx.doi.org/10.1787/a411500a-en>.

StatLink  <http://dx.doi.org/10.1787/888933568452>

Gender inequalities in the provision of informal care

Informal caregiving can have benefits, but it also has costs

Many older people with LTC needs would prefer to be looked after by someone they know, while family and friends often wish to care for them when they become dependent. Indeed, some carers report that the experience of caregiving is rewarding (de Vugt and Verhey, 2013). However, informal carers, who are usually unpaid, may themselves pay a price for caregiving. There is an opportunity cost to the time that they spend providing care, as they could devote that time to paid work or leisure. Informal carers, especially those who give more than 20 hours of care per week, are more likely to work part-time or not at all. And they are 20% more likely than other people to have mental health problems (OECD, 2011).

In recognition of the costs and risks that carers face, OECD countries provide a range of benefits and services. A recent study of 27 EU countries (Courtin et al., 2014) found that financial benefits were the most common form of support to caregivers, followed by respite care and training. While financial benefits (paid directly to the caregiver or via the care recipient) are common, they rarely compensate carers in full for the costs they incur. Moreover, take-up of informal care benefits may be low, especially where significant paperwork is involved. For example, carers in France can be paid via the main LTC benefit, the APA, but it requires them to have an employment contract and, in practice, few people use of this provision. As a result, carers seldom receive enough financial compensation to offset the opportunity cost of caregiving (Muir, 2017).

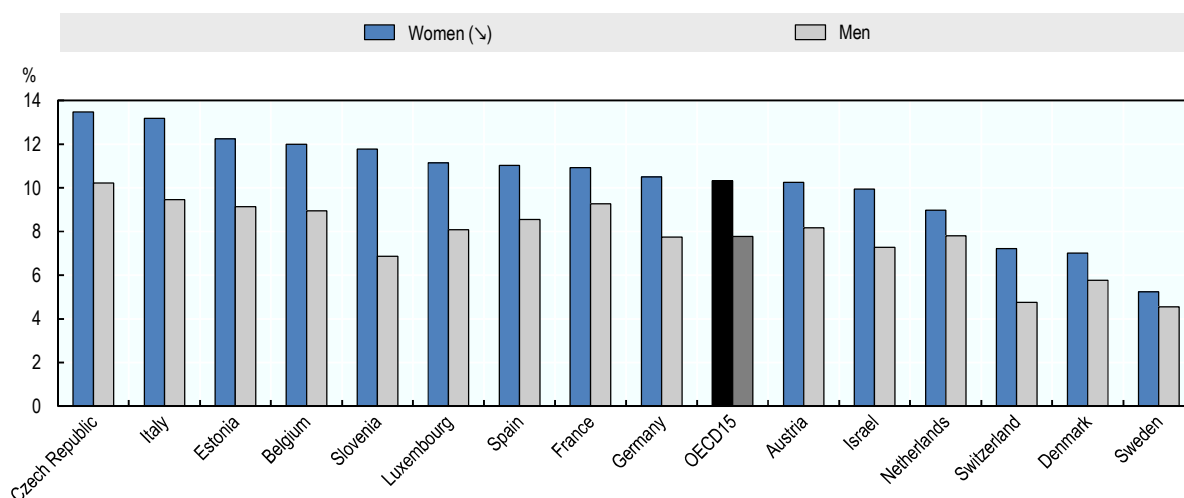
The effectiveness of support services in reducing the risks associated with informal care is unclear. Respite care – where temporary professional care services are used to give informal carers a break from caring duties – is highly valued by carers, but there is limited evidence that they improve outcomes. Similarly, while training and counselling aims to mitigate risks to mental health, evidence of its effectiveness in that regard is again inconclusive (OECD, 2011). It is crucial to strengthen support for carers and evaluate policies in order to understand which approaches work best. Meanwhile, as matters stand, carers are left facing health and employment risks.

Rates of informal care vary significantly between countries and by gender

The proportion of over-50s in the OECD who give daily informal care¹³ varies significantly from country to country – from as low as 5% in Sweden to 13% in Italy and the Czech Republic (Figure 6.21). Everywhere, however, the majority of carers are women. The country with the least unequal gender balance is Sweden, where 57% of daily carers are women, followed by Denmark and the Netherlands with 59%.¹⁴ At the other end of the spectrum lies Slovenia, where women make up 70% of informal carers. Women thus bear most of the costs of providing informal care including income losses and mental health problems leading to a higher risk of impoverishment at higher ages. Women would benefit most from any support provided to informal carers. Improving support services can help to narrow the gender inequalities caused by the unequal division of caring responsibilities.

Figure 6.21. The majority of over-50s providing informal daily care are women

The proportion of over-50s providing informal daily care in 2013, by country and gender



Note: People caring for members of the same household were not asked about the frequency of care, but are included in the definition of “daily informal care”. People who care for their children, step-children, nieces or nephews are excluded from the definition.

Source: OECD analysis of data from the Survey of Health, Ageing and Retirement in Europe (SHARE) wave 5, release 5.0.0.

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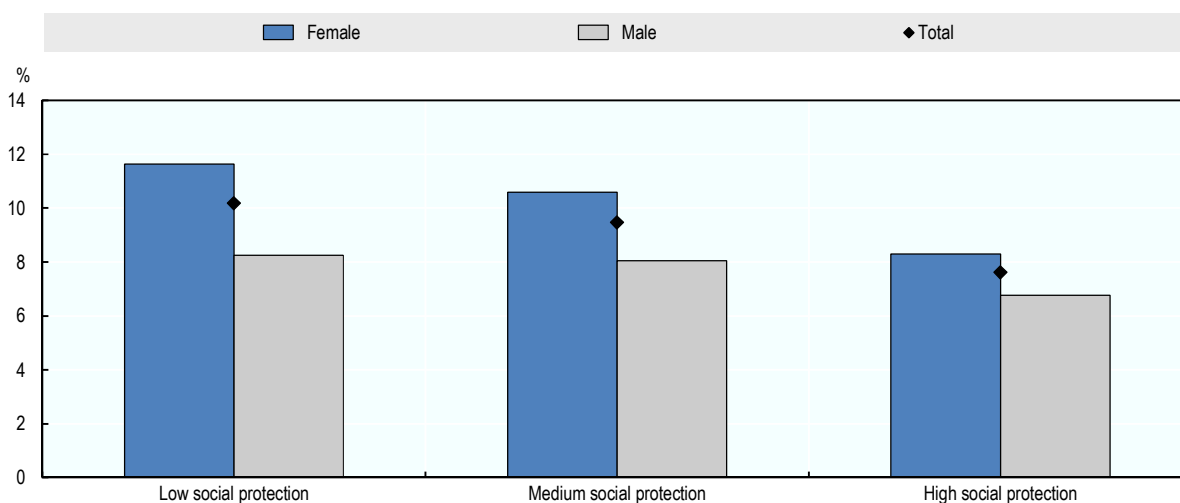
Countries with strong social protection have lower care rates and less gender inequality

Countries with the lowest informal caregiving rates have some of the most comprehensive social protection systems (Figure 6.21). Sweden, Denmark, Switzerland and the Netherlands all spend more than the OECD average on publicly funded LTC. Moreover, while the analysis of social protection for LTC above (see “Comprehensive or well-targeted social protection relieves low-income groups of much LTC cost”) does not cover Denmark or Switzerland, it demonstrates that people in Sweden and the Netherlands have access to affordable LTC services, even if they are on low incomes.

Broadly speaking, in countries whose social protection schemes provide greater support for LTC, fewer people give daily informal care and there is less gender inequality (Figure 6.22). In 2013, women aged 50 and over in countries with low-level social protection (i.e. those where public spending on LTC is less than 1% of GDP) were 41% more likely to provide daily informal care than their male counterparts. The figure for their peers in countries with high levels of social protection (where public spending on LTC exceeds 2% of GDP) was only 23%. While other factors, such as cultural norms and gender stereotypes, may affect rates of informal care, it is likely that stronger support for LTC in social protection systems helps reduce the need for informal care, especially among women.

Figure 6.22. Fewer people give daily informal care in countries with high level social protection schemes

Average shares of the over-50s providing daily informal care by gender and levels of social protection, 2013



Note: People caring for members of the same household were not asked about the frequency of care, but are included in the definition of “daily informal care”. People who care for their children, step-children, nieces or nephews are excluded from the definition.

Public spending on LTC is used as a proxy for social protection: <1% of GDP = low; 1-2% GDP = medium; >2% GDP = high.

Source: OECD analysis of data from the Survey of Health, Ageing and Retirement in Europe (SHARE) wave 5, release 5.0.0, and *OECD Health Data 2016*.

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Higher female labour force participation may not mean lower informal caregiving rates

One reason why women may be more likely to provide informal care is that, for the current generation of women aged over 50, they are less likely to have had full careers than their male counterparts (Figure 6.23, Panel A). Their earning potential and caregiving opportunity costs are thus lower, while they are also more likely to have been caregivers earlier in life (looking after their children, for example). The apparent corollary is that, as female labour force participation increases over the coming decades, fewer women will be informal carers, so narrowing gender disparities and increasing demand for professional LTC services.

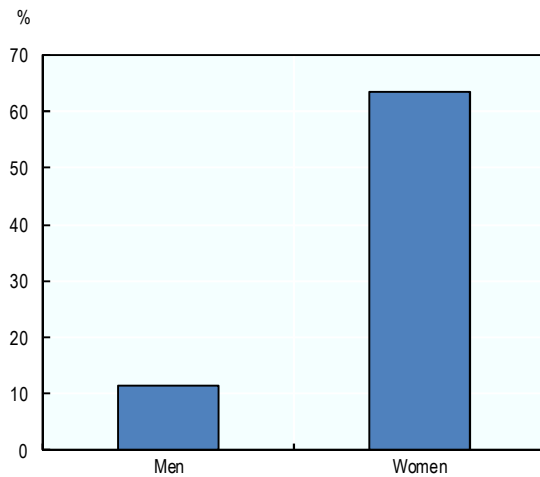
However, patterns of caregiving in the current female population of over-50s suggest that there is no clear correlation between labour force participation and caregiving rates. Women who have had full careers are actually slightly more likely to be providing daily informal care than those who have been out of the labour force for over ten years (Figure 6.23, Panel B). When other factors (such as health, family situation and country of residence) are controlled for,¹⁵ the relationship between career history and caregiving rates is not significant.

This suggests that greater female labour force participation might not, in itself, be enough to narrow gender inequality in the provision of daily informal care. Unless labour force changes are accompanied by a broader shift in expectations of gender roles, it is likely that women will continue to bear most of the burden of informal care – and its costs. Indeed, such costs may well increase, as ageing populations and higher incomes seem likely to lead to a growth in demand for LTC (de la Maisonneuve and Oliveira Martins, 2013). In this context, the provision of adequate social protection and the development of more effective policies to support informal carers will continue to be important in limiting gender inequality.

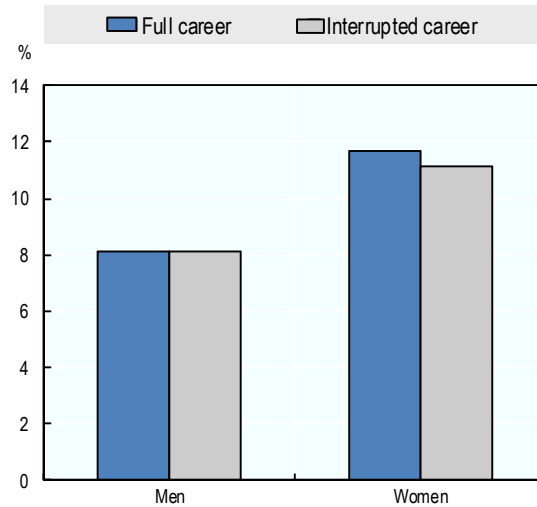
Figure 6.23. Women more often have interrupted careers but these women are less likely to be providing daily informal care compared to full career women

Informal caregiving provided by people who have had full or interrupted careers in 14 OECD countries, by gender

Panel A. Shares of the over-50s by gender with interrupted careers, 2009



Panel B. Shares of the over-50s by gender with full or interrupted careers who provide daily informal caregiving



Note: An interrupted career is defined as ten or more years between the ages of 18 and 65 during which a person is neither in full-time work nor education.

Panel A presents average figures across 14 European Countries, based on representative samples of populations of the over-50s (SHARE Wave 3). Panel B is based on data from Wave 3 of the Survey of Health, Ageing and Retirement in Europe (SHARE) which were matched to other waves of the survey to analyse the relationship between historical and cross-sectional data. The data in Panel B are therefore not strictly representative of country populations.

Source: Survey of Health, Ageing and Retirement in Europe (SHARE) waves 1-5.

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Notes

1. It is useful to keep in mind that other factors such as affordable housing have a large impact on the quality of life of older people as well and vary significantly by region. Housing, transportation and health services are all important component of the age-friendly cities and communities approach of the WHO (WHO, 2007). Housing in areas with limited health care and public transport services is often cheaper, creating an affordable housing trap for the elderly poor. In the rest of this section we will focus on regional ageing trends, regional access to health services and regional access to public transport.
2. According to 2014 data and defined as the share of people aged 65 and over in the total population.
3. Latest available year for Mexico was 2010. It should be noted that many of the countries mentioned, contain very low density regions which are likely to drive the extremes.
4. The earliest available year for Germany is 2006.
5. Unfortunately the data considered in this subsection is only available on TL2 level and not on TL3 as the rest of the section.
6. The choice of 20 minutes driving distance is ad hoc. In Italy's Novara region, for example, reducing the driving distance from 20 to 10 minutes cuts the share of the older population with access to a hospital from 85% to just over 37% (for the analytical approach, see OECD, 2012). Measuring the distance to the closest hospitals in driving time relies on the availability of geo-location data for all hospitals (public and private) in a country. It should therefore be understood that, while the analysis uses the most comprehensive dataset available, the results should be seen as indicative. Hospital data used for this assessment comes from Open Street Map as it provides the only dataset that covers the entire OECD region. For a detailed description of the data and possible constraints due to limitations in geographical coverage, go to: <https://www.openstreetmap.org>.
7. Publicly or privately provided transport services are defined as i) rail-based public transit, like the metro and other light rail; ii) road-based transport: bus, tram and ferry.
8. Women suffer from a higher incidence of non-fatal but disabling diseases (arthritis), while men are more often affected by such fatal illnesses as lung cancer or acute myocardial infarction (Espelt et al., 2010; Sarkeala et al., 2011). Additionally, men are less likely to report limitation due to social norms (see for instance Caroli and Weber, 2016).
9. In Australia this partly reflect the fact that many pensioners have retirement savings in superannuation form or have taken their accumulated pensions as lump sums rather than annuitising them to provide income streams, both of which are not counted as current income,.

10. Trends in elders' living arrangements are likely to vary according to gender. For women, the rise in divorce rates is likely to be more than counterbalanced by a marked reduction in widowhood as the life-expectancy gender gap narrows. Consequently, more may have a spouse to support them in the future should they become dependent. Among men, the drop in widowhood will have a similar, though weaker, effect. As a result, the rise in separations and divorces may lead to situations where either fewer men live with a partner or where there is no change in their likelihood of living with a partner (Gaymu et al., 2008).
11. Additionally, in many countries a (future) shortage of workers is likely to strain long-term care services further (OECD, 2011). This might lead to unmet needs and a further increase of LTC cost.
12. The estimates for France include the APA and related tax deductions. However, some people in France may receive further support from other sources not included in this analysis. Local governments provide some LTC services and some LTC recipients are covered by their health insurance, although the availability of both varies by region. Future research will seek to understand the degree to which benefits are available and how they affect out-of-pocket costs.
13. The analysis in this report focuses on care for older people and so excludes people who care for their children, step-children, nieces and nephews. The SHARE survey does not ask people providing care to someone in the same household about the frequency of caregiving, but the definition of “daily informal care” used here does include them.
14. It should be noted however, that even when rates of informal care are similar between men and women, the type of care provided is often different.
15. A probit regression was run using life history data from Wave 3 of the Survey of Health, Ageing and Retirement in Europe (SHARE) to determine how many years women had spent out of work, cross-referenced with data from SHARE waves 1, 2, 4 and 5 to determine the provision of daily informal care and control variables. The marginal effect of a full career (fewer than ten years out of the labour force) on the likelihood of women or men providing informal care was positive but non-significant.

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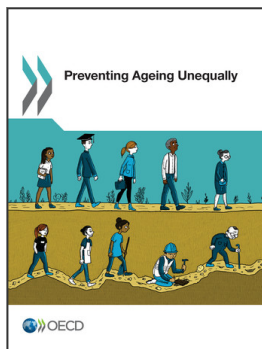
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