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D7.1 – Research report on cross-countries and within country variation in the provision of care for older individuals within Europe

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Deliverable description

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Executive Summary

Introduction

The ageing of the population of the countries in the EU puts the public provision of long-term care services under pressure. In a response to this pressure, many countries aim for ageing-in-place; stimulating older individuals to remain living at home for a long. A successful implementation of ageing in place requires integrated financing and provision of care services at home and appropriate targeting of these services to those older individuals that need them the most. This requires an appropriate assessment system to determine who is eligible for care at home and sufficient (public) provision of these services based on underlying need.

Approach

In this report, we firstly provide a comprehensive overview of care allowance systems for older individuals across 27 EU countries as of 2024. We focus on cash benefits for older people who have limitations due to health impairments. Our main source of information is Mutual Information System on Social Protection (MISSOC, 2024), supplemented by official sources and expert validation. We examine the characteristics of care allowance systems, including payment structures and usage conditions, as well as eligibility criteria and assessment processes.

Secondly, we perform an empirical analysis of home care service usage across Europe using SHARE data. We examine cross-country and within-country differences in care utilization, focusing on how the use of home care is distributed according to the needs of the older population, defined by the ability to perform activities of daily living (ADLs). We also investigate the interplay between formal and informal care, considering whether they act as substitutes or complements in different national contexts. The analysis extends to assessing eligibility requirements for formal home care across countries, estimating the proportion of likely eligible individuals, and evaluating the generosity of each country's eligibility system by applying country-specific rules to the entire European population.

Findings

The analysis reveals significant variations in care allowance eligibility criteria and formal care usage across European countries. Eligibility criteria play a crucial role in determining access to care, with more inclusive systems addressing a broader range of needs while restrictive systems potentially exacerbate health inequalities. We find that differences in formal home care use are not primarily driven by population needs but rather by eligibility system design, public financing, cultural attitudes, and socio-economic conditions. The relationship between care needs and provision varies across countries, with some demonstrating effective targeting according to need while others show gaps in addressing moderate needs. The interplay between formal and informal care is complex, with formal care often complementing rather than substituting informal care in some countries.

Conclusions

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The findings underscore the importance of designing long-term care systems that address a continuum of care needs, from moderate to severe, and suggest expanding eligibility criteria in some contexts to reduce under-coverage. There seems to be considerable scope to strengthen the complementarity between formal and informal care through targeted policies, such as financial allowances or respite services for informal caregivers. The report emphasizes the need for continuous monitoring and comparison of long-term care systems across the EU, leveraging data-driven insights to work towards more equitable and sustainable care provision. By fostering collaboration, sharing best practices, and focusing on inclusivity, countries in the EU can work towards long-term care systems in which all older adults have access to appropriate levels of care at home. This report provides a foundation for these efforts, offering valuable insights into the current state of LTC systems across the EU and their effectiveness in targeting care to those most in need



1. Introduction

Population ageing poses a significant challenge for the financing and organization of long-term care across the European Union (European Commission, 2024). The demographic shift towards an increasingly older population, coupled with rising chronic conditions and physical limitations, has become a pressing concern for policymakers. Although the broad trend of an ageing population with greater care needs is consistent across the EU, the pace and extent of population ageing, as well as the social context, vary between countries.

One of the most substantial shifts in long-term care policy has been the move away from institutional care (e.g., nursing homes) towards "ageing-in-place" models. Traditionally, long-term care systems were heavily focused on institutional care due to high costs and lack of alternatives. However, as the demand for care increases and societal preferences evolve, many countries have introduced policies aimed at enabling older people to live independently for as long as possible. These "ageing-in-place" policies focus on extending the time individuals can remain at home by providing formal home care services, such as domestic assistance, social support, and assistive devices, rather than relying on institutional care. While these policies typically expand the provision of home care, some countries have also implemented strategies that actively restrict access to institutional care to encourage living at home (e.g. Wammes et al. (2023)).

The emphasis on "ageing-in-place" policies is particularly relevant given the increasing reliance on public funding to support these services. The key challenge is ensuring that home care services are appropriately targeted to those most in need. Home care services can often be organized by individuals themselves either through private means or informal support networks. Yet, for vulnerable individuals who lack the resources or ability to arrange care themselves, publicly funded home care services are essential. This raises concerns about inefficiencies in the system, such as deadweight loss (where public funds are used to finance services that individuals would otherwise pay for themselves) and moral hazard (where individuals receive services they would not be willing to pay for privately).

In addressing these issues, our study assesses the targeting of home care services across the EU from two critical perspectives. First, we explore the assessment and eligibility criteria for care allowances. Nearly all EU countries have some form of gatekeeping system to determine eligibility for home care services (both in-kind and cash allowances). These criteria typically assess the degree of limitation in daily activities, but the operationalization of these criteria differs across countries. Social factors, such as income or living conditions, are also taken into account in some countries, while in others, eligibility is based primarily on health-related needs.



Second, our study conducts an empirical analysis to examine how home care services are used across the EU, and how well these services are targeted. We begin by documenting the differences in the share of the older population using formal home care services across EU countries, considering the underlying differences in health-related needs. We explore the variation in care provision across countries and within specific countries based on two critical dimensions: the level of health-related needs (limitations in daily activities) and the availability of informal care (family, friends, or neighbours who provide assistance). By comparing these factors, we can assess whether home care services are provided to the individuals who need them the most.

Moreover, for countries where we can replicate the eligibility criteria for cash allowances using microdata, we analyse differences in the coverage across populations. This analysis will help identify whether there are significant discrepancies between eligibility assessments and actual care utilization, which could indicate inefficiencies in targeting or allocation of resources.

Literature and Context

The literature on ageing-in-place policies and home care targeting has grown significantly in recent years as population ageing becomes an urgent issue for many European countries. The shift from institutional to home-based care is an important policy response to the increasing demand for long-term care services, particularly in the context of rising older populations and chronic conditions (Comas-Herrera et al., 2018; Pani-Harreman et al., 2021)). This shift is also seen as a way to accommodate the social preference for independent living and to address the financial strain of maintaining large institutional care systems.

Many EU countries have adopted policies to encourage ageing-in-place, aiming to provide older individuals with the necessary support to live independently in their homes for as long as possible. Key initiatives include cash-for-care schemes, home care subsidies, and services such as domestic help, social support, and assistive devices. These policies are meant to delay the need for institutional care, which is not only costly but also often less preferred by the older population (Vlaanderen et al., 2021). Studies have shown that ageing-in-place can improve the quality of life for older individuals and prevent unnecessary institutionalization (Bolin et al., 2008; Wammes et al., 2024). However, the success of these policies heavily depends on how well home care services are targeted to those most in need.

Targeting care remains a significant challenge. De la Maisonnette et al. (2020) found evidence of both over-coverage, where individuals who could arrange care independently are provided with publicly funded services, and under-coverage, where individuals who need care do not receive it, are major issues. Bostancı et al. (2019) highlighted that poorly targeted home care services could



lead to "deadweight loss," meaning that public funds are spent on services that individuals would pay for privately, or individuals who do not need support receive services. These inefficiencies result in significant financial waste and undermine the effectiveness of ageing-in-place policies.

Conversely, countries with well-designed eligibility criteria and robust targeting mechanisms have been able to minimize these inefficiencies. Sweden, for example, combines means-tested criteria with health assessments in its universal home care system. This ensures that home care services are allocated to those with the greatest need (Parker et al., 2007). Similarly, the UK has implemented a mixed model of eligibility, where needs assessments and means-testing are used to determine access, prioritizing elderly individuals with significant care needs (Glendinning et al., 2014).

Other European countries also face challenges in balancing care provision with the need for targeted support. In Denmark, the long-term care system is primarily publicly funded and managed by municipalities, which are responsible for providing both informal and formal care, including home care services. Denmark's focus on keeping older people in their homes for as long as possible through public funding and local subsidies has been deemed a successful model for maintaining autonomy while providing necessary support (Gruber et al, 2021 NBER). However, the challenge remains to ensure that these services are delivered efficiently, without over-coverage or under-coverage, especially given the large population needing care.

The Netherlands' long-term care system, reformed in 2015, shifted from institutional to home-based care. The reform aimed to promote self-reliance and reduce institutional care costs, with a strong emphasis on decentralizing responsibility for non-medical care to municipalities. This decentralization allows for more local decision-making but has also raised concerns about variations in service quality and accessibility across different regions (Wammes et al., 2023). The shift to home care has been accompanied by reforms to eligibility criteria, which now focus more on health-related needs and aim to better target home care services to those in need (Gruber et al. NBER, 2023).

In countries like Spain, where long-term care provision is highly decentralized, variations in the quality and availability of services across regions have also been observed. The decentralization has led to disparities in the accessibility and coverage of home care services. Recent reforms in Spain focus on increasing the availability of home care services and improving the quality of care in residential facilities, though concerns remain about how effectively these services are targeted to those most in need (Rotulo et al 2021). In comparison, Sweden's more centralized approach has allowed for greater consistency in the delivery of services, though challenges remain in integrating bottom-up perspectives into policy development (Maliszewska-Nienartowicz and Stefańskim 2024).



Our analysis contributes to the growing body of literature by providing an empirical assessment of how different eligibility criteria and frameworks impact the targeting of the use of home care services across the EU. By comparing different countries' approaches, we can gain valuable insights into the effectiveness of these eligibility systems and offer recommendations for improving the targeting of home care services to vulnerable populations.

2. Eligibility criteria across countries

Approach

We provide a detailed overview of the care allowance systems across 27 EU countries, including all member states as of 2024, focusing on cash benefits provided to older individuals who cannot independently perform essential daily tasks due to health-related impairments. Distinguishing these from other benefits, such as those granted to carers or those for the acquisition of assistive equipment.

This part of the report narrows its scope to cash benefits allocated directly to elderly individuals who need help with their daily activities, rather than benefits targeted towards caregivers. In countries where a dedicated care allowance does not exist, the report identifies alternative forms of assistance, but these are not detailed in the country-specific tables unless they are directly relevant to long-term care.

The primary source of comparative information is the Mutual Information System on Social Protection (MISSOC, 2024) from January 2024. This data was further supplemented by official government websites, relevant ministry publications, and country-specific legislation. To ensure accuracy, country experts were consulted and asked to validate the information gathered. This methodology ensures that the report provides reliable, up-to-date, and comprehensive data on the status of long-term care benefits across the EU.

The report includes country tables that cover two main areas:

1. Characteristics of the care allowance system: This includes details such as whether the care allowance is given in a flat amount or based on income and assets, whether it is dependent on the individual's level of need, and whether the use of the allowance is flexible or bound by certain conditions (e.g., requiring invoices or contracts with the caregiver).



2. Eligibility criteria and assessment process: The report details the eligibility criteria for receiving care allowances, which are primarily based on age and assessed need. In many cases, there are national or regional differences in how these criteria are implemented, and the report includes an analysis of the process used to determine an individual's level of care needs.

The eligibility criteria focus on the age of the individual, which varies across countries. For example, while in Finland, elderly care is available from the age of 16, this report excludes the minimum age limits for non-elderly populations, focusing instead on the age at which elderly individuals become eligible. The report assumes that older individuals' functional capacity will not significantly improve, so it does not account for short-term eligibility for benefits (e.g., when recovery is expected within a certain period). The assessment process typically uses a scoring system based on the number of activities the individual cannot perform independently and the duration of help required.

Additionally, in-kind benefits (e.g., services like personal care) are briefly discussed in relation to cash allowances, providing an overview of whether countries allow for the combination of both cash and in-kind benefits. The report also discusses the presence of cost-sharing mechanisms for in-kind benefits, noting whether individuals receiving home care are required to contribute to the cost.

Results

Out of the 27 EU countries, 24 countries provide a form of care allowance for older individuals in need of long-term care. These countries have a well-established system where care allowances are tied to an individual's assessed need, typically based on the level of dependency for both basic and instrumental daily activities. In these countries, eligibility is largely uniform across regions, and the allowance is most commonly given as a flat amount that is not dependent on the beneficiary's income.

The remaining 3 countries either do not provide a national long-term care cash allowance or offer alternatives. For instance, Hungary and Ireland provide different types of allowances, such as those for caregivers or for purchasing medical equipment. In Sweden, certain municipalities offer cash benefits for informal caregivers, but these are not universally available. In some of the 24 countries that offer care allowance, the eligibility for care allowance is conditioned by a recognised disability degree (e.g., Bulgaria, Estonia, Poland, Romania). Hence, cash benefits are not available for the general elderly population. In Estonia, cash benefits are available in some local government areas, but there is no national scheme. In the Netherlands, the benefit



described in greater detail below is technically considered as an in-kind benefit rather than a cash benefit.

Among the 24 countries that provide care allowances, most have unified eligibility and assessment criteria at the national level. The assessment process primarily evaluates health status and the inability of individuals to perform essential daily activities independently. In these systems, care allowances are often provided in fixed amounts, dependent on the assessed need, and are not income-tested. The use of the care allowance in these countries is typically unrestricted, meaning beneficiaries can use the funds as they see fit without needing to submit receipts or contracts with their caregivers, offering greater flexibility.

However, there are some variations in the design of the system across countries. In Denmark, for example, while the care allowance is individually assessed, it is not based on income or assets. Instead, it focuses on the individual's level of care need and provides flexibility for beneficiaries to decide how the funds should be spent. Similarly, in Slovakia, there are no predefined levels of the care allowance, but the individual is awarded an amount based on the number of hours of care needed.

In contrast, countries with regional variations, such as Finland, where eligibility criteria differ across regions, may have a more complex implementation process. This variation can sometimes lead to differences in the level of benefits provided, which may impact the accessibility and effectiveness of the long-term care system.

The findings suggest that a unified approach with flat amounts based on need and unrestricted use is common across many countries. However, there are notable exceptions, and the effectiveness of these systems in meeting the care needs of the elderly varies depending on the country's approach to eligibility, assessment, and the integration of home care services. This report aims to highlight these differences and provide valuable insights into improving the targeting and efficiency of long-term care systems across Europe.

Table 1 provides a detailed comparative overview of cash benefits for long-term care (LTC) across 27 EU countries, focusing on eligibility criteria, care allowance amounts, and the structure of the care system. The data in this table reflects the diversity in LTC policies and their design in different EU countries, providing a snapshot of how each country addresses the growing needs of an ageing population.

Key Insights:

1. Cash Benefit Availability:



- a. 24 out of 27 countries provide a form of cash benefit for elderly individuals requiring long-term care. These countries offer various levels of care allowance depending on the assessed need, with the amount of the allowance typically based on the severity of the individual's care needs.
 - b. In contrast, 3 countries (Hungary, Ireland, Sweden) either do not provide cash benefits or offer them in forms not directly tied to long-term care needs (e.g., benefits for carers, or subsidies for assistive devices), highlighting a higher reliance on in-kind benefits or benefits for caregivers instead of receivers. In the Netherlands, the personal budget is considered as in-kind benefit.
2. Amount of Care Allowance:
- a. The monthly amounts of care allowances vary significantly between countries. For example, Austria offers a wide range of amounts, from €192 to €2,061.80 depending on the level of care required, while Belgium offers benefits ranging from €404 to €710 depending on the region. On the other hand, some countries, such as Bulgaria and Latvia, offer more modest amounts, with care allowances in the range of €36.82 to €413.43, reflecting differences in national economic capacity and policy priorities. It should be noted, though, that some countries, such as Poland, give priority to cash benefits granted to the care giver rather than the elderly in need. Hence, the amounts might be higher for those benefits.
 - b. In some countries, such as Denmark, the allowance is individually assessed, but not income-based, which allows for more personalized care support. In countries like Sweden and Greece, the absence of standardized, national cash benefits demonstrates the variability in public care provisions across the EU.
3. Eligibility Criteria:
- a. Eligibility for care allowance is typically linked to the degree of functional impairment, with most countries requiring a specific threshold of dependency (such as the inability to perform a certain number of activities of daily living, or ADLs). For example, Finland requires that elderly individuals receive at least weekly help or guidance in personal activities, while Germany and Belgium apply a points-based system, where individuals are assessed based on their ability to perform ADLs and iADLs (instrumental activities of daily living).
 - b. Health status is a key criterion in most countries, with many using disability certificates or assessments to determine eligibility. However, some countries, such as Poland and Latvia, have more straightforward, needs-based systems, where benefits are granted to those who live with (severe) disabilities, without an extensive scoring system.
4. Use of Care Allowance:



- a. Free vs. Bound Use: The report distinguishes between free and bound use of care allowances. In most countries, care allowances are free, meaning beneficiaries can use the funds as they see fit, without needing to submit receipts or contracts with caregivers. This is common in countries like Austria, Belgium, and Croatia, where flexibility in the use of funds allows individuals to manage their own care.
 - b. In contrast, bound use refers to situations where the allowance is tied to specific services, such as submitting invoices from caregivers or formal contracts. France, and Spain represent examples of countries where the use of care allowances is bound to formal caregiving arrangements or specific services, which ensures that the funds are used strictly for care-related expenses.
5. Means Testing:
- a. Means testing is not universally applied. Some countries, such as Germany and Finland, do not apply income-based eligibility for care allowances, making the system more accessible to a wider group of elderly individuals. However, in other countries like Belgium and France, income levels may play a role in determining the amount of benefits provided, reflecting a more targeted approach to financial assistance.
 - b. The lack of means testing in Denmark, where the allowance is based on individual care needs rather than income, highlights the policy's focus on need rather than financial capacity, ensuring that those with the greatest care needs receive support regardless of their financial status.
6. Additional Benefits for Informal Carers:
- a. Informal carers play a critical role in many EU countries, and some countries, including Belgium and Ireland, provide benefits specifically for informal carers. However, in Cyprus and Greece, there are no additional benefits for carers, which suggests that the direct formal support for caregivers is either limited or non-existent in these regions.
7. Choice of Providers:
- a. Many countries, such as Belgium, Croatia, and Estonia, allow beneficiaries to choose their care providers, offering flexibility and empowering individuals to select caregivers who best meet their needs. In contrast, Denmark offers only a limited choice of providers within the framework of its municipal systems, reflecting a more centralized approach to long-term care provision.

There is substantial variation in long-term care policies across the EU, with differences in the structure, accessibility, and generosity of care allowances. While most EU countries provide some form of cash benefits for older individuals, the amount, eligibility criteria, and conditions attached to these benefits differ substantially. In particular, the variation in whether allowances are free or bound, the level of means testing, and the existence of informal carer support

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mechanisms demonstrate the complexity of designing systems that effectively meet the needs of an ageing population.

Table 1: Characteristics of the long-term care benefits, with a focus on the chosen care allowances

COUNTRY	Are there any cash benefits in the country?	What are the levels of the chosen care allowance (monthly)?	What is the threshold for granting the care allowance?	Is there a free or bound use of the care allowance?	Is there means testing for any cash benefits in the country?	Are there any benefits for informal carers?	Is a choice of care providers permitted?
Austria	✓	Pflegegeld (EUR): 192,00 354,00 551,60 827,10 1,123.50 1,568.90 2,061.80	at least 65 hours of help per month	free	✗	cash benefits, other benefits	✓
Belgium	✓	zorgbudget voor ouderen met een zorgnood, allocation pour l'aide aux personnes âgées, Pflegegeld (EUR): Max 404 (Wallonia, Brussels) 710 (Flanders) 447 (German-speaking Community)	at least 7 points out of 18 (Flanders, Wallon, Brussels)	free	✓	cash benefits, other benefits	✓
Bulgaria	✓	финансова подкрепа (BGN): 36.82 78.90 131.50 157.80 299.82	50% degree of disability (certificate of permanent disability needed)	free	✗	training, no cash benefits, no other benefits	✓
Croatia	✓	Inkluzivni dodatak (EUR): 720 480 432 162 138	visual/hearing/voice/language/ speech disorders of II. degree, and/or chronic disease of II. degree of a single adult	free	✓	cash benefits, other benefits	✓
Cyprus	✓	Ελάχιστου Εγγυημένου Εισοδήματος: πρόγραμμα επιχορηγήσεων για άτομα με αναπηρία (EUR):	mild impairments	bound	✓	✗	✓

		100 200 300 400					
Czechia	✓	Příspěvek na péči (CZK): 880 4900 14800 (23000) 27000	help with at least 3 out of 10 ADLs	free	✓	other benefits, no cash benefits	✓
Denmark	✓	Borgerstyret personlig assistance: amount individual, not income-based	✗	bound	✗	cash benefits, other benefits, training	✓
Estonia	✓	care allowance depends on the local government, but there are cash benefits for the disabled Allowance for a person of retirement age with disabilities (EUR): 12.79 26.85 40.91	moderate disability	free	✓ (municipalities have the right to decide)	cash benefits (in most municipalities), other benefits	✓
Finland	✓	Eläkettä saavan hoitotuki (EUR): 83.34 181.56 383.92	at least weekly help or guidance and supervision in personal activities	free	✗	other benefits, training	✗
France	✓	Allocation personnalisée d'autonomie (EUR): max 1,955.60 max 1,581.44 max 1,143.09 max 762.87	needs help with transfers, but once up, can move around; needs help with washing and dressing	bound	✓	cash benefits, other benefits, training	✓
Germany	✓	Pflegegeld (EUR): 332 573 765 947	at least 27 out of 100 points	free	✗	cash benefits, other benefits, training	✓
Greece	✓	εξωϊδρυματικό επίδομα αναπηρίας (EUR): 854	defined medical conditions and severe disability	free	✗	✗ basically no benefits	✓
Hungary	✓	✗	✗	✗	✗	cash benefits	✓

Ireland	✓	X	X	X	✓	cash benefits, other benefits, training	✓
Italy	✓	Indennita di accompagnamento (EUR): 531.76	not unified/transparent	free	✓	other benefits	X
Latvia	✓	Pabalsts cilvēkiem ar invaliditāti, kuriem nepieciešama īpaša kopšana (EUR): 213.43 413.43 (for individual with disability caused by an illness from childhood)	very severe disability plus less than 7 points out of 20	free	X	other benefits, training	✓
Lithuania	✓	Tikslinės kompensacijos, (EUR): 99 181.50 313.50 429	maximum 40 points out of 48 (not linear)	free	X	other benefits	✓
Luxembourg	✓	Dépendance prestation en espèces, weekly (EUR): 12.50 37.50 62.50 87.50 12.50 137.50 162.50 187.50 212.50 262.50	minimum of 3,5 hours per week	bound	X	other benefits, training	✓
Malta	✓	Skema Carer at Home (EUR): max 8000/12=667		bound	X	cash benefits, training	✓
Netherlands	✓	Persoonsgebonden budget (EUR): 38 amounts from 1,630 to 11,517, at least minimal contribution is further deducted	dependent on the group (nursing and care, mentally handicapped, mildly mentally handicapped, physically handicapped, sensory handicapped, mental healthcare)	bound (/in-kind)	X the minimum and maximum contribution for the personal budget depends on income	X	✓
Poland	✓	Zasitek pielęgnacyjny (PLN): 215.84	total dependence on help (no assessment above age 75)	free	✓	cash benefits, other benefits	✓

Portugal	✓	Complemento por dependência, (EUR): 122.90 221.21	unable to perform autonomously the essential ADLs+iADLs	free	✓	cash benefits, other benefits, training	✓
Romania	✓	Indemnizație pentru persoanele cu handicap (lei): 660*0.7=462 660*0.53=350	profound disability	free	✗	cash benefits (compensation for services provided), other benefits, training	✓
Slovakia	✓	Peňažný príspevok na osobnú asistenciu: 5,83 EUR/hour of assistance	no minimum number of hours of help needed	bound	✓	cash benefits, other benefits	✓
Slovenia	✓	Dodatek za pomoč in postrežbo, (EUR): 180.85 361.69 518.66	person needs assistance to perform more than half of the ADLs	free	✗	cash benefits	✓
Spain	✓	Prestación económica vinculada al servicio (EUR): max 313.50 max 445.30 max 747.25	needs help to carry out several basic ADLs+iADLs, at least once a day or has needs for intermittent or limited support for personal autonomy	bound	✓	other benefits, training	✗
Sweden	✓	✗	✗	✗	✗	other benefits	✗

Note: The information and care allowance amounts are valid as of November 2024. The threshold for granting the care allowance refers to the assessment procedure and the threshold level of dependence on help. Bound use of care allowance is defined in this report by the necessity to submit invoices/receipts to authorities to prove the use of care allowance. Or at least by the necessity of naming the caregiver (and having a contract with them). In the countries with a free use of care allowance, the beneficiaries can use the benefit as they see fit. "Other" benefits for informal carers are mainly paid leaves for medical assistance, contributions to social security or healthcare systems on behalf of the informal carer, or the right to flexible work hours. Greater detail can be found in the Appendix (Chapter 8).

3. Empirical analysis of cross-country difference in care use

In this chapter, we conduct an empirical analysis to explore how home care services are used across Europe. We use SHARE data to provide insights into the differences in the use of (home) care services across and within countries and to evaluate whether the use of care by the older population is distributed according to needs.

We begin by documenting the differences in the use of formal home care across European countries. The variation in the use of home care services is not only influenced by national policy frameworks but also by the underlying health-related needs of the population. The level of care required depends on several factors, including physical limitations, cognitive impairments, and the ability to perform basic activities of daily living (ADLs) (Rockwood, 2007). For instance, individuals with severe mobility issues or dementia are more likely to require formal home care services, while those with milder conditions may manage with informal care or self-care (Crocker Houde, 1998). We document differences in care use, focusing on ADLs because we expect impairments as a strong predictor. Typically, home care support involves relieving vulnerable older individuals of (i)ADL related impairments. Therefore, we expect higher (i)ADL impairments to be associated with higher formal care use in a functioning long term care system.

We do the same for informal care, as formal and informal care can be either substitutes or complements. Whether formal care replaces informal care depends on the specific care tasks involved (Bonsang, 2009), but might also depend on country-specific systems; in some countries, reliance on informal care is a result of a lack of (publicly financed) formal services, while in others informal care is actively stimulated through subsidies and other arrangements next to formal care (Lamura & Nies, 2014). We therefore confront the shares of individuals receiving informal – and formal care to assess to what extent these indeed act as substitutes across countries. We further extend this analysis by differentiating between different levels of need.

Some countries have eligibility requirements to access formal home care to ensure a level targeting. Additionally, eligibility requirements may reflect the weight country assigns to home care solutions in long term care. We explore eligibility in two ways. First, we estimate how many individuals are likely to be eligible given the eligibility criteria for home care. We compare this amount to the share of individuals that use home care. Second, we apply the eligibility rules of a country to Europe's population to gauge of how generous a country's eligibility system is independent of its own demographic composition.

Data and Methods

Data

The Survey of Health, Ageing and Retirement in Europe (SHARE) provides microdata of individuals aged over 50 across Europe. SHARE contains representative samples from each participating country. The database includes broad set of health, socio-economic and demographic related variables. We use data from Wave 9, conducted from October 2021 to October 2022 (SHARE-ERIC, 2024). Our sample includes only the population over 65 because that is where home care is concentrated. We exclude users of institutional care facilities because they are not a representative sample in SHARE. Additionally, we drop Luxembourg, Cyprus, and Malta due to the non-representativeness of their home care population. All presented statistics have survey weights from SHARE wave 9 applied so that the country means are representative of the countries' 50 plus population in 2021/22.

Our main variables of interest are formal and informal care use. Formal care is identified using the health care module (HC) of SHARE. Individuals are defined as formal care users if they answer in the affirmative to the following question: "did you receive in your own home any professional or paid services listed on this card due to a physical, mental, emotional or memory problem in the last 12 months?". The listed services include help with personal care in own home, help with domestic tasks in own home, meals-on-wheels, or other activities such as filling medicine dispenser. It is worth noting that SHARE data does not make a distinction between public and private provision of paid formal care. Hence, we can only indirectly assess differences in the use of publicly financed services.

The use of informal care is identified using the social support module (SC) of SHARE. We define an informal care user as one who affirmatively responded to the question, "Which family member(s) from outside the household, friend or neighbour has helped you in the last twelve months" or "Which child provided care". Types of help include personal care, household help, and clerical work. In both cases of formal and informal care, personal care is defined as help with dressing, washing, eating. Finally, formal care and informal care are not mutually exclusive: in case individuals use both formal and informal care, they are included in both categories.

Our principal measures of disability are the activities of daily living (ADLs) and instrumental activities of daily living (iADLS). ADLs refer to activities that represent direct physical limitations. The activities included are, walking 100 metres, sitting for two hours, getting up from a chair, climbing several flights of stairs, climbing one flight of stairs, stooping, kneeling, crouching, reaching or extending arms above the shoulder, pulling or pushing large objects, lifting or carrying weights over 5 kilos, picking up a small coin from a table. iADLS refer to activities that represent overall well-being and independent living. iADLS include difficulties with using a map in a strange place, preparing a hot meal, shopping for groceries, making telephone calls, taking medications, doing work around the house or garden, managing money, leaving the house independently/accessing transportation, and doing personal laundry. ADLs and iADLS were

categorized to identify individuals with varying levels of disability (Wade & Collin, 1988). ADLs and iADLs were grouped together into three categories reflecting increasing care needs: no (i)ADLs, one (i)ADL, and two or more (i)ADLs.

Table 2 presents summary statistics of our sample by country and in total. The sample comprises 49,635 observations across 24 European countries. On average, 44% of respondents are male, with a range from 35% in Estonia and Lithuania to 48% in Germany and Sweden. Females account for 56% of the sample, consistent across countries. The average age of respondents is approximately 74.69 years, with the youngest mean age observed in Slovakia (72.01 years) and the oldest in Sweden (75.87 years). On average, 12% of respondents reported difficulties with one ADL, with the lowest prevalence in Bulgaria (7%) and the highest in Switzerland (15%). Difficulties with two or more ADLs were reported by 42% of respondents, ranging from 25% in Switzerland to 65% in Greece.

Formal care services are used by 9% of respondents on average, with substantial variation across countries. Of the different types of formal care services, personal care services were used by 2% of the sample overall, peaking in Spain (9%). Domestic help was more common (7% overall), with Belgium showing the highest proportion (19%) and Lithuania the lowest (2%). Meals and other forms of formal care were utilized by fewer than 4% of respondents on average.

The use of informal care is more prevalent than formal care use, with 17% of respondents receiving assistance from informal caregivers, particularly for personal needs (3%) and household help (19%). The highest rates of informal household help were observed in the Czechia (34%) and the lowest in Lithuania (9%). Assistance with paperwork was less common, with an average prevalence of 10%, peaking in Greece (22%).

The number of observations per country varies, with Germany (3,046), Poland (3,498), and Austria (2,399) having the highest representation. Conversely, smaller samples were observed in Bulgaria (604) and Slovakia (612).

	AUT	BEL	BGR	CHE	CZE	DEU	DNK	ESP
Mean								
Male	0.41	0.45	0.39	0.46	0.38	0.48	0.48	0.44
Female	0.59	0.55	0.61	0.54	0.62	0.52	0.52	0.56
Age	75.72	74.53	74.39	74.86	74.49	74.59	73.98	76.28
1(i)ADL	0.12	0.13	0.07	0.15	0.14	0.15	0.15	0.07
2+(i)ADLs	0.41	0.40	0.54	0.25	0.43	0.38	0.27	0.48
I) Formal Care	0.13	0.22	0.07	0.09	0.09	0.11	0.11	0.17
A) Personal	0.04	0.05	0.01	0.02	0.02	0.03	0.02	0.09
B) Domestic Help	0.10	0.19	0.03	0.08	0.03	0.08	0.08	0.16
C) Meals	0.04	0.03	0.04	0.02	0.06	0.02	0.03	0.02
D) Other	0.03	0.02	0.02	0.02	0.02	0.03	0.03	0.03
II) Informal Care	0.34	0.24	0.21	0.22	0.38	0.25	0.28	0.15
A) Personal	0.05	0.03	0.05	0.03	0.04	0.03	0.01	0.07
B) Household Help	0.31	0.21	0.19	0.18	0.34	0.22	0.23	0.13
C) Paperwork	0.11	0.09	0.09	0.07	0.17	0.09	0.10	0.10
N	2399	3219	604	1571	2867	3046	1768	1551

	EST	FIN	FRA	GRC	HRV	HUN	ITA	LTU
Mean								
Male	0.35	0.47	0.44	0.45	0.45	0.42	0.44	0.35
Female	0.65	0.53	0.56	0.55	0.55	0.58	0.56	0.65
Age	75.79	74.41	74.79	74.96	73.85	73.29	75.43	75.16
1(i)ADL	0.12	0.13	0.15	0.09	0.10	0.07	0.09	0.10
2+(i)ADLs	0.49	0.32	0.37	0.65	0.49	0.47	0.43	0.52
I) Formal care	0.05	0.08	0.15	0.06	0.05	0.07	0.10	0.03
A) Personal	0.01	0.01	0.03	0.02	0.01	0.01	0.03	0.02
B) Domestic Help	0.03	0.07	0.13	0.05	0.03	0.02	0.08	0.02
C) Meals	0.03	0.01	0.03	0.01	0.01	0.04	0.01	0.01
D) Other	0.02	0.02	0.03	0.02	0.01	0.01	0.02	0.01
II) Informal care	0.30	0.27	0.23	0.27	0.23	0.12	0.12	0.17
A) Personal	0.03	0.02	0.02	0.04	0.04	0.03	0.04	0.05
B) HH Help	0.26	0.22	0.20	0.23	0.22	0.11	0.09	0.16
C) Paperwork	0.14	0.11	0.08	0.22	0.08	0.05	0.08	0.09
N	3217	1410	2247	2445	3133	1343	3035	987

	LVA	NLD	POL	PRT	ROU	SVK	SVN	SWE
Mean								
Male	0.36	0.47	0.44	0.45	0.44	0.48	0.44	0.46
Female	0.64	0.53	0.56	0.55	0.56	0.52	0.56	0.54
Age	74.60	74.22	73.61	74.77	73.40	72.01	74.83	75.87
1(i)ADL	0.12	0.14	0.09	0.09	0.09	0.10	0.10	0.15
2+(i)ADLs	0.48	0.28	0.44	0.47	0.47	0.43	0.40	0.29
I) Formal care	0.03	0.16	0.03	0.12	0.02	0.08	0.04	0.08
A) Personal care	0.01	0.03	0.01	0.03	0.00	0.01	0.01	0.02
B) Domestic Help	0.02	0.14	0.02	0.10	0.01	0.06	0.02	0.07
C) Meals	0.02	0.03	0.01	0.03	0.00	0.03	0.02	0.02
D) Other	0.01	0.03	0.01	0.02	0.02	0.02	0.01	0.02
II) Informal care	0.15	0.23	0.12	0.13	0.16	0.17	0.19	0.21
A) Personal help	0.02	0.02	0.03	0.04	0.05	0.03	0.04	0.01
B) HH Help	0.14	0.19	0.10	0.10	0.16	0.16	0.16	0.18
C) Paperwork	0.06	0.10	0.06	0.07	0.07	0.08	0.09	0.07
N	1072	1920	3498	1077	1058	612	3151	2405

Full Sample	
Mean	
Male	0.44
Female	0.56
Age	74.69
1(i)ADL	0.12
2+(i)ADLs	0.42
I) Formal	0.09
A) Personal	0.02
B) Domestic Help	0.07
C) Meals	0.02
D) Other	0.02
II) Informal Care	0.22
A) Informal Personal	0.03
B) Informal HH Help	0.19
C) Paperwork	0.10
N	49635

Table 2: Descriptive statistics for 65 years old and above in Wave 9 of SHARE by country and in total.

A, B, C refer to sub-categories that compose formal and informal care.

Methods

General approach

Our analysis consists of multiple steps. We begin by comparing differences in the use of formal care and underlying levels of disability across countries. We subsequently relate the intensity of needs in a country to levels of care provision by plotting the use of formal care for individuals with moderate limitations (1 (i)ADL limitation) to the use among individuals with severe limitations (2 or more (i)ADL limitations). We perform a similar analysis for informal care use. Finally, we assess potential substitution of informal care by formal care by correlating the share of formal care users in a country with the share of informal care users, for the entire population and across different levels of need.

Eligibility is a key determinant of explaining formal care use. Therefore, we estimate eligibility within countries based on their eligibility criteria for care allowance (Table 1). We apply these rules to the SHARE data to quantify the population eligible for care or cash allowance (this is explained in more detail in the next section). We further expand the analysis by applying a country's rules to the entire European population to gauge the extensiveness of access to care independent of a country's own population characteristics.

Mapping of eligibility criteria to the SHARE data

We focus on 8 countries for which the available information in the SHARE data enables us to replicate the eligibility criteria used (also see Brugiavini et al. (2017)): **Austria** (Pflegegeld), **Belgium** (Allocation pour l'aide aux personnes âgées = APA; zorgbudget voor ouderen met een zorgnood), **Czechia** (Příspěvek na péči), **France** (APA), **Germany** (Plegegeld), **Hungary** (in-kind benefits), **Latvia** (Pabalsts cilvēkiem ar invaliditāti, kuriem nepieciešama īpaša kopšana), **Spain** (Prestación económica vinculada al servicio = PEVS). The benefits in these countries are awarded to individuals in need based on formalised procedures that can be to a large extent simulated using the SHARE data. By matching the assessment criteria with the SHARE questions, we try to assess what proportion of the population is theoretically eligible for the benefit.

This approach builds on earlier work by Brugiavini et al. (2017). Since the publications, some countries have changed their eligibility rules. We update their analysis by using, Czechia, Germany, Austria, Spain, France, Belgium, Hungary, and Latvia. Our analysis will be done in three steps. First, we explore country specific eligibility. However, this step may only reflect underlying health differences. Second, we apply each country's minimum dataset for home care to the European population to gauge the generosity of each system. Third, we separate eligibility by levels of impairments to understand if system is targeting all disability levels or solely the high disability.

For each of these benefits/countries, the assessment criteria and the corresponding SHARE questions are listed in the Appendix (Chapter 9). The Appendix also lists the weights the individual criteria form within the final measure of dependency of the person who is being assessed. There are two main challenges in our approach: not all the criteria can be perfectly represented by the SHARE questions, (2) most of the assessment mechanisms distinguish between several intensity

levels of help needed, however, the SHARE questionnaire only asks if any help is needed. As for the first challenge, we tried to find the best proxies in the SHARE questionnaire for each criterion. Only criteria related to the specific therapeutic measures used had to be excluded (Austria, Germany). The intensity of help needed was chosen differently across countries, based on the available data. We opted for the 'lower bound' for Germany and Spain. For each criterion, we assigned the lowest level of help needed when the individual expressed in the SHARE questionnaire that she/he could not perform the task without help. The resulting proportion of the population that is deemed eligible based on our procedure is then expected to be lower than the true proportion. The opposite was done for Hungary and Latvia, where the highest level of dependency on help was assigned whenever the need for help was indicated. A middle path was chosen for Belgium. See the description for each country in the Appendix. The intensity of help needed is irrelevant for the procedures in Austria, Czechia and France.

Results

Use of formal home care

Figure 1 visualises the variation in formal care use across Europe. The variation across countries is substantial; Belgium, the Netherlands, and France have the highest rates of formal care use (more than 15%). On the contrary, Romania, Latvia, and Poland show the lowest use (less than 5%). The remainder of the countries make up the body of the bar plot. The overall patterns have many potential explanations. First, they could be reflecting differences in health and limitations across countries. Second, differences could be explained by the targeting of eligibility systems for home care. Finally, it may be due to policy levers such as, means testing for cash benefits, cash benefit provisions, or intended coverage by the system. In the next sections, we will zoom in further on the relation between care provision, health needs, and informal care giving.

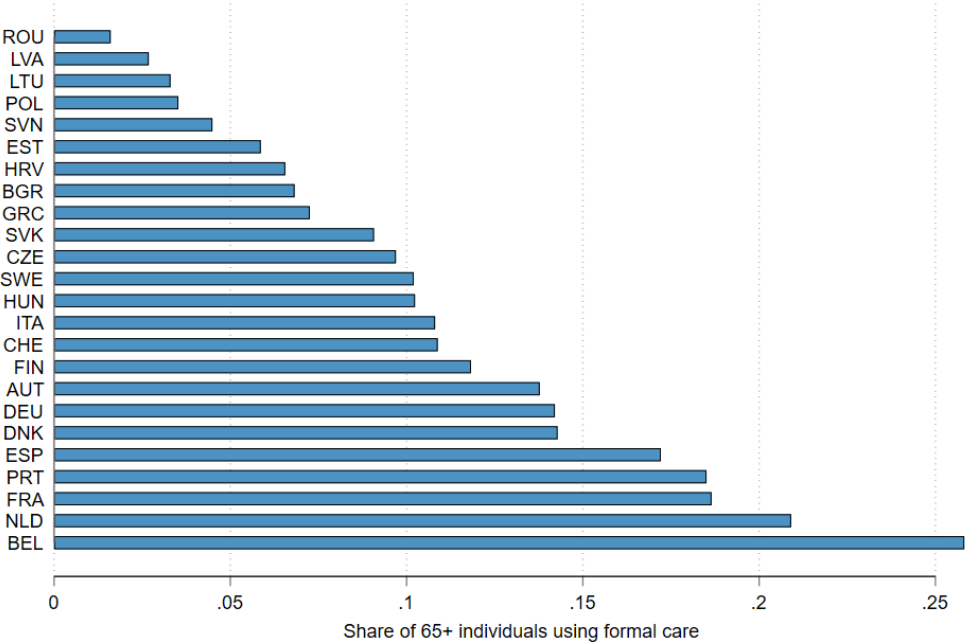


Figure 1: Share of individuals over 65 that are using formal care across Europe.

Disability levels

Figure 2 shows the share of older people experiencing one or more difficulties with Activities of Daily Living (ADLs), categorized into two groups: 1 (i)ADL difficulty (1 (i)ADL) and 2 or more (i)ADL difficulties (2+ (i)ADLs). 47% for the European population have 2+ (i)ADLs limitations and 12% of the European population has 1 (i)ADL limitation.

There is considerable variation in limitations across the different populations. The Eastern and Southern European countries tend to have the highest share of individuals with one or more (i)ADL limitations. Greece, Croatia, and Lithuania have a particularly large burden of impairments, with more than 60% of the older individuals reporting limitations. Some of the Nordic and Western-European countries (Switzerland, the Netherlands, Denmark) have relatively low levels of needs, with less than 50% of the population reporting limitations.

When we zoom in on differences in the intensity of need, a more complex pattern emerges. The first (blue) bar represents the share of the population with 1 (i)ADL limitation. Denmark, Sweden, and Switzerland have the highest proportions, with around 16.5% of individuals, reporting 1 ADL difficulty. These countries thus not only have a relatively low share of total needs, but also a relatively low intensity of need within their population. Conversely, compared to the mean, countries such as Bulgaria, Spain, and Hungary have notably lower proportions, around 6% to 8%. This suggests that some countries may experience a higher prevalence of relatively mild health difficulties in daily living.

When we look at the 2+ ADLs category, the pattern shifts. Greece stands out with the highest proportion of individuals (67.7%) reporting two or more ADL difficulties. This is followed by Croatia, where 57.7% of individuals report similar impairments, and Bulgaria at 56.3%. On the other hand, countries like the Netherlands, Switzerland, Sweden and Denmark have the lowest proportions, all with less than 35% of individuals reporting 2+ ADLs.

A comparison of Figures 1 and 2 already highlights that countries with the highest levels of formal care provision are not necessarily those with the highest levels of needs. This suggests that differences in eligibility criteria and LTC systems play an important role as well. We explore the interaction between need and formal care use further in the next section.

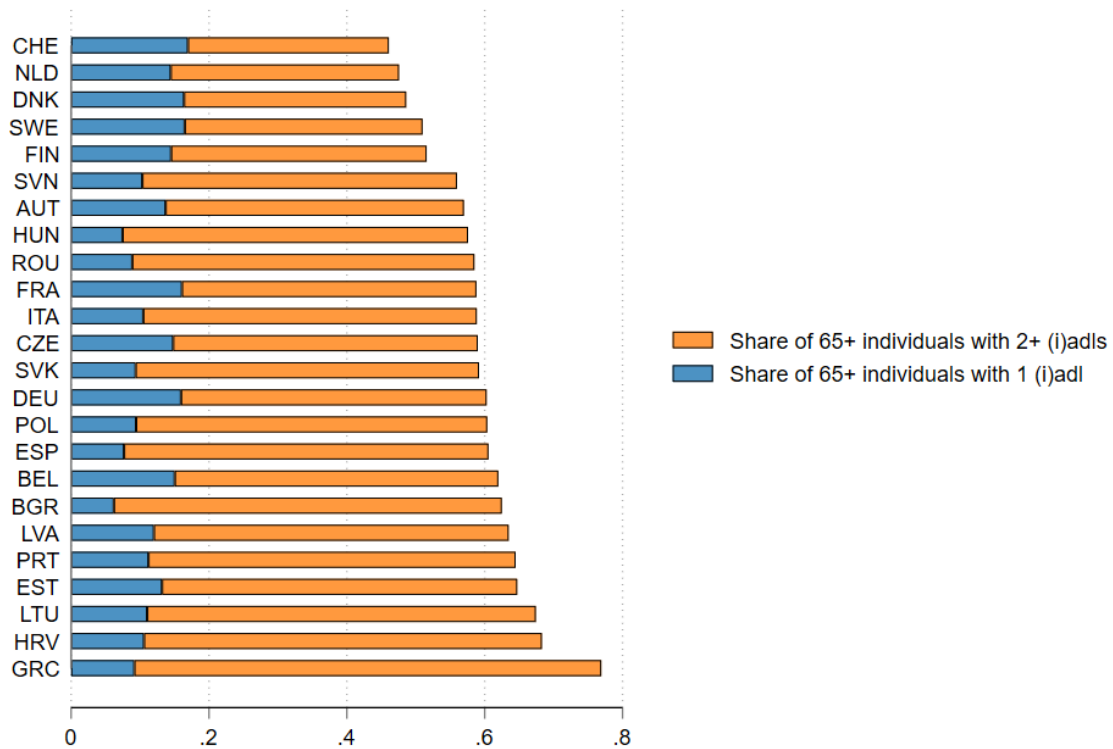


Figure 2: The share of 65+ individuals with 1 and 2+ (i)ADL limitations across countries.

Use of formal care by disability level

Figure 3 plots the share of formal care users among individuals with 1 (i)ADL limitation against the share of care users among individuals with 2+ (i)ADL limitations or more. The aim of the figure is to show how much formal care provision occurs across countries conditional on need. By differentiating between levels of needs, we get an impression of the targeting of care based on the severity of the health problems. In general, the share of individuals receiving formal care is higher among individuals with more than one limitation. There is also a strong correlation between the level of home care provided for individuals with 1 (i)ADL limitation and more than one limitation, suggesting that countries that provide more formal care do so across the entire needs distribution. However, underneath this general pattern, there are differences in the relation between the intensity of care for individuals with moderate and high needs. The top right quadrant represents countries that provide relatively high levels of formal care at both levels of (i)ADL limitations. The Netherlands, Belgium, France, Denmark, and Austria stand out in this regard. The bottom left quadrant shows countries that have a low use of formal home care overall. Romania, Lithuania, Latvia, and Poland are in this group. Countries like Czechia and Portugal (in the top-left quadrant) have a relatively low provision of care for individuals with 1 ADL limitation, but relatively high levels for individuals with at least two ADL limitations. Italy and Hungary provide above average levels of formal care for individuals with 1 ADL limitation, but lower than average levels for individuals with more severe needs.

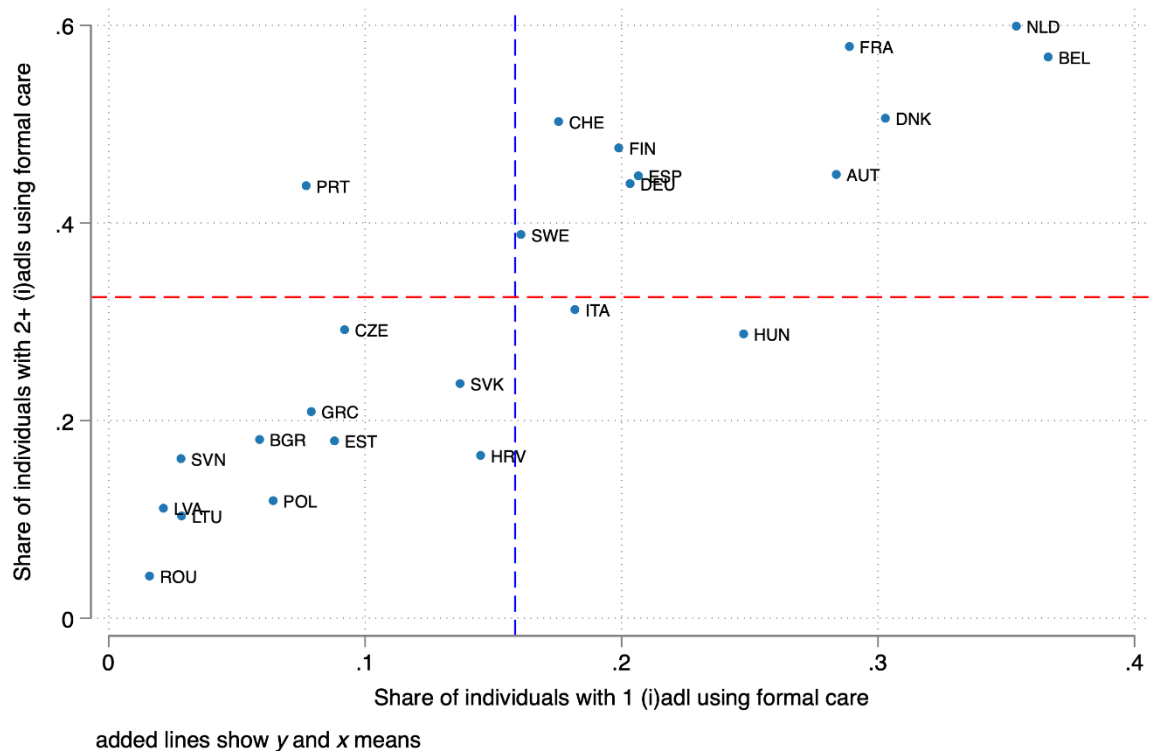


Figure 3: The use of formal care among older (65+) individuals with 1 versus 2+ (i)ADLs limitations.

The vertical and horizontal lines represent the mean of each axis. On average, 16% of individuals with 1 (i)ADL use formal care. On average, 33% of individuals with 2+ (i)ADLs use formal care.

Use of informal care by disability level

Figure 4 shows the use of informal care across levels of need in each country. Levels of informal care provision are generally higher than formal care, suggesting that in all European countries, regardless of their levels of formal care provision, informal care plays an important role in the provision of care to older individuals. Again, there is a strong association between the levels of care provided for moderate and high levels of needs across countries. Interestingly, some of the countries that provide high levels of formal care also provide high levels of informal care, while other countries provide higher levels of informal care compared to informal care or vice versa. This suggests that, partly depending on the country setting, informal care can act as both a substitute and complement to formal care. We explore this further in the next Section.

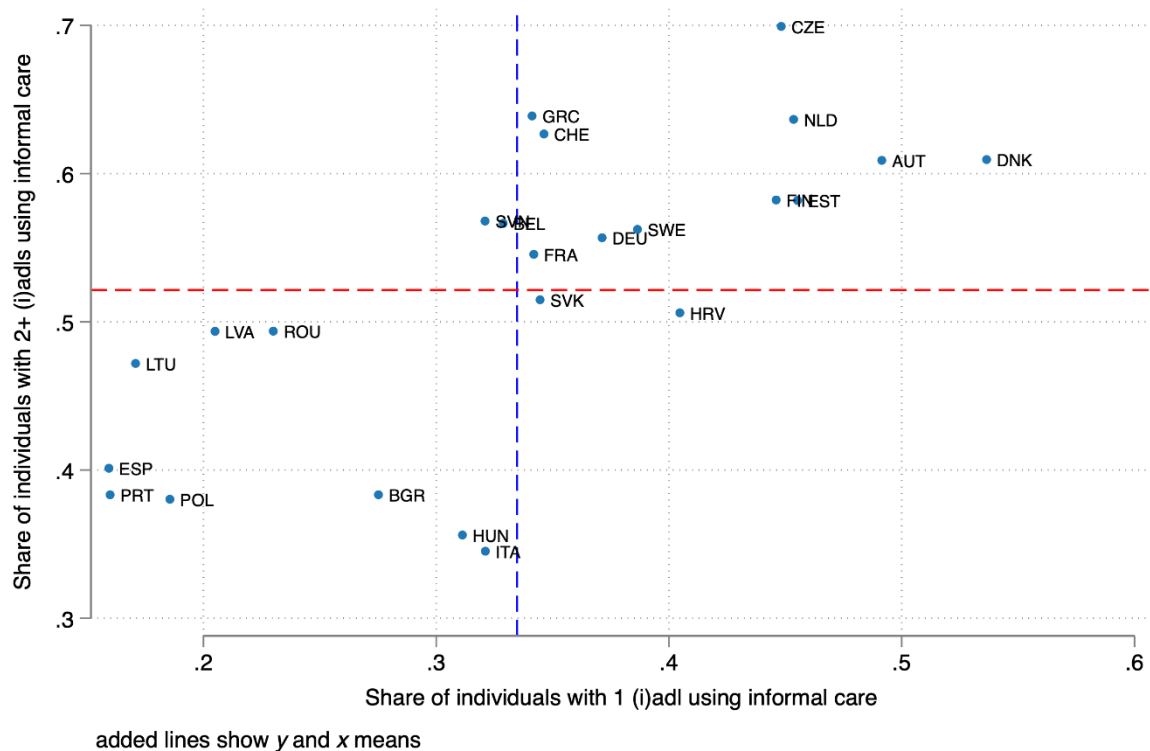
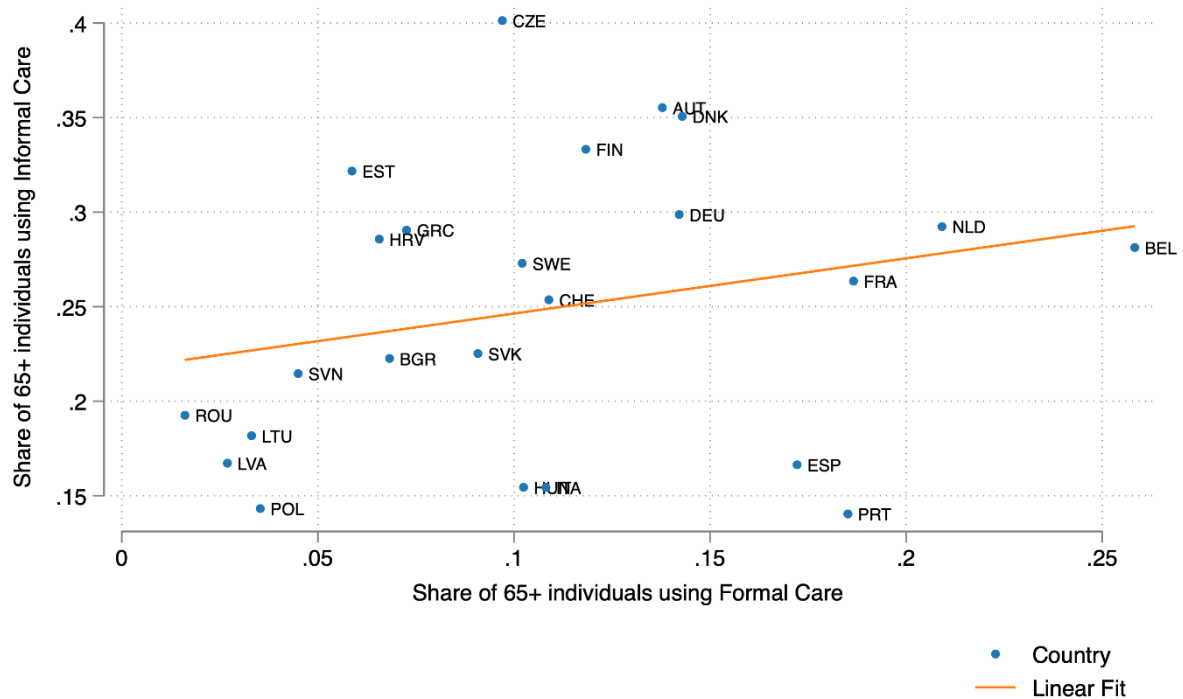


Figure 4: Comparison of individuals with 1 versus 2+ (i)ADLs limitations using informal care.

The vertical and horizontal lines represent the mean of each axis. On average, 34% of individuals with 1 (i)ADL use informal care. On average, 52% of individuals with 2+ (i)ADLs use informal care.

Relation between formal and informal care use

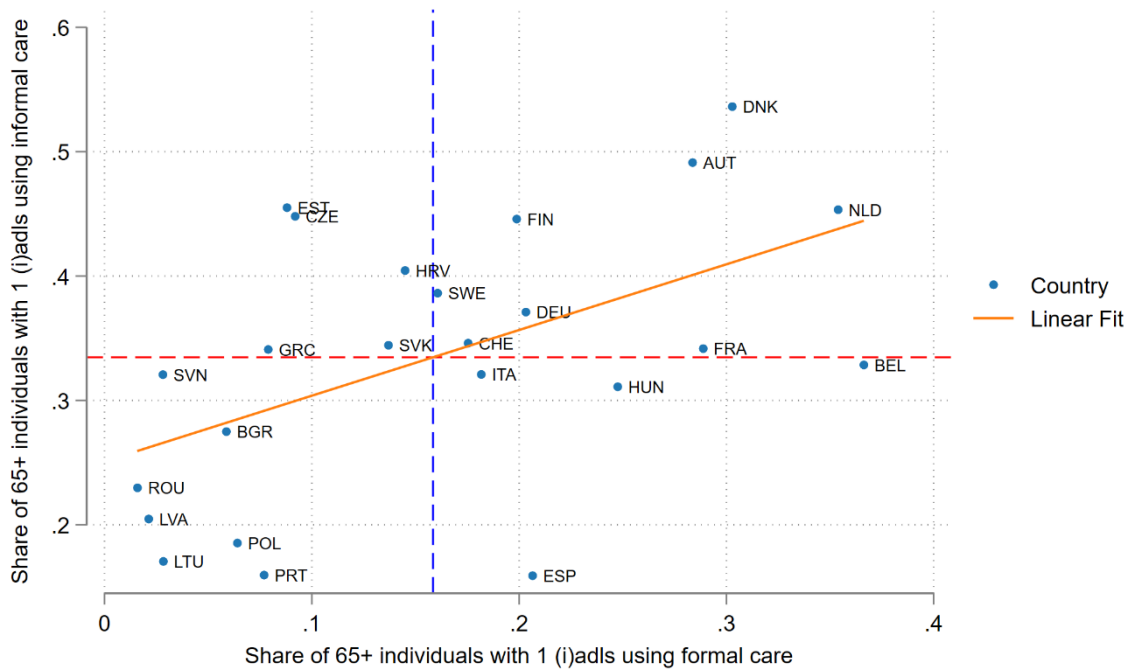
Figure 5 shows the association between the share of formal care and informal care users across countries. As a reference, a linear regression line has also been fitted. In general, there seems to be a positive association between formal and informal care provision; countries that provide higher levels of formal care to their population are also more likely to provide higher levels of informal care. There is, however, substantial heterogeneity. For instance, countries such as Spain and Portugal stand out with high levels of formal care but relatively low levels of informal care. On the contrary, countries like Romania, Latvia, and Poland show low shares of both formal and informal care, clustering near the bottom-left of the graph.



$$\text{Informal Care} = .22 (.03) + .29 (.25) \text{ Formal Care}$$

Figure 5: Relationship between the share of individuals receiving formal and informal care by country. Standard errors in parenthesis.

This simple association is likely to, at least, partly depend on underlying differences in needs across countries. In Figures 6 and 7 we therefore analyse the association between formal and informal care provision *conditional* on need. Figure 6 compares the share of individuals with 1 (i)ADL limitation receiving formal and informal care. For these moderate levels of care need, we observe a positive association between the use of formal and informal care across countries. Again, there is substantial heterogeneity. Countries in the bottom left quadrant, mostly consist of eastern European countries and Portugal, show low levels of both formal and informal care. Countries in the top right quadrant (Denmark, The Netherlands, Austria) have high levels of both formal and informal care. Based on these two sets of countries, formal care seems to act as a substitute to informal care. However, we also observe countries with relatively high levels of formal care but low levels of informal care (in the bottom right quadrant, e.g. Spain). Similarly, we observe countries that rely more strongly on informal care (e.g. Estonia and Czechia).



added lines show y and x means

$$\text{At 1(i)ADL: Informal Care} = .25 (.04) + .53 (.18) \text{ Formal Care}$$

Figure 6: Comparison of formal care use against informal care use among individuals with 1 (i)ADL. Standard errors in parenthesis.

Figure 7 presents the relationship between informal and formal care at 2+ (i)ADL limitations, so at high levels of care needs. Compared to Figure 6, the shares of the populations receiving care are naturally higher. An important similarity with Figure 6 is the location of countries relative to the formal-informal care quadrants. Most countries remain in the same quadrant. However, although there is still a positive cross-country association between the provision of formal and informal care, this association is much weaker for the group with high needs than for the group in moderate needs (compare the slope of the regression line between Figures 6 and 7). This suggests that at these higher levels of care, the role of formal care as a substitute for informal care becomes more important.

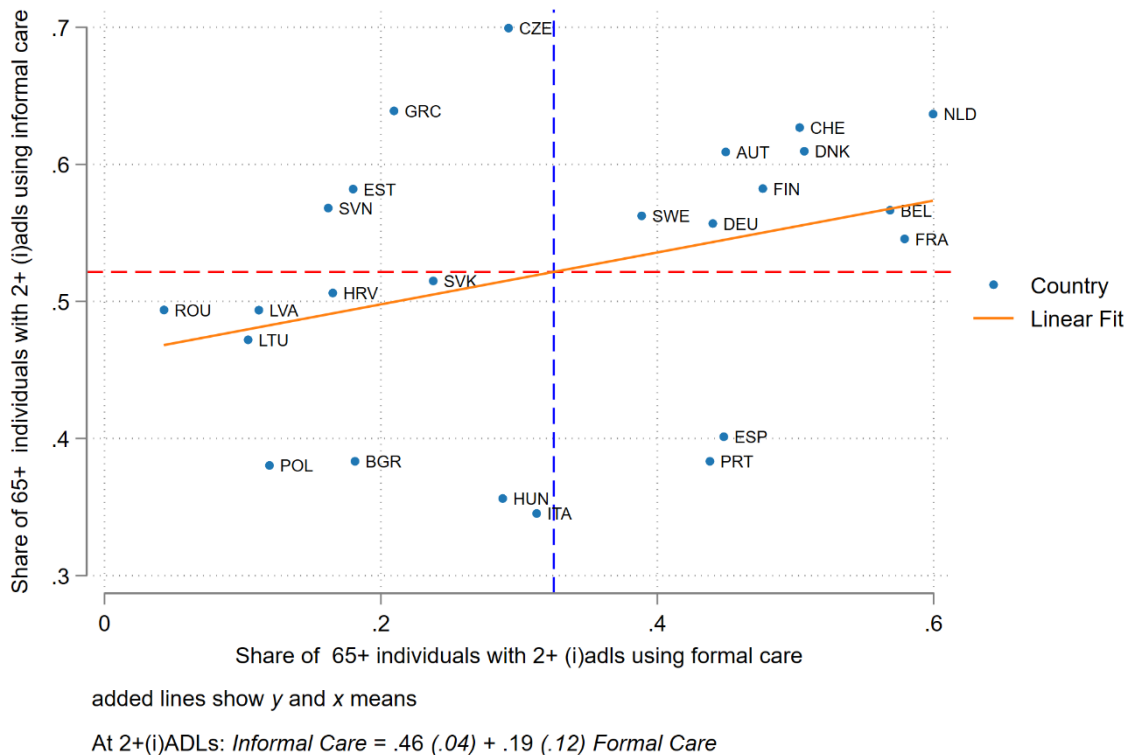


Figure 7: Comparison of formal care against informal care among individuals with 2+ (i)ADLs. Standard errors in parenthesis.

Country Specific and System Specific Eligibility

Figure 8 illustrates the share of 65+ individuals that qualifies for the eligibility for care allowance in a selected number of countries, based on an application of the eligibility criteria of that country to the SHARE data. We find substantial variation in eligibility for care allowance across European countries. Czechia leads by a wide margin at 18.7%, indicating a highly inclusive system. In contrast, Latvia has the lowest eligibility rate at just 1.1%, reflecting a much more restrictive approach. Other countries, such as Belgium, Hungary, and Spain, have moderate eligibility rates, while Austria, France, and Germany show relatively higher eligibility, but still significantly lower than the Czechia. However, it must be noted that the threshold (lowest) care allowance levels differ significantly across these countries (see Table 1). For example, in Czechia, the lowest care allowance was only around €35 in 2024. Prices for an hour of home care differ significantly across providers and Czech regions, but this would be enough to pay only for approximately 2-4 hours of home care per month.

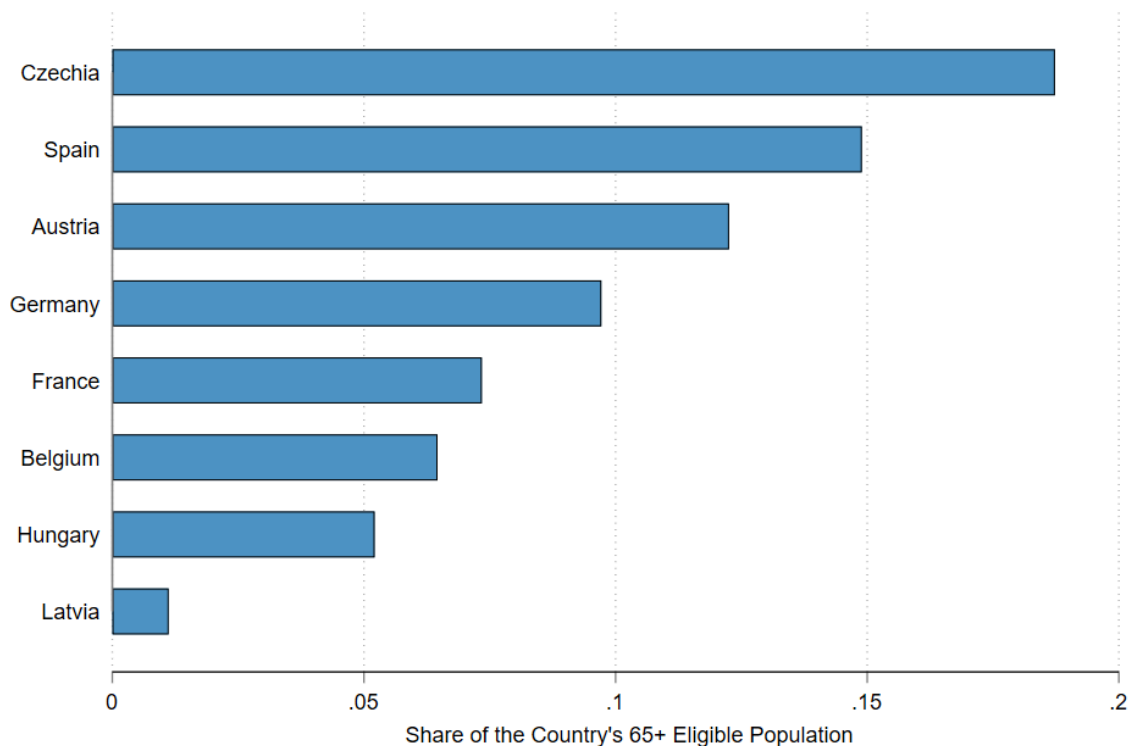


Figure 8: Share of a country's 65+ population that would be eligible for coverage under their own eligibility criteria for home care benefits.

Note: The included benefits: **Austria** (Pflegegeld), **Belgium** (Allocation pour l'aide aux personnes âgées = APA; zorgbudget voor ouderen met een zorgnood), **Czechia** (Příspěvek na péči), **France** (APA), **Germany** (Plegegeld), **Hungary** (in-kind benefits), **Latvia** (Pabalsts cilvēkiem ar invaliditāti, kuriem nepieciešama īpaša kopšana; only individuals with a disability certificate are eligible), **Spain** (Prestación económica vinculada al servicio = PEVS). See the Appendix (Chapter 9) for a detailed description of the eligibility rules and their matching to SHARE questions.

How has eligibility changed over time?

Brugiavini et al. (2017) performed a similar assessment of eligibility criteria using an earlier wave of the SHARE data. They covered Austria, Belgium (as Flanders and Wallonia), Czechia, England, France, Germany, four regions in Italy and Spain. We compare our coverage with those reported by Brugiavini et al. (2017). We observe slight differences in terms of coverage rates. More precisely, Austria saw a gradual tightening, with eligibility rates falling from 13.5% in 2010 to 12% in 2015, before increasing to 12.3% in 2022, indicating moderately broad coverage despite earlier reductions. Belgium reduced from 9.6% in 2010 to 8.2% in 2015, with regional schemes like the Flemish insurance fluctuating significantly, culminating in a national rate reduction to 6.4% by 2022. In contrast, Czechia expanded eligibility substantially, rising from 10.6% in 2010 to 12.2% in 2015, and reaching 18.9% in 2022, the highest among observed countries, reflecting a focus on formal care. Furthermore, France contracted, with rates ranging from 13.4% in 2010 to 14% in 2015, to 7.3% in 2022, underscoring moderate inclusivity. Germany held steady at 11.7% through

2015 but contracted to 9.7% by 2022, indicating a gradual policy shift toward lower accessibility. Spain sustained relatively high eligibility, increasing slightly from 15.3% in 2010 to 16% in 2015 and 14.9% in 2022, emphasizing inclusivity despite slight variation. However, we should be cautious in interpreting these eligibility trends. Other factors beyond eligibility criteria – i.e., changes in the vulnerability profiles of individuals within countries - can influence this evidence. **We should be cautious in interpreting Figure 8 in terms of difference in country’s generosity of coverage. As highlighted by Brugiavini et al. (2017), these are crude rates of eligibility that encompass both the differences in the (generosity of the) eligibility system (regulation effect) and differences in the severity of need across countries (the population effect, see Figure 2). Figure 9 therefore shows the proportion of the entire European population that would be eligible for coverage if the eligibility criteria of a specific country would apply. This is similar to what Brugiavini et al. (2017) call the directly adjusted coverage rates, with the European population functioning as the standard population. There is significant variation in the access to care allowance across countries. The highest eligibility is observed under the Czech system, where over 28% of the population would qualify, indicating an inclusive and broad-reaching approach. In contrast, the Latvian system is the most restrictive, with only 3% of the population meeting eligibility criteria (moreover, a disability certificate is needed). Other systems such as those in Belgium, Hungary, Spain and France also exhibit relatively low coverage, highlighting their more selective frameworks. Austria and Germany represent moderately generous systems, showcasing a balance between inclusivity and restriction.**

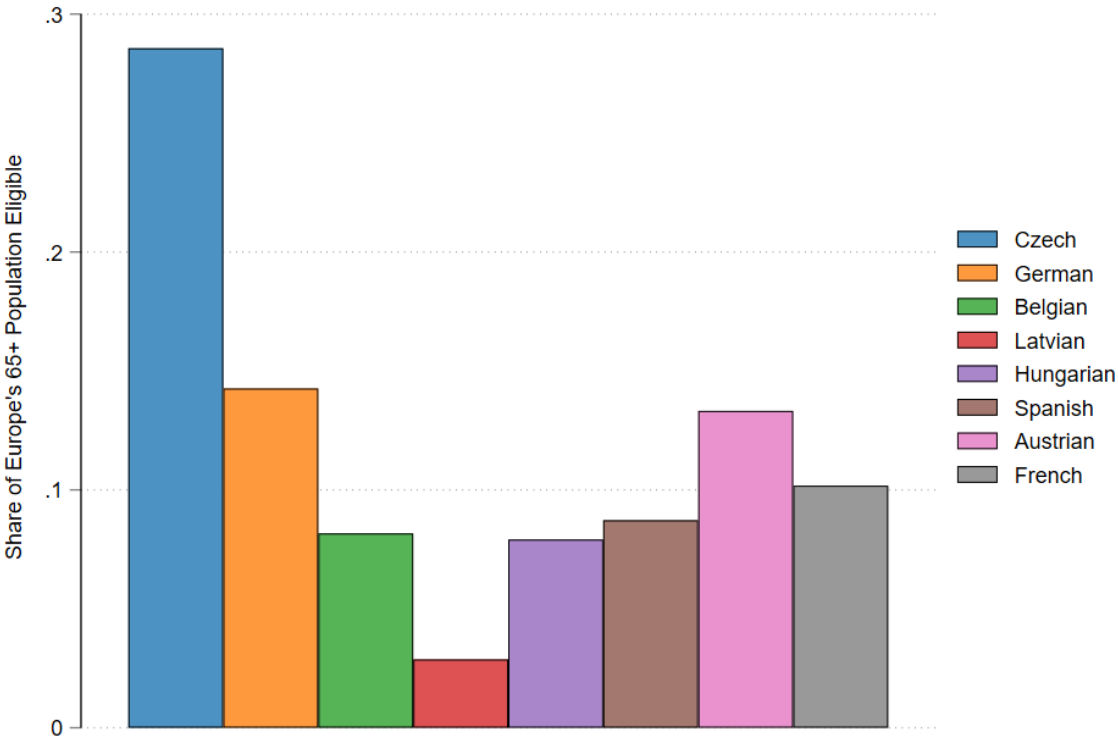


Figure 9: Proportion of Europe’s population that would be eligible for coverage under the eligibility criteria of different national systems.

4. Discussion

Main findings

We find a large variation in both the eligibility criteria used for access to care allowance and the use of formal care across European countries. **Eligibility criteria for care allowance are a key determinant of access, with significant variations across countries in terms of inclusiveness and targeting.** More inclusive systems ensure that a larger proportion of older adults can access formal care services, thereby addressing both moderate and severe needs. Restrictive systems like those in Latvia and Hungary limit access to only the most severely disabled individuals, potentially leaving many moderate-need individuals underserved. This disparity raises questions about the efficiency and equity of LTC systems, as overly restrictive eligibility criteria may exacerbate health inequalities and increase reliance on informal care.

The variation in the use of formal home care does not seem primarily driven by differences in underlying need within the population. Some countries, like The Netherlands and Denmark provide high levels of formal home care across the disability spectrum, while others like Romania, Lithuania and Latvia provide low levels of formal care, also for individuals with several limitations. The differences in formal care use among European countries are related to the design of the eligibility system and the extensiveness of publicly financed long-term care but are also due to different cultural attitudes and socio-economic conditions (Susanet et al., 2012). Our results generally are in line with the often-used classification of European LTC systems into a Nordic/Western-European system with a high reliance on formal care, Southern European countries relying more strongly on informal care, and Eastern European countries being in transition with relatively low levels of care provision (e.g. see Arriaans et al. (2021)).

The analysis of the relation between need (limitations with i(ADL)s) and care use provides insights into the targeting and effectiveness of LTC systems. Countries that align care provision with the severity of need, such as Austria and Belgium, demonstrate the potential for targeted policies to maximize resource efficiency. However, the findings also reveal gaps in addressing moderate needs, which may lead to unmet care demands and delayed interventions.

The relation between formal and informal care use across European countries is nuanced. This underscores the importance of balancing formal and informal care to ensure that neither is disproportionately strained. Formal care does not simply substitute for informal care, but in many cases seems to function as a complement. In some countries, such as the Netherlands and Denmark, a relatively high use of formal care coincides with the use of informal care even at lower levels of disability, suggesting a generous provision of formal care that complements informal care. Conversely, in systems where formal care is less accessible, such as in many Eastern European countries, informal care often substitutes for (lacking) formal services. Differences in the cultural attitudes toward caregiving further complicates the picture (Susanet et al., 2012). For example, in Southern Europe, where family-centred caregiving traditions are strong, informal care

remains a dominant form of support even when formal services are available. In Nordic and Western European countries, there is a much stronger reliance on formal care.

Limitations

Our study has a number of limitations. First, our cross-country analysis of eligibility criteria necessarily had to focus on a specific element of long-term care provision, namely care allowances (mainly cash-benefits) for care receivers. Many countries also provide in-kind services and/or allowances for informal care providers, for which sometimes different eligibility criteria apply. We have discussed these other types of public long-term care when necessary to interpret differences in care allowance across countries, but a complete overview of all these forms of long-term care was beyond the scope of the report. Similarly, some countries have more than one long-term care or allowance system, in which case we had to select one.

Second, in our empirical analysis, we cannot separate publicly financed from privately financed home care use. This complicates the interpretation of our findings. Generally, we do observe that in countries with a more generous public financing of LTC, the use of home care is higher. However, our results on use in itself do not only represent the generosity of the public system, but also reflect the ability of a country's older population to finance formal care themselves.

Third, there might be differences across countries in what people perceive as informal care giving. Although we focus on caregiving by people outside of the household, individuals in different countries might still think differently whether some of the tasks included in the questionnaire are informal care or a normal part of their activities as a family member, friend or neighbour.

Fourth, the assessment of eligibility is based on an approximation of the country-specific criteria with the available information in the SHARE data, which often does not completely match the indicators used in the eligibility assessments. This implies that the analysis of the coverage of different eligibility systems should be seen as a rough approximation. Finally, our empirical analysis of the coverage of the eligibility system focuses solely on whether individuals get access to *any* care allowance (the extensive margin), but not on the level of the allowance (the intensive margin). In many cases, generosity in the access to care coincides with generosity in the level of cash (or in-kind) allowances, but this is not always the case. For instance, based on the access to any kind of allowance, the Czech Republic has a very broad coverage, but the level of allowances is relatively low (see Figure 9 and Table 1)

5. Conclusions

This report shows large differences in the access and use of care for older individuals across and within EU countries. While this variation partly reflects differences in the socio-economic and cultural contexts, it also suggests that **harmonizing long-term care policies** across the EU could improve access and equity in long-term care, particularly in countries with limited or no national care allowances. Furthermore, countries could benefit from sharing best practices on eligibility criteria and the integration of informal care into the formal system to better support older individuals and caregivers alike. For instance, countries with limited formal care systems can draw inspiration from more developed models, such as those in Denmark and the Netherlands, which balance inclusivity with efficiency. Conversely, countries with robust informal care networks can offer insights into integrating familial and community support into formal care frameworks.

There is substantial variation in the way countries target eligibility and care use according to need. This highlights the importance of designing systems that cater to a continuum of care needs, ensuring that individuals receive appropriate support at all stages of disability. This includes expanding eligibility criteria to reduce under-coverage at moderate levels of need. Financial mechanisms, such as subsidies and co-payments can also play a role in targeting care.

There is also substantial variation in the way formal and informal care act as complements or substitutes across levels of needs. In many countries, there seems to be scope to strengthen the complementarity between formal and informal care. Policies that integrate and support informal caregivers—such as providing financial allowances or respite services—may be an effective way to achieve this in Southern European countries, where the reliance on informal care is traditionally high. In Northern European countries, where formal care is more prevalent, efforts are needed to strengthen informal care networks and stimulate a larger involvement of informal caregivers. Fiscal incentives of financial allowances for informal caregivers could play a role.

Moreover, the findings highlight the importance of continuous monitoring and comparison of long-term care systems across the EU. By leveraging data-driven insights, the EU can work toward a more equitable and sustainable LTC provision that supports the well-being of ageing populations. Collaborative efforts to standardize data collection, share successful strategies, and address common challenges will be essential in achieving this goal.

In conclusion, the diversity of LTC systems within the EU is both a challenge and an opportunity. By embracing innovation, fostering collaboration, and maintaining a focus on equity and inclusiveness, the EU can pave the way for a future where all older adults have access to the care they need, regardless of their location or circumstances. This deliverable provides a foundation for these efforts, offering valuable insights into the current state of LTC systems and their ability to target care to those most in need within the population.

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8. Appendix: Eligibility criteria and Assessment mechanisms used to award Care allowance in the EU27 countries

Table A.1: AUSTRIA

Care allowance (Pflegegeld)	
Bound/Free use	Free use
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> Residence in Austria (under certain conditions, the care allowance can also be paid in an EEA state or in Switzerland)
<i>Assessment</i>	
Criteria	<p>A medical/nursing expert assesses care and assistance needs of the person in need and of the main carer (if present), takes the medical history and examines the person.</p> <p>ADLs+iADLs assessed:</p> <ul style="list-style-type: none"> dressing and undressing taking medication (including stoma/catheter/cannulas/enemas/tubes care) mobility personal hygiene preparation of meals and eating/drinking going to the toilet and managing incontinence
Score	Average need of care per month (in hours): each task is assigned a reference number of minutes per day in the Ordinance on the assessment of care needs under the Federal Nursing Allowance Act (BGBl. II No. 37/1999, as amended).
Levels	<ul style="list-style-type: none"> Level 1: more than 65 hours Level 2: more than 95 hours Level 3: more than 120 hours Level 4: more than 160 hours Level 5: more than 180 hours, if exceptional care is necessary Level 6: more than 180 hours, if care measures that cannot be coordinated in terms of time are required and these have to be provided regularly both day and night or the constant presence of a carer is necessary because there is a likelihood of endangerment of oneself or others Level 7: more than 180 hours, if no targeted movements of the four extremities with functional implementation are possible or a similar condition exists
Threshold	<p>Care allowance from Level 1.</p> <p>The need for care is expected to last for at least 6 months.</p>
Benefits in-kind	

Assessment	The assessment is organised differently in each Bundesland (indicators used are based on Land legislation and funding guidelines). 24-hour care can be funded as of Level 3 (from the assessment of care allowance).
Cost-sharing	The contribution is paid from care allowance and the remaining income. The rest is paid by the Land. Support of 24-hour-care: not asset-related, but dependent on the income of the person in need of care. A maximum of 1,600 euros per month is subsidised for two employed caregivers.
Combining	Possible. Recipients of care allowance who are cared for in their home environment are offered free home visits by appropriately trained certified healthcare workers on behalf of the Ministry of Social Affairs. There are various other offers for care and support at home, which are financed differently (including visiting and companion services, meals on wheels, and mobile home nursing care). Cash benefits can be replaced by benefits in-kind if the purpose of care allowance is not reached.
References	<ul style="list-style-type: none"> • Bundesministerium Soziales, Gesundheit, Pflege und Konsumentenschutz. <i>Pflegegeld</i>. https://www.sozialministerium.at/Themen/Pflege/Pflegegeld.html. • Ordinance of the Federal Minister of Labour, Health and Social Affairs on the assessment of care needs under the Federal Nursing Allowance Act (Classification Ordinance to the Federal Nursing Allowance Act – EinstV) StF: BGBl. II No. 37/1999 https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10009142. • Pflege.gv.at Infoplattform für Pflege und Betreuung. Förderung für 24-Stunden-Betreuung. https://pflege.gv.at/de/foerderung-fuer-24-stunden-betreuung.

Table A.2: BELGIUM

Care allowance (Flanders: zorgbudget voor ouderen met een zorgnood, Wallon: allocation pour l'aide aux personnes âgées – APA, Brussels: allocation pour l'aide aux personnes âgées – APA)	
Bound/Free use	Free use
National/Regional	Regional setting – Flanders x Wallon x Brussels (Common Community Commission)
Income-based/Flat	Income-based amount (maximum amount defined for each level)
Eligibility	<ul style="list-style-type: none"> • From the age of 65 • Live in the given region (additionally in Flanders: at least 5 years in Flanders/Brussels, and a membership in an insurance fund) • Family income/wealth not exceeding certain limits
<i>Assessment</i>	
Criteria	The regional authority checks to what extent the disability has an impact on the ADLs+iADLs: <ul style="list-style-type: none"> • moving • preparing and eating food • washing, grooming and dressing

	<ul style="list-style-type: none"> • maintaining home and doing household activities • assessing and avoiding danger • maintaining contact with other people
Score	For each criterion: 0 points = no difficulties, 1 point = some difficulties, 2 points = considerable difficulties, 3 points = impossible without help from others.
Levels	<ul style="list-style-type: none"> • Level 1: 7-8 points • Level 2: 9-11 points • Level 3: 12-14 points • Level 4: 15-16 points • Level 5: 17-18 points
Threshold	Care allowance from Level 1.
Care allowance (German-speaking Community: Pflegegeld)	
Bound/Free use	Free use
National/Regional	Regional setting – German-speaking Community (East Belgium)
Income-based/Flat	Flat amount Low-income seniors receive a social supplement in addition to the basic rate.
Eligibility	<ul style="list-style-type: none"> • From the age of 65 • Live in the given region
<i>Assessment</i>	
Criteria	The Service for Independent Living classifies the need for help and care using the BelRAI-screener. It analyses skills and weaknesses of the person, but also their preferences in everyday life. It examines physical abilities, e.g., walking, and everyday activities such as personal hygiene or shopping.
Score	The BelRAI-screener consists of 5 modules. Between 0 and 6 points can be scored per module.
Levels	<ul style="list-style-type: none"> • Level 1: at least 3 points in both the ADL and iADL modules of the BelRAI-screener • Level 2: between 6 and 12.99 points on the BelRAI-screener • Level 3: between 13 and 30 points on the BelRAI-screener or a score of at least 6 points in the IATL and ATL modules • Level 4: between 13 and 30 points on the BelRAI-screener and between 5 and 18 in the cognitive, psychological and behavioural modules
Threshold	Care allowance from Level 1.
Benefits in-kind	
Assessment	<ul style="list-style-type: none"> • Flanders: the state of dependency is proved by means of a proof of stay in a recognised institution. From June 2023, the use of BelRAI-LTCF is mandatory as a care planning instrument within Flemish residential care centres. Using the BelRAI-screener, the residential care centre can measure the care needs of the person with a care and support need. • Wallon: the degree of dependency is assessed using the Katz scale • Common Community Commission: The dependency degree of elderly persons admitted in an institution (nursing homes) and

	<p>benefitting from a financial intervention is checked according to the system initially implemented at the federal level, i.e. the Kappa control system (correlation coefficient between the assessment done by the nursing home and the assessment done by an external evaluator).</p> <p>In Brussels, the degree of dependency is assessed using the Katz scale.</p> <ul style="list-style-type: none"> • German-speaking Community: the BelRAI-screener is used for rest homes and retirement and nursing homes; it distinguishes 3 dependency categories: autonomous (below 6 points), low support needed (below 13 points), and high support needed. These three categories determine the funding. <p>A counselling certificate by the German-speaking Community Office is requested for a stay in a rest home or in a retirement and nursing home, as well as for assistance to families and seniors.</p>
Cost-sharing	<p>In the residential services (nursing homes), there is a price per day regulated by the regions to be paid by the resident (e.g. for catering, water, electricity, gas, heating, social activities).</p> <ul style="list-style-type: none"> • Flanders: The Flemish social protection system reimburses a large part of the care and staff costs in care institutions for the elderly (residential care centres, day care centres, short stay centres, etc.). • Wallon pays a large part of the care and salaried staff costs in accommodation and hosting establishments for the elderly (residential care centres, day care centres, short-stay centres, etc.) • German-speaking Community: resident participation for accommodation in rest homes, retirement and nursing homes, protected housing, short stay. These are fixed prices regardless of the type of care provided, with supplements for some services such as personal laundry, telephone or other (specific to each institution). This is the same in all regions.
Combining	Possible
References	<ul style="list-style-type: none"> • Vlaamse Sociale Bescherming. <i>Zorgbudget voor ouderen met een zorgnood</i>. https://www.vlaamsesocialebescherming.be/het-zorgbudget/zorgbudget-voor-ouderen-met-een-zorgnood. • Vlaamse Sociale Bescherming. Je zorgzwaarte of zelfredzaamheid: hoe wordt mijn handicap of gezondheidsprobleem ingeschat? https://www.vlaamsesocialebescherming.be/je-zorgzwaarte-of-zelfredzaamheid-hoe-wordt-mijn-handicap-of-gezondheidsprobleem-ingeschat. • Wallonie. <i>Bénéficiaire de l'allocation pour l'aide aux personnes âgées (APA)</i>. https://www.wallonie.be/fr/demarches/beneficiaire-de-lallocation-pour-laide-aux-personnes-agees-apa. • myriscare. <i>Questions fréquentes</i>. https://www.myriscare.brussels/fr/faq/. • Das Bürgerinformationsportal der Deutschsprachigen Gemeinschaft Belgiens. <i>Pflegegeld</i>. https://ostbelgienlive.be/desktopdefault.aspx/tabid-7460/. • Vlaanderen. <i>BelRAI binnen de ouderenzorg</i>. https://www.zorg-en-gezondheid.be/beleid/ezorgzaam-vlaanderen/belrai/belrai-binnen-de-ouderenzorg. • Wallonie familles santé handicap AVIQ. APA – Frequently asked questions. https://www.aviq.be/fr/faq-apa#2.

Table A.3: BULGARIA

Care allowance (финансова подкрепа)	
Bound/Free use	Free use
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> • Residence in Bulgaria • Certified disability
<i>Assessment</i>	
Criteria	<p>Granting the Financial support depends exclusively on the disability degree; however, the Individual needs self-assessment must be fulfilled as a part of the application.</p> <p>The evaluation of the disability degree is based on the medical documentation.</p> <p>The self-assessment of needs reports thoroughly on the ability to perform ADLs+iADLs independently.</p>
Score	Degree of disability (in %).
Levels	<ul style="list-style-type: none"> • Level 1: 50-70.99% degree of disability • Level 2: 71-90% degree of disability • Level 3: over 90% degree of disability, • Level 4: over 90% degree of disability, dependent on external care, receiving invalidity pension • Level 5: over 90% degree of disability, dependent on external care, receiving social disability pension
Threshold	Care allowance from Level 1.
Benefits in-kind	
Assessment	The provision of in-kinds benefits is mostly dependent on the individual assessment of needs that consists of the self-assessment for difficulties at home and outside (ADLs+iADLs), disability/health condition, type and degree of difficulties, degree of inclusion in the social environment, mobility in the social environment/outside home, and other circumstances.
Cost-sharing	The amount depends on each service provided.
Combining	Possible
References	<ul style="list-style-type: none"> • ЗАКОН ЗА ХОРАТА С УВРЕЖДАНИЯ, В сила от 01.01.2019 г. https://lex.bg/bg/laws/ldoc/2137189213. • Агенция за социално подпомагане Министерство на труда и социалната политика. <i>Право на месечна финансова подкрепа.</i> https://asp.government.bg/bg/deynosti/podkrepa-na-horata-s-uvrezhdaniya/pravo-na-mesechna-finansova-podkrepa/. • ЗАКОН ЗА ЛИЧНАТА ПОМОЩ, В сила от 01.01.2019 г. https://lex.bg/bg/laws/ldoc/2137189250.

Table A.4: CROATIA

Care allowance (Inkluzivni dodatak)	
Bound/Free use	Free use
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> • Residence in Croatia • Level 4 and 5 allowance (the lowest) is not granted to a person who owns another apartment or house, apart from the one where they live; or owns business premises that are not used for registered activities • The allowance cannot be combined with personal disability benefits, compensation for physical impairments, housing cost allowances, orthopaedic allowances and similar benefits (Social Welfare Act), and with accommodation service or organised housing
<i>Assessment</i>	
Criteria	The level of care allowance (1-5) is determined based on the assessment of physical/mental/visual/hearing/speech impairment. The Regulation on Expertise Methodologies (Uredba o metodologijama vještačenja) defines the severity of impairment in each category (degrees I-IV). For the physical impairment, it is based on the movement, hand/arm function, spinal function, consequences of damage to CNS, hereditary/congenital/acquired neurological disorders.
Score	<p>The degree of impairment is described in words and with the use of Barthel index. For example, degree IV of physical impairment is defined by the inability to move independently (even with aids) or perform any activity of daily living. Complete dependence on another person in maintaining personal hygiene, fulfilling physiological needs, feeding, and (un)dressing. Barthel index 0-35.</p> <p>The Barthel index assessing the ability to perform the activities of daily living ranges from 0 to 100 (lower score for more severe disabilities).</p>
Levels	<ul style="list-style-type: none"> • Level 1: <ul style="list-style-type: none"> • physical impairment IV. degree with a Barthel index of 0 – 20, and/or • autism spectrum disorders IV. degree with additional difficulty, and/or • mental illness IV. degree with additional difficulty • Level 2: <ul style="list-style-type: none"> • physical impairment IV. degree with a Barthel index of 21 – 35, and/or • visual impairment IV. degree without residual light sensation or with additional difficulty, and/or • hearing impairment IV. degree with additional difficulty, adults with deafblindness IV. degree, and/or • autism spectrum disorders IV. degree without additional difficulty, and/or • mental illness IV. degree without additional difficulty, and/or

	<ul style="list-style-type: none"> • chronic disease IV. degree with the existence of a need for specific care with the performance of medical-technical procedures • Level 3: <ul style="list-style-type: none"> • physical impairment III. degree with a Barthel index of 36 – 60, and/or • visual impairment III. or IV. degree without additional difficulty, and/or • hearing impairment III. or IV. degree without additional difficulty, adults with deafblindness III. degree, and/or • mental illness III. degree, adults with chronic disease IV. degree, and/or • voice, language and speech disorders IV. degree • Level 4: <ul style="list-style-type: none"> • physical impairment II. degree with a Barthel index of 61 – 90, and/or • chronic disease III. degree, and/or • voice, language and speech disorders III. degree • Level 5: <ul style="list-style-type: none"> • visual impairment II. degree, and/or • hearing impairment II. degree, and/or • single adults with chronic disease II. degree, and/or • voice, language and speech disorders II. degree
Threshold	Allowance paid out in all levels.
Benefits in-kind	
Assessment	In-kind benefits can be granted based on the disability degrees (I-IV).
Cost-sharing	Cost-sharing applies. The amount depends on income and assets.
Combining	Possible The care allowance cannot be paid out to individuals whose right to accommodation service or organised housing has been recognised.
References	<ul style="list-style-type: none"> • Zakon o inkluzivnom dodatku, NN 156/23 na snazi od 01.01.2024. https://www.zakon.hr/z/3670/Zakon-o-inkluzivnom-dodatku. • NN 96/2023 (23.8.2023.), Uredba o metodologijama vještačenja. https://www.zakon.hr/cms.htm?id=57769.

Table A.5: CYPRUS

Care allowance (Ελάχιστου Εγγυημένου Εισοδήματος: πρόγραμμα επιχορηγήσεων για άτομα με αναπηρία)	
Bound/Free use	Bound use The contract between the beneficiary and the provider (physical/legal entity) must be submitted to the Social Welfare Services (Υπηρεσίες Κοινωνικής Ευημερίας).
National/Regional	National criteria

	A disabled person who becomes a beneficiary of the Guaranteed Minimum Income is additionally provided with a monthly disability allowance.
Income-based/Flat	Flat amount
Eligibility	<p>To become a recipient of Guaranteed Minimum Income:</p> <ul style="list-style-type: none"> • Residence in Cyprus (in the 5 years immediately preceding the application submission; exceptions for refugees) • Total income of members of the family unit must be below a threshold (there have been efforts to remove this condition), assets are also considered <p>To become a recipient of this long-term care benefit:</p> <ul style="list-style-type: none"> • Recipient of the Guaranteed Minimum Income (with some exceptions) • Disability certificate
<i>Assessment</i>	
Criteria	The Social Welfare Services or the Department of Social Inclusion of Persons with Disabilities are responsible for assessing the care needs of GMI applicants/recipients using specialised assessment tools. The person in need completes a self-assessment questionnaire on difficulties in areas of daily life (based on the International Classification of Functioning, Disability and Health, ICF) and special aids needed. The Specialised Assessment Teams then visit the applicant to assess the need for care using specific questionnaires. These consist of ICF groups that evaluate the state of health and functionality of the person in need – movement, visual, auditory, and mental capacities, and a general ICF group used for people with multiple disabilities. Additional reports may be requested (medical report stating the main medical issues; follow-up reports by rehabilitation professions, social workers, psychologists or other specialists).
Score	Disability is considered in two dimensions: physical impairments and impairments of bodily functions. The latter is examined through two dimensions: activity (individual level) and participation (social level).
Levels	<p>For individuals aged 80 and above</p> <ul style="list-style-type: none"> • Level 1: need for partial home services • Level 2: need for full home services <p>For other individuals:</p> <ul style="list-style-type: none"> • Level 1: mild impairments • Level 2: moderate impairments • Level 3: severe impairments • Level 4: total impairments
Threshold	Care allowance granted from Level 1.
Benefits in-kind	
Assessment	Beneficiaries of the guaranteed minimum income may be provided with care services by the social welfare services. Should a person

	request care then they will be assessed by the social welfare services and, depending on their needs, will receive the corresponding care. Disability assessment is the same independently on the benefit in question.
Cost-sharing	Generally, there is no cost-sharing. There is a co-payment for a home visit by a medical specialist when this service was accessed directly by the beneficiary.
Combining	Possible
References	<ul style="list-style-type: none"> EC (2024). <i>Your social security rights in Cyprus</i>. Το περί των Ελάχιστου Εγγυημένου Εισοδήματος και Γενικότερα περί Κοινωνικών Παροχών Νόμων (Ανάγκες για Κατ' Οίκον Φροντίδα Ηλικιωμένων) Διάταγμα του 2018 (Κ.Δ.Π. 158/2018). https://www.wbas.dmsw.gov.cy/dmsw/ydep.nsf/all/AC961DA47C735D98C22587D90050F6B1/\$file/%CE%9A%CE%94%CE%A0%20158_2018.pdf?openelement. Το περί των Ελάχιστου Εγγυημένου Εισοδήματος και Γενικότερα περί Κοινωνικών Παροχών Νόμων (Ανάγκες για Κατ' Οίκον Φροντίδα Ατόμων με Αναπηρίες) Διάταγμα του 2017 (Κ.Δ.Π. 365/2017). https://www.wbas.dmsw.gov.cy/dmsw/ydep.nsf/all/AC961DA47C735D98C22587D90050F6B1/\$file/%CE%9A%CE%94%CE%A0%20365_2017.pdf?openelement. Ο Περί Ελάχιστου Εγγυημένου Εισοδήματος και Γενικότερα περί Κοινωνικών Παροχών Νόμος του 2014 (109(I)/2014). https://www.cylaw.org/nomoi/enop/non-ind/2014_1_109/full.html. Υφυπουργείο Κοινωνικής Πρόνοιας Τμήμα Κοινωνικής Ενσωμάτωσης Ατόμων με Αναπηρίες. <i>Το Έργο: Έργο Συστήματος Αξιολόγησης Αναπηρίας</i>. http://www.dmsw.gov.cy/dmsw/dsid/dsid.nsf/dsdpd06_gr/dsdpd06_gr?OpenDocument.

Table A.6: CZECHIA

Care allowance (Příspěvek na péči)	
Bound/Free use	Free use But the law stipulates the obligation of the person to use Care Allowance to obtain the care services (of formal or informal carers). The Labour Office can check whether the Care Allowance is indeed used for obtaining care services. Nevertheless, a new legislative amendment is expected to turn the free use into a bound used from 2025 (the name of the carer will have to be submitted).
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> Residence in Czechia
Assessment	
Criteria	<p>The health status of the applicant is assessed by a physician. Then, the following basic living needs are assessed (usually at the applicant's home) to determine the level of allowance. For each of the ten needs, individual tasks are assessed. If the person cannot manage independently an activity within one category, the whole category should be considered as not managed.</p> <ul style="list-style-type: none"> Mobility (e.g., standing up and sitting down, taking and changing positions, walking step by step (possibly with stops) in the apartment and in normal terrain within a range of at least 200 m (on

	<p>uneven surfaces), walking up and down stairs in the range of one floor, getting on and off means of transport including barrier ones)</p> <ul style="list-style-type: none"> • Orientation (e.g., recognizing and distinguishing by sight and hearing, having adequate mental competence) • Communication (e.g., expressing oneself in an intelligible spoken language and communicating with others using common vocabulary corresponding to the age and social status, understanding the content of received and communicated messages, creating a handwritten short message) • Eating • Dressing and putting on shoes • Body hygiene • Exercising physiological needs • Health care (e.g., following the established treatment regime) • Personal activities (e.g., establishing contacts and relationships with other persons, establishing and following a daily schedule) • Household care (e.g., managing money within the framework of household income, regular shopping)
Score	Number of living needs (0-10) not managed independently
Levels	<ul style="list-style-type: none"> • Level 1: 3 or 4 needs • Level 2: 5 or 6 needs • Level 3: 7 or 8 needs • Level 4a: 9 or 10 needs (if the person is provided with assistance by a provider of residential social services) • Level 4b: 9 or 10 needs (otherwise)
Threshold	Care allowance from Level 1.
Benefits in-kind	
Assessment	<p>No minimum level of dependency for social in-kind benefits, no fixed set of indicators.</p> <p>The need for long-term care depends on the assessment of the patient's state of health by the attending physician or GP. Indicators may include: pain management, nutritional status, physical performance and self-sufficiency, nursing stress test, Barthel test, Instrumental activity daily living test, functional degree of independence, mobility assessment, balance and walking test, assessment of mental health and mental well-being etc.</p>
Cost-sharing	Cost sharing for board and lodging in residential social facilities.
Combining	Cumulation of cash benefits and in-kind benefits is possible.
References	<ul style="list-style-type: none"> • Ministerstvo práce a sociálních věcí. Příspěvek na péči. https://www.mpsv.cz/-/prispevek-na-peci. • Vyhláška č. 505/2006 Sb., kterou se provádějí některá ustanovení zákona o sociálních službách. https://www.zakonyprolidi.cz/cs/2006-505.

Table A.7: DENMARK

Care allowance (Borgerstyret personlig assistance = BPA)	
Bound/Free use	Bound use Subsidies to cover the cost of employing care assistants and of supervision and attendance of those with considerable and permanent physical or mental impairment, who require special support.
National/Regional	Regional criteria Assessment procedures may vary across municipalities.
Income-based/Flat	Amount individual, not income-based The amount of the grant varies from a case. The subsidy from the municipality can be a maximum of the actual costs associated with the scheme.
Eligibility	<ul style="list-style-type: none"> • Residence in Denmark • The person in need must act as a supervisor for the helpers (must be able to organise the help and be the day-to-day manager of the assistants). The person should also act as an employer, but this obligation can be transferred to a close relative, an association or a private company, which then becomes the employer of the helpers.
<i>Assessment</i>	
Criteria	<p>The assessment is based on what the individual can manage in order to be able to live a normal life like other non-disabled people, both inside and outside the home.</p> <p>Assessment procedures may vary across municipalities. However, most of them use “Fælles Sprog”, which is a method and standard to document the need for care.</p> <p>The functional assessment model classifies users on four functional levels measured from nine assessment areas: the citizen overcomes/oversees/takes the initiative; largely manages to overcome/oversee/take the initiative; has difficulty coping/overseeing/taking the initiative; is unable to overcome/oversee/take the initiative. A variety of daily activities are taken into account such as dressing, eating, toileting, cleaning the house, managing finances etc.</p>
Score	No specific international scale is used. Most of the municipalities use the Fælles Sprog.
Levels	No specific categories of need for long-term care. During the assessment, a decision is made as to which tasks or needs are to be covered by the support, how large the scope is and when the help is to be provided. And then, what amount will be paid.
Threshold	No specific threshold. The citizen has to have a significant and permanently reduced physical or mental ability to function, which makes it necessary to receive the very special support for care, monitoring and accompaniment, which is part of the scheme.

Benefits in-kind	
Assessment	The local authority decides whether a citizen requires assistance which cannot be given in the form of home care. If a citizen is offered residential accommodation, s/he can choose between different alternatives within the municipality or even elsewhere.
Cost-sharing	No cost sharing. Personal and practical assistance is free of charge.
Combining	No cash subsidy can normally be granted for the employment of helpers when the recipient lives in housing where the help is organised for several residents. This applies, for example, to residents in care homes or in nursing homes, residential facilities or the like.
References	<ul style="list-style-type: none"> • BEKENDTGØRELSE AF LOV OM SOCIAL SERVICE LBK NR 170 AF 24/01/2022. https://www.retsinformation.dk/eli/lta/2022/170#P96. • SOCIAL-, BOLIG- OG ÆLDREMINISTERIET. BPA - <i>Borgerstyret Personlig Assistance</i>. https://www.sm.dk/arbejdsomraader/handicap/personlig-stoette/bpa-borgerstyret-personlig-assistance. • DUKH. <i>Borgerstyret personlig assistance (BPA)</i>. https://www.dukh.dk/Selvhj%C3%A6lp/Viden-om-voksenhandicapomr%C3%A5det/Borgerstyret-personlig-assistance--BPA-. • DSR. <i>FÆLLES SPROG FORRINGER PLEJEN</i>. https://dsr.dk/fag-og-udvikling/sygeplejersken/arkiv/sygeplejersken-2000-50/faelles-sprog-forringer-plejen/.

Table A.8: ESTONIA

Care allowance (Puudega vanaduspensioniealise inimese toetus)	
Bound/Free use	Free use
National/Regional	National criteria for the allowance for a person of retirement age with disabilities. There is no care allowance for the general elderly population at the national level. The support comes mainly from in-kind benefits. However, some local governments distribute benefits to individuals in need with the aim to cover costs of receiving care. The amount is related to the costs of the service and the recipient's own contribution.
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> • Residence in Estonia • Recognised disability
<i>Assessment</i>	
Criteria	Social Insurance Board determines the severity of disability based on the submitted application, information provided by the attending physicians, and other attached documents. The decisive factors are the state of health and the forecast of its change, the ability to cope with basic daily activities, and the need for additional assistance and guidance, which occur and persist despite the use of technical aids or medications.
Score	Degree of disability
Levels	<ul style="list-style-type: none"> • Level 1: moderate disability • Level 2: severe disability • Level 3: profound disability

Threshold	Care allowance from Level 1.
Benefits in-kind	
Assessment	The assessment of the need for services is organised by local municipalities. There are no specific tools or methods established by the state. The identification of the need for assistance is based on person's ability to cope and participate in society, including: 1) circumstances related to the functional capacity of the person (such as eating, dressing, washing, cleaning the house, moving etc); 2) circumstances related to the physical and social environment of the person (housing, income, area of residence, relationships etc.). There are no different levels of need for long-term care provided in legislation.
Cost-sharing	Generally, all those who receive benefits in kind have to make a contribution. Most local authorities assess each case individually to determine the level of co-payment, which depends on the income of the beneficiary and their family, on other assets (savings, real estate what can be sold or rent out etc) or other possibilities to pay for the service.
Combining	Possible
References	<ul style="list-style-type: none"> Sotsiaalhoolekande seadus. https://www.riigiteataja.ee/akt/114122023003?leiaKehtiv. Riigiportaal. Eakate toimetulek ja hoolekanne. https://www.eesti.ee/et/perekond/eakad/eakate-toimetulek-ja-hoolekanne. Republic of Estonia. Social Insurance Board. Allowance for a person of retirement age with disabilities. https://sotsiaalkindlustusamet.ee/en/disability-and-welfare-services/benefits-disabled-people/allowance-person-retirement-age. Republic of Estonia. Social Insurance Board. Determining the severity of disability of a person of retirement age. https://sotsiaalkindlustusamet.ee/en/disability-and-welfare-services/determination-disabilities/determining-severity-disability-person.

Table A.9: FINLAND

Care allowance (Eläkettä saavan hoitotuki)	
Bound/Free use	Free use
National/Regional	National/Regional criteria Assessment practices may vary across regions
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> Full-time retirement (old-age pension, disability pension, rehabilitation subsidy or surviving spouse's pension from Finland or from abroad, etc.) <ul style="list-style-type: none"> those with only part-time pension are eligible for disability allowance Residence in Finland (person covered under the Finnish social security system)
<i>Assessment</i>	
Criteria	A physician's statement and a decision by SII (Kela) is needed to be deemed eligible. The assessment then must consider the physical, cognitive, psychological, and social functioning of the elderly person, as well as

	<p>the factors related to the accessibility of their environment, the safety of their housing and the availability of local services.</p> <p>Assessed ADLs+iADLs: mobility, personal hygiene, dressing, eating, taking medication (following prescribed treatment), social interaction.</p>
Score	<p>Assessment practices may vary across regions, but in 2023, the RAI assessment system became statutory in assessing service needs (RAI=Resident Assessment Instrument). Still, municipalities may also use other tools in addition to it.</p> <p>Decisive: the extent and frequency of supervision (checking, reminding, urging) or assistance needed with the ADLs+iADLs.</p>
Levels	<ul style="list-style-type: none"> • Level 1 (basic rate): person who needs at least weekly help or guidance and supervision in personal activities, (eg getting dressed, personal hygiene) • Level 2 (middle rate): time-consuming assistance with several personal activities OR considerable extent of regular guidance and supervision • Level 3 (highest rate): needs care and supervision round-the-clock, can only cope alone for short periods of time
Threshold	<p>Care allowance from Level 1.</p> <p>Care allowance cannot be granted when only help with household chores or daily errands is needed.</p>
Benefits in-kind	
Assessment	<p>The wellbeing services a county grants are provided on the basis of an individual assessment of needs. Assessment practices may vary across regions, but in 2023, the RAI assessment system became statutory in assessing service needs. Based on the identified needs, a service plan is drawn up. An administrative decision is then made by a public servant concerning the services that the municipality is responsible for providing.</p>
Cost-sharing	<p>Cost-sharing based on the patient's ability to pay (applies to home care, as well as the residential care).</p>
Combining	<p>Possible. Care allowance can be used to cover co-payments for services. The allowances are not dependent on the service provision.</p>
References	<ul style="list-style-type: none"> • infoFinland. <i>Tuki- ja palveluansuminem</i>. https://www.infofinland.fi/en/housing/supported-and-service-housing. • Kela. Eläkettä saavan hoitotuki. https://www.kela.fi/care-allowance-for-pensioners. • Terveystieteiden tutkimuskeskus. <i>Palvelutarpeiden arviointi RAI-järjestelmällä</i>. https://thl.fi/aiheet/ikaantymisen/palvelutarpeiden-arviointi-rai-jarjestelmalla. • Laki ikääntyneen väestön toimintakyvyn tukemisesta sekä iäkkäiden sosiaali- ja terveyspalveluista. https://www.finlex.fi/fi/laki/ajantasa/2012/20120980.

Table A.10: FRANCE

Care allowance (Allocation personnalisée d'autonomie = APA)	
Bound/Free use	<p>Bound use</p> <p>The beneficiaries of the APA must declare to the departmental council that provides APA the identity of the person(s) or home help service paid through this allowance. The departmental council can verify the proper use by requesting proof of expenditure.</p> <p>The APA can be paid directly to the service provider.</p>
National/Regional	<p>National criteria</p> <p>But the amounts can vary across local areas</p>
Income-based/Flat	<p>Income-based amount awarded</p> <p>The benefit depends on the assistance plan minus the co-payment, calculated according to the beneficiary's means.</p>
Eligibility	<ul style="list-style-type: none"> • From the age of 60 • Residence in France
<i>Assessment</i>	
Criteria	<p>10 “discriminatory” variables on the loss of physical and mental autonomy – used to determine the GIR (groupe iso-ressources)</p> <ul style="list-style-type: none"> • Communicating verbally and/or non-verbally, behaving in a logical and sensible manner accepted by society • Locating oneself in space and time • Washing yourself • Getting dressed, undressing • Serving and eating • Assuming hygiene of urinary and faecal elimination • Getting up, lying down, sitting down; moving between these positions • Moving around the living space • Moving outside the living space • Use a means of remote communication (telephone, alarm, doorbell, etc.) in order to alert if necessary <p>7 “illustrative” variables:</p> <ul style="list-style-type: none"> • Preparing meals so they can be served • Managing affairs, using money and knowing the value of things, carrying out administrative procedures, completing forms • Carrying out all routine household work • Voluntarily using a means of collective or individual transport • Purchasing goods voluntarily • Following the doctor's prescription and managing own treatment • Voluntarily practicing various leisure activities, alone or in a group
Score	<p>The loss of autonomy is measured using the AGGIR grid (6 levels/GIRs).</p> <p>The illustrative variables are not taken into account for GIR but provide information for the assistance plan.</p>

	Each of the 17 sections is rated (A, B, C) according to the independence with which the applicant performs them.
Levels	<ul style="list-style-type: none"> • Level (GIR) 1: Applicant confined to bed or chair, whose mental functions are seriously impaired and who requires the essential and continuous presence of caregivers • Level (GIR) 2: Applicant confined to bed or chair, whose mental functions are not totally impaired and whose condition requires support for most activities Or applicant whose mental functions are impaired, but who is able to move around and who requires constant monitoring • Level (GIR) 3: Applicant who has retained his mental autonomy, partially his locomotor autonomy, but who needs daily and several times a day help with personal care • Level (GIR) 4: Applicant who needs help with transfers but who, once up, can move around within the accommodation, and who needs help with washing and dressing Or applicant who does not have locomotor problems but who must be helped with personal care and meals • Level (GIR) 5: Applicant who only needs occasional help with washing, preparing meals and cleaning • Level (GIR) 6: Applicant still independent for essential acts of daily life
Threshold	Only the first 4 GIRs qualify for the allowance for loss of autonomy. The applicant classified in GIRs 5 or 6 cannot obtain the APA but can request household assistance from the pension fund.
Benefits in-kind	
Assessment	The APA in an establishment falls into 3 possible dependency rates based on the AGGIR grid (GIR 1+2, GIR 3+4, GIR 5+6). The assessment for the GIRs remains the same as for the cash benefits.
Cost-sharing	The APA in an establishment helps to pay part of the dependency rate charged to residents of EHPADs (accommodation establishments for dependent elderly people) and USLDs (long-term care units). The amount of this aid depends on the GIR and département. The rest is paid by the person in need.
Combining	The APA in an establishment and the APA at home cannot be combined.
References	<ul style="list-style-type: none"> • Service-Public.fr. The official website of the French administration. <i>Apa : qu'est-ce que le Gir 1, 2, 3 ou 4 de la grille Aggir?</i> https://www.service-public.fr/particuliers/vosdroits/F1229. • Service-Public.fr. The official website of the French administration. <i>Allocation personnalisée d'autonomie (Apa)</i>. https://www.service-public.fr/particuliers/vosdroits/F10009. • Service-Public.fr. The official website of the French administration. <i>L'APA en établissement</i>. https://www.pour-les-personnes-agees.gouv.fr/vivre-dans-un-ehpad/aides-financieres-en-ehpad/lapa-en-etablissement.

Table A.11: GERMANY

Care allowance (Pflegegeld)	
Bound/Free use	Free use Care allowance is the only care benefit where the money is given for free use without proof of costs.
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> • Long-term care insurance (compulsory)
<i>Assessment</i>	
Criteria	<p>There are six modules of criteria (up to 16 fixed criteria per module). The expert must determine whether the person is able to do these independently or is dependent on help (partly/fully). Score for each module is added and weighted to the overall score.</p> <ul style="list-style-type: none"> • Mobility (weight=10%; 5 criteria): How independently does the person move around, hold himself up, sit upright, climb stairs? • Cognitive and communicative skills (weight=15% together with module 3; 11 criteria): Can the applicant orient himself spatially and temporally in everyday life? Can she/he make decisions for her/himself, recognize risks, have conversations, and communicate her/his needs? • Behavioural and psychological problems (weight=15% together with module 2; 13 criteria): How often does the person need help because of psychological problems such as aggressive or anxious behaviour? Does she/he suffer from delusions or damage objects? • Self-care (40%; 13 criteria): How independently can the person wash, care for and feed themselves on a daily basis? • Mastering and dealing independently with demands and burdens related to illness or therapy (weight=20%; 16 criteria): What help does the applicant need when dealing with illness, therapies and treatments such as dialysis or changing dressings? • Organizing everyday life and social contacts (weight=15%; 6 criteria): How independently can the person plan their daily routine, keep themselves busy or maintain contacts? <p>Furthermore, activities outside the house (e.g. leaving the area of the house or the facility, participation in other activities with other people) and household management (e.g. shopping, dealing with financial affairs) are assessed. The responses in these areas are not used for the classification of the need for long-term care.</p>
Score	Weighted number of activities that cannot be performed independently, rated by the severity of dependence. Each module has its own scale for the intensity of help needed, mostly 0-1-2-3. The sum of points in the module is then transposed into the final points based on the module's weight.
Levels	<ul style="list-style-type: none"> • Level 1: [12.5-27) points

	<ul style="list-style-type: none"> • Level 2: [27-47.5) points • Level 3: [47.5-70) points • Level 4: [70-90) points • Level 5: [90-100] points
Threshold	Care allowance from Level 2. Only 'relief amount' in Level 1.
Benefits in-kind	
Assessment	The same assessment as for cash benefits (see above)
Cost-sharing	Long-term care insurance For inpatient care, the cost-sharing depends on the length of stay. In addition, patients must cover their own living costs (e.g., accommodation, food).
Combining	Entitlement to care allowance is reduced when benefits in-kind are claimed. As a rule, people choose care allowance if they are cared for in whole or in part by relatives.
References	<ul style="list-style-type: none"> • Pflege.de. <i>Pflegegrad 1: Geld, Leistungen und Voraussetzungen</i>. https://www.pflege.de/pflegekasse-pflegerecht/pflegegrade/pflegegrad-1/. • Pflege.de. <i>Pflegebegutachtung & Pflegegutachten</i>. https://www.pflege.de/pflegekasse-pflegefinanzierung/pflegeversicherung/pflegebegutachtung-pflegegutachten/. • Federal Medical Service (2023): <i>Guidelines for determining the need for care</i>. https://md-bund.de/fileadmin/dokumente/Publikationen/SPV/Begutachtungsgrundlagen/BRI_Pflege_29092023.pdf

Table A.12: GREECE

Care allowance (εξωϊδρυματικό επίδομα αναπηρίας)	
Bound/Free use	Free
National/Regional	National criteria There is also the total disability benefit (επίδομα απόλυτης αναπηρίας) that is mutually exclusive with the non-residential care benefit (εξωϊδρυματικό επίδομα αναπηρίας). The total disability benefit can be assigned to the old-age pensioners only if they are blind and in need of constant supervision.
Income-based/Flat	Flat
Eligibility	<ul style="list-style-type: none"> • Insurance in Greece (direct or indirect), minimally for a defined period of time • Suffering from specific diseases (e.g. dementia, paraplegia, quadriplegia, health issues associated with amputation)
<i>Assessment</i>	
Criteria	The assessment depends on the existence of chronic illness, that leads to limitations in functioning. The assessment of disability degree is based on the available certification of specific health conditions and the predefined, expected level of impairment associated with that condition in the official assessment schedule. The invalidity levels on account of certain illnesses are assessed by

	physicians. The degree of disability is assessed by the Centre for Certifying Disability (KEPA).
Score	Degree of disability (in %).
Levels	<ul style="list-style-type: none"> • Level 1: severe invalidity: at least 80% • Level 2: normal invalidity: between 67% and 79% • Level 3: partial invalidity: between 50% and 66%
Threshold	For each medical condition the threshold invalidity degree differs – either Level 1 or 2. For some medical conditions the specific disability degree is not defined. However, in all cases, the individual must have been assessed as in need of constant supervision and intensive care.
Benefits in-kind	
Assessment	<p>All residents are eligible for in-kind benefits. Eligibility to the Aid at Home (main publicly available long-term care programme) is related to age, income, marital status, state of health and the temporary or permanent nature of the dependence. National assessment criteria apply. KEPA assesses the level of invalidity:</p> <ul style="list-style-type: none"> • severe invalidity: at least 80% • normal invalidity: between 67% and 79% • partial invalidity: between 50% and 66% <p>The disability rate is determined for each medical condition separately and then combined in one rate (depending on which condition is the main one). The invalidity levels result in different levels of care provision.</p>
Cost-sharing	The cost of long-term care services provided by either private non-profit or public entities contracted with the National Service Provider Organization Health (EOPYY) can be covered by resources transferred by the Ministry of Social Cohesion and Family. The daily compensation fee allocated by EOPYY covers almost the full cost of the services provided.
Combining	Not possible to combine with residential care services.
References	<ul style="list-style-type: none"> • ΕΦΗΜΕΡΙΔΑ ΤΗΣ ΚΥΒΕΡΝΗΣΕΩΣ, 4830/τ. Β'/13.09.2022. https://www.et.gr/SearchFek. • e-Efka.gov. Κέντρο Πιστοποίησης Αναπηρίας (ΚΕ.Π.Α.). https://www.efka.gov.gr/el/menoy/kentro-pistopoiases-anaperias-kepa. • State of long-term care in Greece. Technical report. WHO/EURO:2024-10369-50141-75518. • e-Efka.gov. Εξωϊδρυματικό επίδομα. https://www.efka.gov.gr/el/menoy/sychnes-eroteseis/syntaxeis/aponomes-kyrion-syntaxeon/aponomes-kyrion-syntaxeon/exoidrymatiko-epidoma.

Table A.13: HUNGARY

Care allowance ()	
Bound/Free use	-
National/Regional	National criteria No cash benefits paid to the individuals in need. Caring family members can receive a nursing fee (Ápolási díj).
Income-based/Flat	-
Eligibility	-
Assessment	

Criteria	-
Score	-
Levels	-
Threshold	-
Benefits in-kind	
Assessment	<p>National criteria apply for in-home social assistance service, taking into account the following ADLs+iADLs:</p> <ul style="list-style-type: none"> • orientation in time and space • appropriate behaviour • eating • dressing • personal hygiene • using the toilet • continence • communication • following the prescribed treatment • change of position • movement • self-sufficiency (ability to manage life) • seeing • hearing <p>Each criterium is evaluated with 0-4 points:</p> <ul style="list-style-type: none"> • 0=independent/no problems performing • 4=needs full help/unable to do <p>The points are summed up into a final score.</p> <p>There are four levels of care. Each associated with a different set of in-kind benefits that can be provided.</p> <ul style="list-style-type: none"> • Level 0: 0-19 points <ul style="list-style-type: none"> • the individual can manage and do activities on his/her own • Level 1: 20-34 points <ul style="list-style-type: none"> • the individual needs support in some activities • Level 2: 35-39 points <ul style="list-style-type: none"> • the individual needs partial support • Level 3: 40-56 points <ul style="list-style-type: none"> • the individual needs full support
Cost-sharing	<p>The beneficiaries are expected to pay contribution, which must not exceed a certain percentage of their income. Maximum rates of charge differ based on the service (30% for meals, 25% for home help, etc.)</p>
Combining	-
References	<ul style="list-style-type: none"> • 1993. évi III. Törvény, a szociális igazgatásról és szociális ellátásokról. https://njt.hu/jogszabaly/1993-3-00-00. • 36/2007. (XII. 22.) SZMM rendelet, a gondozási szükséglet, valamint az egészségi állapoton alapuló szociális rászorultság vizsgálatának és igazolásának részletes szabályairól. https://net.jogtar.hu/jogszabaly?docid=a0700036.smm. • 1/2000. (I.7.) SZCSM rendelet a személyes gondoskodást nyújtó szociális intézmények szakmai feladatairól és működési feltételeiről. https://net.jogtar.hu/jogszabaly?docid=a0000001.scm.

Table A.14: IRELAND

Care allowance ()	
Bound/Free use	-
National/Regional	<p>National criteria</p> <p>No cash benefits are provided to the elderly person in need as care allowance. There is Carer's allowance, Constant attendance allowance and other cash benefits but these are for the informal carers or targeting those injured during work or other groups. Individuals above 66 years do not qualify for Disability allowance but for a state pension.</p>
Income-based/Flat	-
Eligibility	-
<i>Assessment</i>	
Criteria	-
Score	-
Levels	-
Threshold	-
Benefits in-kind	
Assessment	<p>All residents are eligible for home support services and nursing homes support scheme. Home support services target those above 65 (no age conditions for nursing homes). Currently, there is no standardised assessment at national level.</p> <p>Home Support Service provision is based on an assessment of care needs that considers applicant's:</p> <ul style="list-style-type: none"> • ability to carry out ADLs+iADLs (bathing, shopping, dressing, moving around) • medical, health and other support services provided • family, social and community support • wishes and preferences <p>Nursing Homes Support Scheme (aka Fair deal) care needs assessment takes into account:</p> <ul style="list-style-type: none"> • ability to carry out ADLs+iADLs (e.g., bathing, shopping, dressing, moving around) • mental abilities (e.g., levels of attention, memory, learning, language) • any health and personal services received (e.g., home care assistant or nurse) • the family and community support available to the applicant • own wishes and preferences <p>The assessment may include a physical examination by a healthcare professional.</p> <p>While there is legislation underpinning an entitlement to nursing home care, there is no such legislation for home support services yet.</p>
Cost-sharing	The financial assessment determines the applicant's co-payment in Nursing Homes Support Scheme. The contribution depends on the

	<p>applicant's income and assets and family status. Single individuals contribute up to 80% of their assessable income and 7.5% of the value of any assets towards their long-term residential care costs.</p> <p>Home Care is funded through the Health Service Executive's budget. There is a limited number of home care hours funded in a given year. If care is available for elderly in need, there are no out of pocket payments.</p>
Combining	-
References	<ul style="list-style-type: none"> HSE. <i>After you apply: the Care Needs Assessment</i>. https://www.hse.ie/eng/home-support-services/after-you-apply-the-care-needs-assessment/. HSE. <i>Care needs assessment</i>. https://www2.hse.ie/services/schemes-allowances/fair-deal-scheme/care-needs-assessment/.

Table A.15: ITALY

Care allowance (Indennita di accompagnamento)	
Bound/Free use	Free use
National/Regional	National procedure / Regional criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> Residence in Italy Recognition of total and permanent disability (100%) is not required for those above 65 (it is sufficient that these individuals are recognised as unable to walk alone or to carry out activities of daily living)
<i>Assessment</i>	
Criteria	The impairment must be recognised in a report issued after a health assessment. A general practitioner completes an introductory medical certificate based on results of examinations (performed by certified physicians). Local health authorities then invite the individual for a meeting of a medico-legal commission that evaluates the disability percentage. The National Social Security Institute (INPS) takes the final decision based on the materials.
Score	It is not transparent and unified across the local health authorities how the committees make decisions on the disability percentage. It is not clear how to evaluate the ability to perform ADLs.
Levels	Only one level exists. However, the amount is increased for individuals who are totally blind.
Threshold	Care allowance is provided.
Benefits in-kind	
Assessment	To access services at the regional/local level, needs assessment is required after a disability level has been recognised. The assessment procedures differ by region and also by the level – if it is performed for a specific service or a variety of services.
Cost-sharing	Co-payments depend on the type of benefit and degree of invalidity. It might also vary depending on the region. Totally disabled individuals do not pay contributions.

Combining	<p>Possible</p> <p>The care allowance (Indennita di accompagnamento) cannot be combined with similar allowances paid due to disability that has arisen due to war, work or service.</p> <p>Moreover, it cannot be paid out to individuals who spend more than 29 days in a facility where the fees are paid by the state or public bodies.</p>
References	<ul style="list-style-type: none"> • OECD (2023), <i>Disability, Work and Inclusion in Italy: Better Assessment for Better Support</i>, OECD Publishing, Paris, https://doi.org/10.1787/dc86aff8-en. • LEGGE 11 febbraio 1980, n. 18, Indennità di accompagnamento agli invalidi civili totalmente inabili. https://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:legge:1980:18. • LEGGE 21 novembre 1988, n. 508. Norme integrative in materia di assistenza economica agli invalidi civili, ai ciechi civili ed ai sordomuti. https://www.normattiva.it/atto/caricaDettaglioAtto?atto_dataPubblicazioneGazzetta=1988-11-25&atto.codiceRedazionale=088G0583&atto.articolo.numero=0&atto.articolo.sottoArticolo=1&atto.articolo.sottoArticolo1=0&qId=27f4793f-140c-4061-a115-5a1eba25214f&tabID=0.21762845067494463&title=lbl.dettaglioAtto • INPS. Indennità di accompagnamento agli invalidi civili. https://www.inps.it/it/it/dettaglio-approfondimento.schede-informative.indennit-di-accompagnamento-agli-invalidi-civili.html.

Table A.16: LATVIA

Care allowance (Pabalsts cilvēkiem ar invaliditāti, kuriem nepieciešama īpaša kopšana)	
Bound/Free use	Free use
National/Regional	<p>National criteria</p> <p>There is no special LTC care allowance targeting the elderly. This is a benefit for people with disabilities in need of care that can be combined with other state social security benefits and old-age pension.</p>
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> • Residence in Latvia (permanent, not temporary) • Disability group I (very severe disability)
<i>Assessment</i>	
Criteria	<ul style="list-style-type: none"> • eating • moving (from bed to chair and back) • mobility (walking or using a wheelchair) • using stairs • getting dressed • care about appearance (e.g. shaving) • washing • move bowels (able/unable to control) • urination (able/unable to control) • using the toilet
Score	<p>The ability to perform the activity (independently) is evaluated for each question. Each question is assigned points accordingly. The overall score is then the sum of the points from the 10 questions (the less, the more severe disability).</p> <p>The scale is not the same for all questions, it is either 0-1, 0-2, or 0-3.</p>

	<ul style="list-style-type: none"> • 0 = needs help • 1 = independent <ul style="list-style-type: none"> • 0 = unable to perform this action on his/her own • 1 = needs help • 2 = independent <ul style="list-style-type: none"> • 0 = unable to perform this action (e.g. motionless) • 1 = needs a lot of help • 2= needs some help • 3 = independent
Levels	<p>Only one level which is granted when less than 7 points (out of 20) are achieved in the assessment.</p> <p>The amount is increased for adults whose disability was caused by an illness from childhood.</p>
Threshold	Care allowance is provided
Benefits in-kind	
Assessment	<p>All residents are eligible for in-kind benefits. Services are provided based on the evaluation of needs and resources. The ability to care for oneself and the level of independence are evaluated in %. The minimum level to qualify for long-term care is 75% ability for self-care and independence. In total, there are 4 levels. There is the national procedure for assessment of the dependency level, with criteria:</p> <ul style="list-style-type: none"> • functional disorders (movement disorders, speech impediments, hearing impairment, vision disorders, other health disorders) • use of technical aids • getting dressed • caring for appearance, personal hygiene and oral hygiene • taking a bath or washing • using toilet • orientation in space, time • communication, behaviour, settlement of conflicts
Cost-sharing	<p>The amount of payment depends on the level of the beneficiary's income and the service received.</p> <p>Individuals with severe mental disability are exempt from co-payments for the care in long-term care and social rehabilitation institutions.</p>
Combining	Possible (care allowance suspended when the recipient is in a state-funded long-term social care institution)
References	<ul style="list-style-type: none"> • Ministru kabineta noteikumi Nr.1608. Noteikumi par pabalstu personām ar invaliditāti, kurām nepieciešama kopšana. https://likumi.lv/ta/id/202853-noteikumi-par-pabalstu-personam-ar-invaliditati-kuram-nepieciessama-kopsana. • Labklājības ministrija. <i>Pabalsts cilvēkiem ar invaliditāti, kuriem nepieciešama īpaša kopšana</i>. https://www.lm.gov.lv/lv/pabalsts-cilvekiem-ar-invaliditati-kuriem-nepieciessama-ipasa-kopsana?utm_source=https%3A%2F%2Fwww.google.com%2F. • 8.pielikums Ministru kabineta 2014.gada 23.decembra noteikumiem Nr.805. Kritēriji atzinuma sniegšanai par īpašas kopšanas nepieciešamību personai ar invaliditāti no 18 gadu vecuma (Pielikums grozīts ar MK 12.09.2017. noteikumiem Nr. 544). https://www.lm.gov.lv/sites/lm/files/data_content/krit_p.kops1.pdf. • Valsts sociālās apdrošināšanas aģentūra. <i>Pabalsts personai ar invaliditāti, kurai nepieciešama kopšana</i>. https://www.vsaa.gov.lv/lv/pakalpojumi/pabalsts-personai-ar-invaliditati-kurai-nepieciessama-kopsana.

Table A.17: LITHUANIA

Care allowance (Tikslinės kompensacijos)	
Bound/Free use	Free use
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> • Residence in Lithuania
<i>Assessment</i>	
Criteria	<p>The lack of autonomy is assessed based on the ability of the person to participate in the following activities:</p> <ul style="list-style-type: none"> • cognition (14 questions) <ul style="list-style-type: none"> • concentration, memory, orientation in time, understanding everyday problems and ways to solve them, everyday problem solving, learning and applying new things, perception of visual information, perception of auditory information, perception of information through other sense organs, writing, calculating, reading, talking, sensory sensitivity • mobility/movement (13 questions) <ul style="list-style-type: none"> • fine motor skills, shoulder and/or arm control, sitting, standing up from a sitting position, moving from one position to another, standing, climbing the stairs, movement at home, walking a short distance (within 50-100 meters), long-distance walking, orientation in the environment, using public transport, using private and/or specialised transport • self-care (6 questions) <ul style="list-style-type: none"> • washing, selection of appropriate clothing, dressing, eating, using the toilet, staying at home alone • communication and daily activities (12 questions) <ul style="list-style-type: none"> • communication with strangers (e.g. cashier), communication with relatives and friends, understanding and following the norms of socially acceptable behaviour, using things (finding them, taking them, moving them, using them according to their intended purpose), cooking, housework (speed of execution, efficiency, completion), managing personal affairs in institutions (e.g.: post office, hairdresser, bank, migration service, car service), performing daily tasks at work or in an educational institution, using telephone and/or computer equipment, shopping, shopping and budget planning, taking care of health (e.g.: use of prescribed medicines, exercise, awareness of the importance of a healthy diet, periodic follow-up of health status at a health care facility), sleep quality • participation (involvement/engagement) (4 questions) <ul style="list-style-type: none"> • engagement in various forms of employment, engagement and/or participation in social activities (holidays, religious services, community gatherings, etc.), engagement in social activities, physical barriers and obstacles affecting engagement social activities <p>It also takes into account the findings of other institutions, such as a health care professional, about the person's condition and problems.</p>

<p>Score</p>	<p>Based on the help needed, each of the 49 questions is assigned 0-4 points:</p> <ul style="list-style-type: none"> • 0 points – there is no need for help • 1 point – low need for help, when the person rarely needs help, has little difficulty in performing ADLs+iADLs, and/or has slightly impaired cognitive functions and abilities • 2 points – average need for help, when the person sometimes needs help, has moderate difficulties in performing ADLs+iADLs, sometimes does not perform actions independently and safely and/or has partially impaired cognitive functions and abilities • 3 points – high need for help, when the person has great difficulty in performing ADLs+iADLs, often does not perform actions independently and safely, and/or has markedly impaired cognitive functions and abilities • 4 points - constant need for help, when the person constantly needs help with ADLs+iADLs and/or does not perform actions by himself due to very clearly impaired cognitive functions and abilities <p>Based on the resulting number of points (0-196, where 196=49x4), a coefficient is assigned to the person:</p> <ul style="list-style-type: none"> • 0.7 for 181-196 points • 0.8 for 149-180 points • 0.9 for 98-148 points • 1.0 for 51-97 points • 1.1 for 11-50 points • 1.2 for 0-10 points <p>This coefficient then multiplies the “basic level” of functioning that applies to the person’s health condition. These basic-level conditions fall into 4 categories rated by 10, 20, 30, and 40 points respectively.</p> <ul style="list-style-type: none"> • There are overall 49 basic-level conditions (see Order No. A1-765/V-1530), eg: <ul style="list-style-type: none"> • Complete impairment of general and specific mental functions resulting from all forms of schizophrenia, exit stage (10 points) • Dementia, amnesic syndrome, when there is a severe cognitive impairment (20 points) • Advanced malignancy, when the disease has progressed and palliative treatment is given to relieve the symptoms of the cancer, but not to cure the cancer (30 points) • Ankylosis of the shoulder and/or elbow joints, when at least 3 joints are affected (40 points). <p>The basic-level number of points (10-40) multiplied by the coefficient (0.7-1.2) is decisive for the level of care allowance.</p>
<p>Levels</p>	<ul style="list-style-type: none"> • Level 1: <ul style="list-style-type: none"> • 7, 8, 9, 10, 11, 12 or 14 points • long-term or irreversible impairment, completely dependent, unable to orient or move, requires constant help or care of another person • Level 2:

	<ul style="list-style-type: none"> • 16, 18, 20 or 21 points • requires help/care for 6-10 hours a day • Level 3: <ul style="list-style-type: none"> • 22, 24, 27, 28 or 30 points • requires help/care for 4-6 hours a day • Level 4: <ul style="list-style-type: none"> • 32, 33, 36 or 40 points • requires help/care for no more than 4 hours a day <p>If the number of points is higher than 40 points, the need for individual assistance compensation is not determined.</p>
Threshold	Allowance paid out in all levels.
Benefits in-kind	
Assessment	<p>The need for social care of a person with disability is determined based on their ability to take care of themselves. The assessment first evaluates the living environment, communication skills, dependence in daily activities, ability to manage personal and family life, health and other factors influencing social independence, and the possibilities of informal care. When it is recommended that general social services should be provided to the individual, then further assessment is conducted. It takes into account the need for individual assistance, which is assessed using the 49 questions categorised in 5 fields (as with the care allowance):</p> <ul style="list-style-type: none"> • cognition (14 questions) • mobility/movement (13 questions) • self-care (6 questions) • communication and daily activities (12 questions) • participation (involvement/engagement) (4 questions). <p>Based on the help needed, each of the 49 questions is assigned 0-4 points (see care allowance). The sum of points over all questions determines the level of personal independence.</p> <p>Levels of personal independence:</p> <ul style="list-style-type: none"> • Level 1: self-sufficient person (up to 49 points) • Level 2: partially self-sufficient person (50-196 points) • Level 3: dependent (147-196 points and the first or second level need for compensation of the costs of providing individual assistance or the third level need due to mental retardation or mental disorders) <p>Each level gives entitlement to different services according to the specific situation.</p>
Cost-sharing	All long-term care recipients have to contribute by paying their share of charges based on their income and assets (in case of residential care). For an adult, it must not exceed 80 percent of the individual's income. The amount depends on the kind of long-term care and the person in need of care.
Combining	No cumulation of cash benefits with benefits in kind.
References	<ul style="list-style-type: none"> • Order No. 1062230ISAK000A1-94, Dėl Asmens (šeimos) socialinių pastaugų poreikio nustatymo, skyrimo ir organizavimo tvarkos aprašo, Senyvo amžiaus asmens bei suaugusio asmens su negalia socialinės globos poreikio nustatymo metodikos ir Socialinės globos

	<p>poreikio vaikui su negalia nustatymo metodikos patvirtinimo. https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.274454/dkiGQYGsDM.</p> <ul style="list-style-type: none"> Lietuvos Respublikos socialinės apsaugos ir darbo ministerija. <i>Socialinė integracija</i>. https://socmin.lrv.lt/lt/veiklos-sritys/socialine-integracija/. Order No. 1052230ISAK78/V-179, Dėl Dalyvumo lygio nustatymo kriterijų ir tvarkos aprašo patvirtinimo (Appendix 3). https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.252941/asr?positionInSearchResults=0&searchModelUUID=3914683f-fb74-4594-bc58-bf13188dfd95. Act No. 0911010ISTA001-2044, LIETUVOS RESPUBLIKOS ASMENS SU NEGALIA TEISIŲ APSAUGOS PAGRINDŲ ĮSTATYMAS. https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.2319/asr. Order No. 2018-12-29 Nr. 2018-21943, Dėl Individualios pagalbos teikimo, lengvojo automobilio ar jo techninio pritaikymo išlaidų kompensacijų poreikių nustatymo tvarkos aprašo patvirtinimo. https://www.e-tar.lt/portal/lt/legalAct/ef7052500aa811e9a5eaf2cd290f1944/UsDcbVEeuB. Lietuvos Respublikos socialinės apsaugos ir darbo ministerija. <i>Tikslinės kompensacijos</i>. https://socmin.lrv.lt/lt/veiklos-sritys/socialine-integracija/negalios-reforma-ir-asmenu-su-negalia-itrauktis/individualios-pagalbos-teikimo-islaidu-kompensacijos/tikslines-kompensacijos/. Lietuvos Respublikos socialinės apsaugos ir darbo ministerija. Sulaukiau senatvės. https://socmin.lrv.lt/lt/veiklos-sritys/socialine-parama-kas-man-priklauso/sulaukiau-senatves/. Asmens su negalia teisių apsaugos agentūra prie Lietuvos Respublikos socialinės apsaugos ir darbo ministerijos. Individualios pagalbos teikimo, lengvojo automobilio ar jo techninio pritaikymo išlaidų kompensacijos poreikių nustatymas. https://anta.lrv.lt/lt/veiklos-sritys/individualios-pagalbos-teikimo-lengvojo-automobilio-ar-jo-techninio-pritaikymo-islaidu-kompensacijos-poreikiu-nustatymas/.
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Table A.18: LUXEMBOURG

Care allowance (Dépendance prestation en espèces)	
Bound/Free use	Bound use No invoices/proofs needed. But the chosen informal carer needs to undergo an assessment of the capabilities and availability, as well as of their requirements in terms of management and training.
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> Coverage by sickness insurance (anyone covered in Luxembourg by sickness insurance is also covered by long-term care insurance) <ul style="list-style-type: none"> one-year qualifying period for insured with voluntary health insurance affiliation
<i>Assessment</i>	
Criteria	<p>Based on the application of the potential beneficiary and a report from the general practitioner, the State Office for Assessment and Monitoring first assesses the assistance and care needs of the applicant as well as the qualification and availability of his/her possible caregiver. The Office then determines the benefits required as well as their frequency.</p> <p>The essential ADLs include:</p> <ul style="list-style-type: none"> corporeal hygiene: assistance and care for bodily cleanliness excretion: assistance and care for excretion of waste from the body nutrition: assistance and care in securing absorption of food, hydration and enteral nutrition

	<ul style="list-style-type: none"> getting dressed: assistance and care in getting dressed and undressed mobility: assistance and care in changing position, moving around, and accessing and entering their home.
Score	Length (in minutes) of help needed to perform the ADLs.
Levels	Based on minutes of care per week provided by a carer: <ul style="list-style-type: none"> Level 1: less than 61 Level 2: 61-120 Level 3: 121-180 Level 4: 181-240 Level 5: 241-300 Level 6: 301-360 Level 7: 361-420 Level 8: 421-480 Level 9: 481-540 Level 10: 541 minutes or more
Threshold	Care allowance from Level 1. There must be a need for at least 3.5 hours of care per week (i.e. at least Level 1 in the assessment described below).
Benefits in-kind	
Assessment	Based on the assessment of assistance and care for basic daily tasks, the applicant is allocated 1 of 15 need levels, from Level 1 (210 to 350 minutes per week) to Level 15 (more than 2,171 minutes per week).
Cost-sharing	No cost-sharing.
Combining	Possible The person in need may opt to receive the combination of benefits in kind and cash benefits if he/she seeks assistance from an informal caregiver who does not belong to a care network or care facility and is qualified and available.
References	<ul style="list-style-type: none"> Code de la Sécurité sociale. https://legilux.public.lu/eli/etat/leg/code/securete_sociale/20240101. Le gouvernement luxembourgeois. L' Administration d'évaluation et de contrôle L' Assurance dépendance. Procédure. https://aec.gouvernement.lu/fr/l-assurance-dependance/procedure.html. Luxembourg government. State office for the assessment and monitoring of the long-term care insurance. <i>International considerations in matters concerning long-term care insurance</i>. https://aec.gouvernement.lu/en/l-assurance-dependance/international.html.

Table A.19: MALTA

Care allowance (Skema Carer at Home)	
Bound/Free use	Bound use The benefit is granted to employ a home carer. A copy of the contract has to be submitted for the person in need to receive the allowance.
National/Regional	National criteria
Income-based/Flat	Flat amount A proportional amount is granted if the carer is employed only part time.

Eligibility	<ul style="list-style-type: none"> • Residence in Malta • Individuals above 60 years • The carer must have a recognised qualification
Assessment	
Criteria	The benefit is subject to an assessment after medical documentation is submitted. Applicants between the ages of 60 and 79 are assessed remotely via a call in order to establish their need for assistance (questions on the need for assistance in transferring, using the toilet, etc.). If needed, nurses carry out a home visit prior to deciding on the approval. They undertake a similar assessment as described below for in-kind benefits. All applicants over 80 years of age are approved.
Score	
Levels	An amount is defined for a full-time care worker and granted pro-rata for a part time carer.
Threshold	Care allowance is provided
Benefits in-kind	
Assessment	<p>The dependency level is primarily determined using the Barthel Score with the assessed activities:</p> <ul style="list-style-type: none"> • Bowels • Bladder • Grooming • Toilet use • Feeding • Transfer (bed to chair) • Mobility • Dressing • Stairs • Bathing <p>The assessment then takes into account medical history, drug treatment and need for nursing care, communication abilities, mental state, and social state.</p>
Cost-sharing	Beneficiaries are expected to make contributions for in-kind services. These co-payments cannot leave the resident with less than a defined amount of money.
Combining	Possible
References	<ul style="list-style-type: none"> • Anzjanita Attiva u Kura fil-Komunita. <i>Skema Carer at Home</i>. https://aacc.gov.mt/what-we-offer/other-community-services/carer-at-home/?lang=en. • Act No. X of 1987, ATT DWAR IS-SIGURTÀ SOĊJALI. https://legislation.mt/eli/cap/318/mlt. • Barthel Index of Activities of Daily Living. https://socialsecurityforms.blob.core.windows.net/aloaha/BarthelIndexScoreMedicalBoardEN.pdf.

Table A.20: The NETHERLANDS

Care allowance (Persoonsgebonden budget = PGB)	
Bound/Free use	Bound use The personal care budget (PGB) within the Long-term Care Act can be used by the person in need of care to buy care independently. The issuer of PGB directly pays the caregiver on behalf of the person receiving care. But the person in need chooses the service provider. It is considered in the Netherlands as an in-kind benefit.
National/Regional	National criteria
Income-based/Flat	Flat amount But there is a minimum and maximum personal contribution.
Eligibility	<ul style="list-style-type: none"> • Residence in the Netherlands (Anyone coming from abroad becomes eligible, but they are subject to a waiting period of one month for every year that they were uninsured, up to a maximum of twelve months) • Long-term care is only provided if people need permanent supervision or continuous 24-hour care close by.
Assessment	
Criteria	The Care Needs Assessment Centre assesses the need for care based on the diseases, conditions and disorders the person has. It is assessed if the need for help is continuous (with eating, drinking, washing, dressing and undressing, going to the toilet, brushing teeth, combing hair, cutting nails, etc.) Then a care profile is assigned. The care profile must match the basis(s), disorders and limitations and the resulting current care needs.
Score	The need for care is assessed according to the International Classification of Functioning, Disability and Health (ICF) of the World Health Organisation. Which diseases, conditions and disorders the person has, is based on the ICD-10, DSM-IV and DSM-5.
Levels	38 care profiles across 6 sectors (nursing and care, mentally handicapped, mildly mentally handicapped, physically handicapped, sensory handicapped, mental healthcare) depending on how much care is needed. Each care profile is associated with a budget (maximum amount). From 2025, tailor-made personal budget based on client's specific care needs will replace the maximum amount per person. First experiences with the customized PGB show that it leads to lower healthcare costs.
Threshold	There is no personal budget for mildly mentally handicapped, for some categories in mental health care profile, and for the Recovery-oriented treatment with nursing and care.
Benefits in-kind	
Assessment	The in-kind benefits under the Long-term Care Act depend on the care profile assigned.

Cost-sharing	<p>The amount of the personal contribution depends on the insured's income, assets and the form of delivery.</p> <p>There are two kinds of cost-sharing:</p> <ul style="list-style-type: none"> • high contribution for people receiving residential care including housing costs, • low contribution for people receiving care at home or in a facility where they need to pay rent.
Combining	<p>Personal budget and in-kind care can be combined.</p> <p>Care can be received via a personal budget or via in-kind care. For in-kind care, the municipality, the care office or the health insurer determine which care organisation will be chosen.</p>
References	<ul style="list-style-type: none"> • Rijksoverheid. <i>Persoonsgebonden budget (pgb)</i>. https://www.rijksoverheid.nl/onderwerpen/persoonsgebonden-budget-pgb. • Rijksoverheid. <i>Vraag en antwoord</i>. https://www.rijksoverheid.nl/onderwerpen/persoonsgebonden-budget-pgb/vraag-en-antwoord/verschil-pgb-zorg-natura. • Beleidsregels indicatiestelling Wlz 2024. https://wetten.overheid.nl/BWBR0049184/2024-01-01. • CAK. <i>Ik heb een pgb voor de Wet langdurige zorg (Wlz)</i>. https://www.hetcak.nl/uw-situatie/ik-heb-een-persoonsgebonden-budget/pgb-wet-langdurige-zorg-wlz/. • Slimme lijst: Pgb-tarieven 2024. https://www.pgb.nl/slimme-lijst/slimme-lijst-pgb-tarieven-2024/.

Table A.21: POLAND

Care allowance (Zasitek pielęgnacyjny)	
Bound/Free use	Free use
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> • Residence in Poland • Certificate of high degree of disability (or moderate disability if it was acquired before the age of 21) OR age above 75 • It cannot be combined with another type of care allowance: Dodatek pielęgnacyjny
<i>Assessment</i>	
Criteria	<p>To assign the degree of disability, the committee considers the results of medical examinations and further evaluates individual's:</p> <ul style="list-style-type: none"> • capacity to work • need for help with: <ul style="list-style-type: none"> • personal hygiene • feeding • self-service activities • running a household • facilitating contacts • need for assistance in fulfilling social roles (depending on age, gender, social and cultural factors): <ul style="list-style-type: none"> • support in self-service activities • support in running a household • help with treatment, rehabilitation, education
Score	Level of impairment/dependence:

	<ul style="list-style-type: none"> total/permanent/long-term vs temporary/partial
Levels	<ul style="list-style-type: none"> Level 1: <ul style="list-style-type: none"> incapacity to work total dependence on help need for permanent/long-term assistance in fulfilling social roles Level 2: <ul style="list-style-type: none"> need for part-time/periodical assistance in fulfilling social roles Level 3: <ul style="list-style-type: none"> significant reduction in the ability to perform work some limitations in fulfilling social roles BUT ability to compensate for limitations using orthopaedic items, auxiliary means or technical means
Threshold	<p>Care allowance can be provided to individuals with disability certificate of Level 1; of Level 2 if disability has been acquired before the age of 21.</p> <p>Individuals aged above 75 do not have to submit a certificate of disability with the application.</p>
Benefits in-kind	
Assessment	The assessment depends on the benefit in question. For semi residential and residential care the International Barthel Scale is used.
Cost-sharing	Cost-sharing depends on the type of benefit and the individual's income. Some services are without cost-sharing, e.g., care in centres and homes which provide residential and semi-residential care.
Combining	Possible The care allowance (Zasitek pielęgnacyjny) cannot be distributed when the person is placed in an institution providing 24-hour care.
References	<ul style="list-style-type: none"> Ministerstwo Rodziny, Pracy i Polityki Społecznej. Zasitek pielęgnacyjny. https://www.gov.pl/web/rodzina/zasitek-pielagnacyjny. Serwis Rzeczypospolitej Polskiej. Uzyskaj orzeczenie o stopniu niepełnosprawności. https://www.gov.pl/web/gov/uzyskaj-orzeczenie-o-stopniu-niepelnosprawnosci. ROZPORZĄDZENIE MINISTRA GOSPODARKI, PRACY I POLITYKI SPOŁECZNEJ z dnia 15 lipca 2003 r. w sprawie orzekania o niepełnosprawności i stopniu niepełnosprawności. https://sip.lex.pl/akty-prawne/dzu-dziennik-ustaw/orzekanie-o-niepelnosprawnosci-i-stopniu-niepelnosprawnosci-17045552.

Table A.22: PORTUGAL

Care allowance (Complemento por dependência)	
Bound/Free use	Free use
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> Residence in Portugal Status of a pensioner, or an individual in a situation when the dependency has been recognised by the social security services
<i>Assessment</i>	

Criteria	Dependency is assessed by the capacity to autonomously perform essential ADLs+iADLs: <ul style="list-style-type: none"> • housekeeping (domestic services) • eating (support with food) • mobility • personal hygiene
Score	Number of ADLs+iADLs that cannot be performed independently.
Levels	<ul style="list-style-type: none"> • Level 1: unable to perform autonomously the essential ADLs+iADLs • Level 2: person in the situation corresponding to Level 1 who is, moreover, confined to bed or severely demented
Threshold	Care allowance from Level 1.
Benefits in-kind	
Assessment	To receive the services provided by the National network of integrated long-term care (RNCCI), patients must be referred by a hospital or a primary health care centre then an assessment is made by medical teams. The assessment is based on a set of criteria including an evaluation of dependency based on the International Classification of Functioning, Disability and Health and/or on the existence of a serious illness or injury.
Cost-sharing	Participation in the social security system varies according to personal or family income and the level of care and dependency.
Combining	Possible
References	<ul style="list-style-type: none"> • Decreto-Lei n.º 265/99, Procede à criação de uma nova prestação destinada a complementar a protecção concedida aos pensionistas de invalidez, velhice e sobrevivência dos regimes de segurança social em situação de dependência. https://diariodarepublica.pt/dr/legislacao-consolidada/decreto-lei/1999-34482875. • Ministério do Trabalho, Solidariedade e Segurança Social. <i>Complemento por dependência</i>. https://www.seg-social.pt/complemento-por-dependencia#. • Decreto-Lei n.º 360/97, Procede à definição do sistema de verificação de incapacidades (SVI), no âmbito da segurança social. https://diariodarepublica.pt/dr/legislacao-consolidada/decreto-lei/1997-34491875. • Decreto-Lei n.º 352/2007, de 23 de outubro. https://diariodarepublica.pt/dr/detalhe/decreto-lei/352-2007-629107.

Table A.23: ROMANIA

Care allowance (Indemnizație pentru persoanele cu handicap)	
Bound/Free use	Free
National/Regional	National criteria
Income-based/Flat	Flat
Eligibility	<ul style="list-style-type: none"> • Residence in Romania • Certificate of disability level (severe, profound, medium)
<i>Assessment</i>	
Criteria	To assign the disability level, a complex assessment is performed, building on medical reports from physicians. The resulting report

	includes the recommended disability level and the proposed care program.
Score	The severity and type of disability
Levels	<ul style="list-style-type: none"> • Level 1: mild disability • Level 2: medium disability • Level 3: profound disability • Level 4: severe disability
Threshold	Monthly allowance accompanied by the Complementary personal budget can be awarded to those with severe and profound disability. Those with medium disability are entitled to the Complementary personal budget. No care allowance is awarded to those with mild disability.
Benefits in-kind	
Assessment	<p>The assessment based on a socio-medical evaluation form takes into account the psychic and mental integrity of the elderly, as well as his/her ability to perform the basic and instrumental activities of daily life. The criteria consist of:</p> <ul style="list-style-type: none"> • Activities of daily living <ul style="list-style-type: none"> • Body hygiene (general, intimate, toilet) • Dressing/Undressing • Eating (Possibility to serve and feed oneself) • Contenance (elimination hygiene) • Moving from one position to another (standing, sitting, lying down) • Indoor mobility • Outdoor mobility (without means of transport) • Communication (remote communication) • Instrumental activities <ul style="list-style-type: none"> • Food preparation • Housekeeping activities • Budget management • Shopping • Compliance with medical treatment • Use of means of transport • Free time activities (cultural, intellectual, physical activities) • Sensory and psychological status <ul style="list-style-type: none"> • Visual and hearing acuity, speech impairment, orientation, memory, judgment, coherence, behaviour, affective disorders (depression) <p>Each activity is evaluated based on the level of help needed:</p> <ul style="list-style-type: none"> • 0 = no need for supervision and assistance • 1 = need for temporary supervision or partial assistance • 2 = need for permanent supervision or full assistance <p>One of eight degrees is then assigned (three main levels with subcategories).</p>

Cost-sharing	Co-payments depend on the type of services provided and the person's income, without exceeding the established cost by the local authorities. Elderly with no income do not pay any charges for social services.
Combining	Not possible (individuals cared for at home by a professional personal assistant or in public residential institutions with social, medico-social character are not entitled to care allowance)
References	HOTĂRÂRE nr. 886 din 5 octombrie 2000 pentru aprobarea Grilei naționale de evaluare a nevoilor persoanelor vârstnice. https://legislatie.just.ro/Public/DetaliiDocument/24673 . LEGE nr. 448 din 6 decembrie 2006 privind protecția și promovarea drepturilor persoanelor cu handicap. https://legislatie.just.ro/Public/DetaliiDocument/77815 Ministerul Muncii și Solidarității. Evaluare grad de handicap. Assessment of the degree of disability. https://anpd.gov.ro/web/dizabilitate/evaluarea-in-grad-de-handicap/ . HOTĂRÂRE nr. 430 din 16 aprilie 2008 pentru aprobarea Metodologiei privind organizarea și funcționarea comisiei de evaluare a persoanelor adulte cu handicap. https://legislatie.just.ro/Public/DetaliiDocument/92004 . Ordin nr. 2.298 din 23 august 2012 privind aprobarea Procedurii-cadru de evaluare a persoanelor adulte în vederea încadrării în grad și tip de handicap. https://legislatie.just.ro/Public/DetaliiDocument/141527 .

Table A.24: SLOVAKIA

Care allowance (Peňažný príspevok na osobnú asistenciu)	
Bound/Free use	Bound use (The person is required to submit a monthly report on the hours of personal assistance provided.)
National/Regional	National criteria
Income-based/Flat	Flat amount per hour of provided help
Eligibility	<ul style="list-style-type: none"> • Residence in Slovakia • Wealth below a ceiling • Peňažný príspevok na osobnú asistenciu cannot be combined with the Attendance Service Benefit (Peňažný príspevok na opatrovanie) which is paid to the carer.
<i>Assessment</i>	
Criteria	21 activities used to determine the extent of the necessary personal assistance: <ul style="list-style-type: none"> • getting up • lying down • positioning • personal hygiene <ul style="list-style-type: none"> • washing, bathing, combing, shaving, nail trimming, makeup, bowel and bladder emptying • dressing • undressing

	<ul style="list-style-type: none"> • food preparation • serving food • administration of medicines • shopping • help with housework • care of the aid (for example, a personal motor vehicle) • communication <ul style="list-style-type: none"> • writing, reading, calling, mediating communication for the hearing-impaired and the deaf-blind persons, reading for the blind, mediating communication in the form of augmentative and alternative communication • supervision • help with acute illness • help during vacation • escorting child to/from school • assistance to a deaf parent of a hearing child/deaf child • assistance to a blind parent of a blind/sighted child • transport to work activities, educational activities, civic activities, family activities and leisure activities • assistance to the parent with severe disability to manage care of a child below three years of age
Score	<p>The extent of personal assistance is determined by the number of activities and hours required to perform them. The number of hours that will be paid for might be proposed by the person in need and is then officially determined by the Labour office. Medical report forms a part of the application.</p> <p>There is no guideline on the number of hours per activity. The annual maximum number of hours is 7300 (but only 1460 hours if care is provided by family members).</p>
Levels	<p>No levels.</p> <p>Each person is assigned a number of hours based on the complex assessment.</p>
Threshold	No threshold, no minimum number of hours.
Benefits in-kind	
Assessment	<p>Based on a medical and social assessment, a dependency level is assigned.</p> <p>12 areas of assessment:</p> <ul style="list-style-type: none"> • eating and drinking • emptying the bladder • colon emptying • personal hygiene • taking bath • dressing, undressing • changing position, sitting and standing • moving up the stairs • movement on a flat surface • orientation in the environment • adherence to the prescribed treatment • need for supervision

	<p>In each area, 0, 5, or 10 points are assigned. In a simplified way, 0 points are assigned when help is needed, 5 when help is sometimes needed (with some of the subtasks), 10 when no help is needed.</p> <p>Based on the total number of points, the person is assigned the dependency level:</p> <ul style="list-style-type: none"> • Level 1: 105-120 points <ul style="list-style-type: none"> • average number of hours of help needed per day: 0 • Level 2: 85-104 points <ul style="list-style-type: none"> • average number of hours of help needed per day: 2-4 • Level 3: 65-84 points <ul style="list-style-type: none"> • average number of hours of help needed per day: 4-6 • Level 4: 45-64 points <ul style="list-style-type: none"> • average number of hours of help needed per day: 6-8 • Level 5: 25-44 points <ul style="list-style-type: none"> • average number of hours of help needed per day: 8-12 • Level 6: 0-24 points <ul style="list-style-type: none"> • average number of hours of help needed per day: more than 12 <p>The legislation then stipulates what type of service/care can be provided in the given dependency level.</p>
Cost-sharing	<p>Recipients of benefits in kind have to pay for services during a stay in a facility according to their income and assets, but they have to be left with a certain minimum income (25% of the subsistence minimum). In case of home care services, the recipient must be left with at least 165% of the subsistence minimum.</p>
Combining	<p>Care allowance (Peňažný príspevok na osobnú asistenciu) can be combined with some of the in-kind benefits, e.g., outpatient form of social service or a weekly residential social service, with the exception of the hours during which the social service is provided. On the other hand, it cannot be combined with a nursing service.</p>
References	<p>ZÁKON z 29. októbra 2008 o peňažných príspevkoch na kompenzáciu ťažkého zdravotného postihnutia a o zmene a doplnení niektorých zákonov. https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2008/447/.</p> <p>Ministerstvo práce, sociálnych vecí a rodiny Slovenskej republiky. Peňažný príspevok na osobnú asistenciu. https://www.employment.gov.sk/sk/rodina-socialna-pomoc/tazke-zdravotne-postihnutie/penazne-prispevky/pp-osobnu-asistenciu/.</p> <p>ZÁKON z 29. októbra 2008 o peňažných príspevkoch na kompenzáciu ťažkého zdravotného postihnutia a o zmene a doplnení niektorých zákonov, Príloha č. 3. https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2008/448/20230101#prilohy.priloha-priloha_c_3_k_zakonu_c_448_2008_z_zoznacenie.</p>

Table A.25: SLOVENIA

Care allowance (Dodatek za pomoč in postrežbo)	
Bound/Free use	Free use
National/Regional	National criteria
Income-based/Flat	Flat amount
Eligibility	<ul style="list-style-type: none"> • Residence in Slovenia • Recipient of old-age, early retirement, invalidity, or family pension
<i>Assessment</i>	
Criteria	<p>Cash benefits are provided on the basis of an assessment of the ability to perform basic ADLs:</p> <ul style="list-style-type: none"> • Moving inside the apartment • Moving outside of the apartment • Eating • Dressing • Undressing • Putting shoes on • Taking shoes off • Care for personal hygiene (washing hands and face, showering is not included) • Performing physiological needs
Score	<p>Number of ADLs that the individual is unable to perform independently and needs constant help and service to fulfil the basic needs.</p> <p>Decisive is the length of the required help as well.</p>
Levels	<ul style="list-style-type: none"> • Level 1: person needs assistance to perform the majority of ADLs (more than half of the listed ADLs) • Level 2: person needs assistance to perform all basic ADLs • Level 3: person is severely disabled and needs 24-hour supervision
Threshold	Care allowance from Level 1.
Benefits in-kind	
Assessment	<p>The assessment for benefits in kind is based on the ability to perform ADLs+iADLs.</p> <p>The type of residential care of the elderly (65+) depends on the individual assessment and is organised on four levels:</p> <ul style="list-style-type: none"> • Level 1: for persons who, for reasons of age or other reasons accompanying age, are unable to live fully independently and require a small amount of direct personal assistance • Level 2: for persons with moderate age and health problems who need a greater amount of direct personal assistance • Level 3: for persons with the most complex age and health problems who fully need direct personal assistance, namely: a) persons in need of direct personal assistance to meet all basic living needs; b) the most severely affected persons • Level 4: for persons with more complex long-term mental health problems who require partial or complete personal assistance and

	supervision due to age-related dementia or related conditions (care of persons with dementia)
Cost-sharing	Social services are subject to partial payment by the beneficiary according to the financial possibilities. Beneficiaries are obliged to cover part of the costs in case of home care (up to 50%) and 100% of social services in case of residential care according to their financial abilities.
Combining	Combination of cash benefits and benefits in kind is possible for home services and residential services.
References	<ul style="list-style-type: none"> • Zavod za pokojninsko in invalidsko zavarovanje Slovenije. <i>Dodatek za pomoč in postrežbo</i>. https://www.zpiz.si/cms/content2019/dodatek-za-pomo-in-postrebo. • Zavod za pokojninsko in invalidsko zavarovanje Slovenije. <i>Potreba po pomoči in postrežbi drugega</i>. https://www.zpiz.si/cms/content2019/ii-potreba-po-pomoi-in-postrebi-dругega. • Zakon o pokojninskem in invalidskem zavarovanju (ZPIZ). https://pisrs.si/pregledPredpisa?id=ZAKO200.

Table A.26: SPAIN

Care allowance (Prestación económica vinculada al servicio = PEVS)	
Bound/Free use	Bound use Linked to the purchase of services.
National/Regional	National assessment criteria, regional level of benefits (within national min-max range) and co-payment varying across Autonomous Communities
Income-based/Flat	Income-based amount (depends on the economic capacity of the beneficiary)
Eligibility	<ul style="list-style-type: none"> • Residence in Spain (residence in Spain for at least 5 years, 2 of which must immediately precede the application date)
<i>Assessment</i>	
Criteria	<p>Assessment based on the scale Baremo de Valoración de la Situación de Dependencia (BVD).</p> <p>Assessed ADLs+iADLs:</p> <ul style="list-style-type: none"> • eating and drinking • personal hygiene related to urination and defecation • washing up • other body care (wash hair, combing, brushing teeth, cutting nails) • dressing • health maintenance • changing and maintaining body positions • moving around home • travel outside home • housework chores • taking decisions
Score	For each of the ADLs+iADLs, the performance level and problem are identified and the type (supervision, partial physical assistance, maximum physical assistance, special assistance) and frequency

	<p>(hardly ever, sometimes, quite a few times, most of the time, always) of the necessary support in those tasks.</p> <ul style="list-style-type: none"> • Positive performance: when the valued person is capable of carrying out the task, on his or her own and adequately, in his or her usual environment. • Negative performance: when it is demonstrated that the person requires the essential support of another person to carry out the task adequately, or that the person is not capable of carrying it out in any way. <p>The final BVD score is obtained as a weighted sum of the values assigned to the tasks in which the situation of dependency has been established.</p>
Levels	<ul style="list-style-type: none"> • Level 1: Moderate dependence: when the person needs help to carry out several basic ADLs+iADLs, at least once a day or has needs for intermittent or limited support for personal autonomy. BVD score: 25-49 points • Level 2: Severe dependency: when the person needs help to carry out several basic ADLs+iADLs two or three times a day but does not require the permanent support of a caregiver or has extensive support needs for personal autonomy. BVD score: 50-74 points. • Level 3: Great dependency: when the person needs help to carry out several basic ADLs+iADLs several times a day and, due to their total loss of physical, mental, intellectual or sensory autonomy, they need the indispensable and continuous support of another person or have needs for widespread support for personal autonomy. BVD score: 75-100 points. <p>There are two levels within each degree based on personal autonomy and the intensity of care required: (grade I level 1: 25-39, grade I level 2: 40-49, grade II level 1: 50-64, grade II level 2: 65-74, grade III level 1: 75-89, grade III level 2: 90-100).</p>
Threshold	Economic benefit from Level 1.
Benefits in-kind	
Assessment	The same assessment as for cash benefits (see above). Once the assessment has been carried out, the Individual Care Program (PIA) is prepared, which establishes the most appropriate intervention: service or economic benefit.
Cost-sharing	The user's participation is determined by the municipality where they reside.
Combining	Cumulation of cash benefits with in-kind benefits is not possible, except with services to prevent situations of dependency, promotion of personal autonomy and tele assistance. The best intervention is proposed in the Individual Care Program (PIA).
References	<ul style="list-style-type: none"> • Ley 39/2006, de 14 de diciembre, de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia. https://www.boe.es/buscar/act.php?id=BOE-A-2006-21990. • Real Decreto 174/2011, de 11 de febrero, por el que se aprueba el baremo de valoración de la situación de dependencia establecido por la Ley 39/2006, de 14 de diciembre, de

	<p>Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia. https://www.boe.es/buscar/doc.php?id=BOE-A-2011-3174.</p> <ul style="list-style-type: none"> Comunidad de Madrid. <i>Guía práctica sobre dependencia</i>. https://www.comunidad.madrid/servicios/servicios-sociales/guia-practica-dependencia.
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Table A.27: SWEDEN

Care allowance ()	
Bound/Free use	-
National/Regional	<p>Regional criteria</p> <p>The eligibility criteria and services provided vary across the 290 municipalities that have the main responsibility.</p> <p>Priority is given to benefits in-kind.</p> <p>In some municipalities, cash benefits for informal carers exist (attendance allowance: <i>hemvårdsbidrag/anhörigbidrag</i> and carer's allowance: <i>anhöriganställning</i>).</p>
Income-based/Flat	-
Eligibility	-
<i>Assessment</i>	
Criteria	-
Score	-
Levels	-
Threshold	-
Benefits in-kind	
Assessment	<p>Access to social care is based on a needs assessment. There is no national model, no legal framework on needs assessment or required instruments. All residents are eligible for long-term social care, there is no age condition. People have no free choice between home care and residential care. Long term care is provided as a benefit in kind and not a cash benefit.</p> <p>Some municipalities use the KATZ ADL-index or any other type of scale. Others use an administrative application form.</p> <p>The National Board of Health and Welfare has developed a structured instrument for needs assessment. The instrument (BAS) is a questionnaire that can be used in conversations with people applying for any kind of elderly care or to follow-up of previously granted benefits. The answers are used as one of several bases for the assessment of the person's need for care.</p> <p>BAS consists of nine overall questions that deal with areas of activity in daily life. If the elderly person considers himself to have difficulties in any of these areas, follow-up questions can be asked. Then follow other questions: on the home and personal support and how the elderly person has been feeling recently. For each area where the elderly person says they have difficulties, the caseworker must ask if the elderly person wants help or support.</p> <p>The answers are not scored, but the result is descriptive: the answers can give an overall picture of the aspects in which the elderly</p>

	<p>person describes difficulties and can be compared with the answers during a follow-up.</p> <p>The questions follow the ICF terminology:</p> <ul style="list-style-type: none"> • learning and applying knowledge (solving problems or making decisions about something that needs to be done) • general information and requirements (planning, managing, and completing daily activities) • communication (making oneself understood, receiving information) • movement (changing body position, walking or getting from one place to another) • personal care (hygiene, dressing and undressing, eating and drinking or taking care of one's own health) • home life (cooking, shopping, running errands, or doing other household work) • interpersonal interactions and relationships (contacts with other people, in private or in more formal contexts) • important areas of life (paying bills or handling money when making purchases) • community, social and civic life (pursuing leisure or cultural pursuits, participating in religious activities or being able to vote in general elections)
Cost-sharing	<p>There is a national high-cost protection. The individuals are entitled to reserve an amount of money for rent and for daily living costs before the municipality can charge a fee for elderly care.</p>
Combining	-
References	<ul style="list-style-type: none"> • Socialstyrelsen. <i>BAS (Behov av stöd)</i>. https://www.socialstyrelsen.se/kunskapsstod-och-regler/omraden/evidensbaserad-praktik/metodguiden/bas-behov-av-stod/.

9. Appendix: Matching the countries' assessment mechanisms with the SHARE questionnaire

AUSTRIA (Pflegegeld)

Setting: 8 (groups) of ADLs+iADLs or other tasks are assessed together with 7 auxiliary tasks. Each task must be assessed. Each task is assigned a given number of minutes/hours by the Ordinance on the assessment of care needs. If the given tasks cannot be performed independently, help of the relevant length of time should be provided. The final measure of help needed comes from the sum of hours over all the tasks.

Execution: The threshold for eligibility has been downscaled as some of the tasks could not have been matched with the SHARE data. The information on the therapeutic measures is not available in the SHARE data. We consider the individual eligible if at least 56.38 ($=65 \times 0.8674$) hours of help are needed based on the answers in the SHARE questionnaire.

	ADLs+iADLs	SHARE questions used	Hours in 30 days
1	Dressing and undressing	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks 	20
2a	Caring/Cleaning for incontinent patients	<ul style="list-style-type: none"> Do you use - incontinence pads? Yes 	20
2b	Emptying and cleaning the toilet chair	<ul style="list-style-type: none"> not used 	
3a	Taking medications	<ul style="list-style-type: none"> Taking medications 	3
3b	Anus praeter care	<ul style="list-style-type: none"> not used 	
3c	Cannula or probe care	<ul style="list-style-type: none"> not used 	
3d	Catheter care	<ul style="list-style-type: none"> not used 	
3e	Enemas	<ul style="list-style-type: none"> not used 	
4	Mobility assistance in the narrower sense	<ul style="list-style-type: none"> Walking across a room OR Getting in or out of bed OR Getting up from a chair after sitting for long periods 	15
5	Daily Body Care	<ul style="list-style-type: none"> Bathing or showering 	25
6	Meal preparation	<ul style="list-style-type: none"> Preparing a hot meal 	30
7	Eating meals	<ul style="list-style-type: none"> Eating, such as cutting up your food 	30
8	Physiological needs	<ul style="list-style-type: none"> Using the toilet, including getting up or down 	30
a1	Procuring food and medicines	<ul style="list-style-type: none"> Shopping for groceries 	10
a2	Cleaning home and personal effects	<ul style="list-style-type: none"> Doing work around the house or garden 	10
a3	Care of underwear and bed linen	<ul style="list-style-type: none"> Doing personal laundry 	10

a4	Heating in the living space, including the provision of heating materials	<ul style="list-style-type: none"> Doing work around the house or garden 	10
a5	Mobility assistance in the broader sense	<ul style="list-style-type: none"> Using a map to figure out how to get around in a strange place; Leaving the house independently and accessing transportation services 	10
a6	Motivational talks	<ul style="list-style-type: none"> Depression scale EURO-D>3 OR Do you currently take drugs at least once a week: for anxiety or depression? Yes 	10
a7	Care for persons with a severe intellectual or severe psychological disability, in particular a dementia illness	<ul style="list-style-type: none"> [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? - Yes 	45

Note: Unless otherwise specified in the table, the SHARE respondents indicate whether they have any difficulty (yes/no) with the activities because of a physical, mental, emotional or memory problem, e.g. "Getting in or out of bed."

Source: Ordinance of the Federal Minister of Labour, Health and Social Affairs on the assessment of care needs under the Federal Nursing Allowance Act (Classification Ordinance to the Federal Nursing Allowance Act – EinstV) StF: BGBl. II No. 37/1999.
<https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10009142>

BELGIUM (Allocation pour l'aide aux personnes âgées = APA; zorgbudget voor ouderen met een zorgnood)

Setting: There are 6 ADLs+iADLs. Each is assessed on a scale 0-1-2-3, where 0 means 'no difficulties', while 3 points mean it is 'impossible for the assessed individual to perform the task without help from the others.' The final measure is an unweighted sum of the points.

Execution: As the intensity of help needed is not revealed in the SHARE data, we assigned 2 points for each of the 6 ADLs+iADLs. Nobody would be eligible if we assigned only 1 point, as the eligibility threshold is set at 7 points.

	ADLs+iADLs	SHARE questions used
1	Mobility	<ul style="list-style-type: none"> Walking across a room, OR Getting in or out of bed, OR Getting up from a chair after sitting for long periods
2	Shopping, preparing and eating a meal	<ul style="list-style-type: none"> Shopping for groceries, OR Preparing a hot meal, OR Eating, such as cutting up your food
3	Grooming a dressing yourself	<ul style="list-style-type: none"> Bathing or showering, OR Dressing, including putting on shoes and socks

4	Maintaining home and doing household activities	<ul style="list-style-type: none"> • Doing work around the house or garden, OR • Doing personal laundry, OR • Managing money, such as paying bills and keeping track of expenses
5	Independent living, assessing and avoiding danger	<ul style="list-style-type: none"> • Orientation in time (date, month, year and day of week) – levels 0-2 out of 4 (=good), OR • Taking medications, OR • Using the toilet, including getting up or down
6	Communicating, making and maintaining contacts with other people	<ul style="list-style-type: none"> • Making telephone calls, OR • Satisfaction with relationships – 0-3 out of 10 (=completely satisfied)

Note: Unless otherwise specified in the table, the SHARE respondents indicate whether they have any difficulty (yes/no) with the activities because of a physical, mental, emotional or memory problem, e.g. “Getting in or out of bed.”

Source: Vlaamse Sociale Bescherming. Je zorgzwaarte of zelfredzaamheid: hoe wordt mijn handicap of gezondheidsprobleem ingeschat? <https://www.vlaamsoesocialebescherming.be/je-zorgzwaarte-of-zelfredzaamheid-hoe-wordt-mijn-handicap-of-gezondheidsprobleem-ingeschat>. (2) Wallonie familles santé handicap AVIQ. APA – Frequently asked questions. <https://www.aviq.be/fr/faq-apa#2>

CZECHIA (Příspěvek na péči)

Setting: 10 ADLs+iADLs are assessed. Each is specified by multiple subtasks. If any of these subtasks cannot be performed independently, the whole group should be considered as not managed. The 10 ADLs+iADLs are equally weighted. No intensity of dependency is specified for the tasks. The final measure is the number of (groups of) ADLs+iADLs not managed independently.

	ADLs+iADLs (with subtasks)	SHARE questions used
1	Mobility (standing up, sitting down, standing, changing positions, walking around the apartment/in normal terrain at least 200 m, opening and closing doors, walking up and down stairs – one floor, getting on and off means of transport including barrier ones)	<ul style="list-style-type: none"> • Getting in or out of bed, OR • Stooping, kneeling, or crouching, OR • Getting up from a chair after sitting for long periods, OR • Walking across a room, OR • Walking 100 metres, OR • Climbing one flight of stairs without resting, OR • Leaving the house independently and accessing transportation services
2	Orientation (recognising and distinguishing by sight and hearing, having adequate mental competence, orienting oneself in time/place, orienting oneself in the natural social environment, orienting oneself in usual situations and reacting appropriately in them)	<ul style="list-style-type: none"> • Quality of seeing (seeing things at a distance, recognising a friend across the street) – fair/poor, OR • Quality of hearing – fair/poor, OR • Orientation in time (date, month, year and day of week) – levels 0-2 out of 4 (=good)

3	<p>Communication (expressing oneself in an intelligible spoken language, communicating in the range of common vocabulary corresponding to age and social status, understanding the content of received and transmitted messages, creating a handwritten short message, understanding commonly used basic visual symbols and sound signals, using common means of communication)</p>	<ul style="list-style-type: none"> • Making telephone calls, OR • How would you rate your writing skills – fair/poor, OR • How would you rate your reading skills – fair/poor, OR • Help with reading instructions, pamphlets, or other written material from your doctor or pharmacy needed – always, often, sometimes
4	<p>Eating (choosing a ready-made drink and food for consumption, pouring a drink, dividing the food into smaller pieces and serving it, eating and drinking, following a prescribed diet, consuming food in the usual daily regime, moving the drink and food to the place of consumption)</p>	<ul style="list-style-type: none"> • Eating, such as cutting up your food, OR • Picking up a small coin from a table
5	<p>Dressing and putting on shoes (choosing clothing and footwear appropriate to the circumstances, recognizing the back and front of clothes and layering them correctly, dressing/undressing and putting on/off shoes, handling clothes in connection with the daily routine)</p>	<ul style="list-style-type: none"> • Dressing, including putting on shoes and socks
6	<p>Body hygiene (using hygiene equipment, maintaining personal hygiene, washing and drying individual body parts, performing general hygiene, combing, performing oral hygiene, shaving)</p>	<ul style="list-style-type: none"> • Bathing or showering <ul style="list-style-type: none"> •
7	<p>Physiological needs (using the toilet on time, taking a suitable position, defecating, performing a cleansing, using hygiene aids)</p>	<ul style="list-style-type: none"> • Using the toilet, including getting up or down
8	<p>Health care (adhering to the prescribed treatment regimen, carrying out the prescribed measures, using the necessary drugs or aids, recognizing a health problem and, if necessary, seeking or calling for help)</p>	<ul style="list-style-type: none"> • Taking medications

9	Personal activities (establishing contacts and relationships with other persons, planning and organizing personal activities, establishing and following a daily schedule, performing activities of the usual age and environment)	<ul style="list-style-type: none"> • Hopes for the future – none mentioned, OR • Time spent yesterday on leisure time activities – 0 hours, OR • Leisure activities done in the past 12 months – none chosen, OR • Feeling isolated – often, OR • Satisfaction with relationships – 0-3 out of 10 (=completely satisfied)
10	Household management (managing money within the framework of personal/household income, manipulating objects of daily use, getting regular shopping, controlling common household appliances, cooking a simple hot meal, performing normal household chores, doing laundry, washing dishes, operating the heating, maintaining order)	<ul style="list-style-type: none"> • Managing money, such as paying bills and keeping track of expenses, OR • Shopping for groceries, OR • Preparing a hot meal, OR • Doing work around the house or garden, OR • Doing personal laundry

Note: Unless otherwise specified in the table, the SHARE respondents indicate whether they have any difficulty (yes/no) with the activities because of a physical, mental, emotional or memory problem, e.g. “Getting in or out of bed.”

Source: Decree No. 505/2006 Coll., as amended, on provisions of the Act on Social Services. <https://www.zakonyprolidi.cz/cs/2006-505#cast1>.

FRANCE (Allocation personnalisée d'autonomie = APA)

Setting: The Social Act specifies 10 discriminatory and 7 illustrative variables that are evaluated. The allocation to levels of care (GIRs), however, is “calculated by a complex algorithm” but is not specified in the Act. Nevertheless, the Act defines the characteristics of the applicant by words.

Execution: We took the description of individuals who fall into GIR 4 (the least impaired who are eligible for care allowance) and matched these characteristics with the SHARE questions.

Characteristics of the applicant in GIR 4 (which is the first level to be eligible for care allowance)	SHARE questions used
Applicant who needs help with transfers but who, once up, can move around within the accommodation, and who needs help with washing and dressing OR Applicant who does not have locomotor problems but who must be helped with personal care and meals	<ul style="list-style-type: none"> • Bathing or showering OR Dressing, including putting on shoes and socks AND • Getting in or out of bed OR Getting up from a chair after sitting for long periods OR Eating, such as cutting up your food OR Orientation in time (date, month, year and day of week) – levels 0-2 out of 4 (=good)

Note: Unless otherwise specified in the table, the SHARE respondents indicate whether they have any difficulty (yes/no) with the activities because of a physical, mental, emotional or memory problem, e.g. “Getting in or out of bed.”

Source: Social Act and Families Code (articles R232-1 and R232-6).

https://www.legifrance.gouv.fr/codes/section_lc/LEGITEXT000006074069/LEGISCTA000006190052/.

GERMANY (Pflegegeld)

Setting: 6 modules (=groups) of ADLs+iADLs are defined. Each containing several tasks. Each task needs to be evaluated. The intensity of help needed is measured on a different scale for each module. The number of points per module is not a simple sum but rather a range matching. This already takes into account the weight of each module. The final number of points is then a simple sum of these 6 resulting subsums per module.

Execution: The threshold for eligibility has been downscaled as the Module 5 could not have been matched with the SHARE data. The information on the therapeutic measures is not available in the SHARE data. We consider the individual eligible if at least 21.6 (=27*0.8) points are attained based on the answers in the SHARE questionnaire. As the intensity of help needed is not revealed in the SHARE data, we assigned always the lowest intensity on the module's scale when problems with the task were indicated.

	ADLs+iADLs with subtasks	SHARE questions used
1	Mobility	Weight: 10%; Scale: 0-1-2-3
1a	Changing position in bed	<ul style="list-style-type: none"> Getting in or out of bed
1b	Maintaining a stable sitting position	<ul style="list-style-type: none"> Getting up from a chair after sitting for long periods
1c	Transferring from one seat to another	<ul style="list-style-type: none"> Getting up from a chair after sitting for long periods
1d	Moving around the living area	<ul style="list-style-type: none"> Walking across a room
1e	Climbing stairs	<ul style="list-style-type: none"> Climbing one flight of stairs without resting
2	Cognitive and communicative skills	Weight: 15% together with group 3; Scale: 0-1-2-3
2a	Recognising people in the immediate environment	<ul style="list-style-type: none"> Quality of seeing (seeing things at a distance, recognising a friend across the street) – fair/poor, OR [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? - Yes
2b	Local orientation	<ul style="list-style-type: none"> Orientation in time (date, month, year and day of week) – levels 0-2 out of 4 (=good), OR Does [he/ she] ever get lost in a familiar environment? - Yes
2c	Temporal orientation	<ul style="list-style-type: none"> Orientation in time (date, month, year and day of week) – levels 0-2 out of 4 (=good)
2d	Remembering important events or observations	<ul style="list-style-type: none"> How would you rate your memory – fair/poor
2e	Controlling multi-step everyday actions	<ul style="list-style-type: none"> Preparing a hot meal, OR Shopping for groceries, OR Making telephone calls, OR

		<ul style="list-style-type: none"> • Taking medications, OR • Managing money, such as paying bills and keeping track of expenses, OR • Doing personal laundry, OR • [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? - Yes
2f	Making decisions in everyday life	<ul style="list-style-type: none"> • Preparing a hot meal, OR • Shopping for groceries, OR • Taking medications, OR • Managing money, such as paying bills and keeping track of expenses, OR • [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? - Yes
2g	Understanding facts and information	<ul style="list-style-type: none"> • Making telephone calls, OR • How would you rate your reading skills – fair/poor, OR • Help with reading instructions, pamphlets, or other written material from your doctor or pharmacy needed – always, often, sometimes, OR • [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? - Yes
2h	Recognising risks and dangers	<ul style="list-style-type: none"> • Can [he/she] be left alone for an hour or so? - No
2i	Communicating basic needs	<ul style="list-style-type: none"> • Thinking about the activities that you have problems with, does anyone ever help you with these activities? – Yes AND • Who answered questions in the Physical health section? – Respondent only
2j	Understanding requests	<ul style="list-style-type: none"> • Who answered questions in the Demography section? – Respondent and proxy OR Proxy only • Who answered questions in the Physical health section? – Respondent and proxy OR Proxy only • How would you rate [his/her] memory at the present time? - proxy question answered (not NA)
2k	Participating in a conversation	<ul style="list-style-type: none"> • How is your concentration? For example, can you concentrate on a television programme, film or radio programme? - Difficulty in concentrating on entertainment
3	Behavioural and psychological problems	Weight: 15% together with group 2; Scale: 0-1-3-5

3a	Motor-related behavioural abnormalities (restlessness, going back and forth, wandering away)	<ul style="list-style-type: none"> • Does [he/ she] ever wander off and not return by [himself/ herself]? – Yes, OR • Does [he/ she] ever get lost in a familiar environment? - Yes, OR • How is your concentration? For example, can you concentrate on a television programme, film or radio programme? - Difficulty in concentrating on entertainment AND Can you concentrate on something you read? - Difficulty in concentrating on reading • AND Walking across a room - Possible
3b	Nighttime restlessness	<ul style="list-style-type: none"> • Have you had trouble sleeping recently? – Yes, OR • Do you currently take drugs at least once a week for sleep problems - Yes
3c	Self-harming and auto-aggressive behaviour	<ul style="list-style-type: none"> • In the last month, have you felt that you would rather be dead? - Any mention of suicidal feelings or wishing to be dead, OR • Have you been irritable recently? – Yes, OR • [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? – Yes, OR • Can [he/ she] be left alone for an hour or so? - No
3d	Damaging objects	<ul style="list-style-type: none"> • Have you been irritable recently? – Yes, OR • [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? – Yes, OR • Can [he/ she] be left alone for an hour or so? - No
3e	Physically aggressive behaviour towards other people	<ul style="list-style-type: none"> • Have you been irritable recently? – Yes, OR • [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? – Yes, OR • Can [he/ she] be left alone for an hour or so? - No
3f	Verbal aggression	<ul style="list-style-type: none"> • Have you been irritable recently? – Yes, OR • [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? – Yes, OR
3g	Other care-relevant vocal abnormalities	<ul style="list-style-type: none"> • Have you been irritable recently? – Yes
3h	Resisting nursing and other supportive measures (not deliberate)	<ul style="list-style-type: none"> • Have you been irritable recently? – Yes, OR • Do you have a hearing aid? – Yes AND Are you usually wearing the hearing aid? - No

3i	Delusions	<ul style="list-style-type: none"> Does [he/ she] ever see or hear things that are not really there? – Yes
3j	Anxiety	<ul style="list-style-type: none"> In the last month, have you been sad or depressed? – Yes, OR Do you currently take drugs at least once a week for anxiety or depression? - Yes
3k	Lack of motivation in depressive moods	<ul style="list-style-type: none"> In the last month, have you been sad or depressed? – Yes, OR Do you currently take drugs at least once a week for anxiety or depression? – Yes, OR What have you enjoyed doing recently? - Failed to mention any enjoyable activity
3l	Socially inappropriate behaviour	<ul style="list-style-type: none"> [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? – Yes, OR Can [he/ she] be left alone for an hour or so? - No
3m	Other care-relevant inappropriate actions	<ul style="list-style-type: none"> Can [he/ she] be left alone for an hour or so? - No
4	Self-care	Weight: 40%; Scale: 0-1-2-3
4a	Washing the front of the upper body	<ul style="list-style-type: none"> Bathing or showering
4b	Personal care in the head area	<ul style="list-style-type: none"> Bathing or showering, OR Reaching or extending your arms above shoulder level
4c	Washing the intimate area	<ul style="list-style-type: none"> Bathing or showering
4d	Showering and bathing including washing the hair	<ul style="list-style-type: none"> Bathing or showering, OR Reaching or extending your arms above shoulder level
4e	Dressing and undressing the upper body	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks, OR Reaching or extending your arms above shoulder level
4f	Dressing and undressing the lower body	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks
4g	Preparing food in bite-sized pieces and pouring drinks	<ul style="list-style-type: none"> Eating, such as cutting up your food
4h	Eating	<ul style="list-style-type: none"> Eating, such as cutting up your food
4i	Drinking	<ul style="list-style-type: none"> Eating, such as cutting up your food
4j	Using a toilet or commode	<ul style="list-style-type: none"> Using the toilet, including getting up or down
4k	Coping with the consequences of urinary incontinence and dealing with indwelling catheters and urostomies	<ul style="list-style-type: none"> Do you use incontinence pads? - Yes
4l	Coping with the consequences of feecal incontinence and dealing with stomas	<ul style="list-style-type: none"> Do you use incontinence pads? – Yes
4m	Parenteral nutrition or via tube	<ul style="list-style-type: none"> Do you use special eating utensils? - Yes

5	Mastering and dealing independently with demands and burdens related to illness or therapy	Weight: 20%
5a	Medication	
5b	Injections	
5c	Provision of intravenous access (e.g. port)	
5d	Suction and oxygen administration	
5e	Rubbing or cold and heat applications	
5f	Measurement and interpretation of physical conditions	
5g	Body-related aids	
5h	Changing dressings and wound care	
5i	Stoma care	
5j	Regular single-use catheterization and use of laxative methods	
5k	Therapeutic measures in the home environment	
5l	Time- and technology-intensive measures in the home environment	
5m	Visitations to the doctor	
5n	Visits to other medical or therapeutic facilities (up to three hours)	
5o	Extended visits to other medical or therapeutic facilities (longer than three hours)	
5p	Adherence to a diet and other disease- or therapy-related behavioural rules	
6	Organizing everyday life and social contacts	Weight: 15%; Scale: 0-1-2-3
6a	Organising the daily routine and adapting to changes	<ul style="list-style-type: none"> • Orientation in time (date, month, year and day of week) – levels 0-2 out of 4 (=good)
6b	Resting and sleeping (maintain a day-night rhythm, ability to recognise the need for rest periods, deal with insomnia, physical functions - to get to bed)	<ul style="list-style-type: none"> • Getting in or out of bed, OR • Have you had trouble sleeping recently? – Yes, OR • Do you currently take drugs at least once a week for sleep problems? – Yes
6c	Keeping yourself busy	<ul style="list-style-type: none"> • Have you done any of these activities in the last twelve months? (Done voluntary or charity work, Attended an educational or training course, Gone to a sport, social or other kind of club, Taken part in a political or community-related organization, Read books, magazines or newspapers, Did word or number games such as crossword puzzles or

		Sudoku, Played cards or games such as chess) – None of these
6d	Making future-oriented plans	<ul style="list-style-type: none"> • What are your hopes for the future? – No mentioned
6e	Interacting with people inside your immediate environment	<ul style="list-style-type: none"> • How much of the time do you feel lonely? – Often, OR • How your hearing [using a hearing aid as usual] – poor, OR • Compared with two years ago, how is [he/she]; at recalling conversations a few days later? – Does not apply, OR • During the past twelve months, how often did you have contact with your children either in person, by phone, mail, email or any other electronic means? – Never (first seven children considered)
6f	Maintaining contact with people outside your immediate environment (including using the phone)	<ul style="list-style-type: none"> • Have you done any of these activities in the last twelve months? (Done voluntary or charity work, Attended an educational or training course, Gone to a sport, social or other kind of club, Taken part in a political or community-related organization, Read books, magazines or newspapers, Did word or number games such as crossword puzzles or Sudoku, Played cards or games such as chess) – None of these, OR • How much of the time do you feel isolated from others? – Often, OR • Making telephone calls

Note: Unless otherwise specified in the table, the SHARE respondents indicate whether they have any difficulty (yes/no) with the activities because of a physical, mental, emotional or memory problem, e.g. “Getting in or out of bed.”

Source: Bund, M. D. (2024). *Richtlinien des Medizinischen Dienstes Bund zur Feststellung der Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches.*

HUNGARY (in-kind benefits)

Setting: 14 ADLs+iADLs are defined. Each is assessed on a scale 0-1-2-3-4, where 0 means ‘no difficulties’, while 4 points mean that the individual ‘needs full help/is unable to perform the task alone.’ The final measure is an unweighted sum of the points.

Execution: We opted for a higher-bound estimated here and assigned the highest (=4) level of dependency within each task if the individual expressed some level of difficulties in the SHARE questionnaire.

	ADLs+iADLs	SHARE questions used
1	Orientation in time and space	<ul style="list-style-type: none"> • Orientation in time (date, month, year and day of week) – levels 0-2 out of 4 (=good)
2	Appropriate behaviour	<ul style="list-style-type: none"> • Have you been irritable recently? – Yes, OR

		<ul style="list-style-type: none"> • [Has a doctor ever told you that you had/ Do you currently have] Alzheimer's disease, dementia, organic brain syndrome, senility or any other serious memory impairment? - Yes
3	Eating	<ul style="list-style-type: none"> • Eating, such as cutting up your food
4	Dressing	<ul style="list-style-type: none"> • Dressing, including putting on shoes and socks
5	Personal hygiene	<ul style="list-style-type: none"> • Bathing or showering
6	Using the toilet	<ul style="list-style-type: none"> • Using the toilet, including getting up or down
7	Continence	<ul style="list-style-type: none"> • Do you use - incontinence pads? Yes AND • Dressing, including putting on shoes and socks
8	Communication	<ul style="list-style-type: none"> • How would you rate your reading skills – fair/poor, OR • How would you rate your memory – fair/poor
9	Following the prescribed treatment	<ul style="list-style-type: none"> • Taking medications
10	Change of position	<ul style="list-style-type: none"> • Getting in or out of bed
11	Movement	<ul style="list-style-type: none"> • Walking across a room
12	Self-sufficiency (ability to manage life)	<ul style="list-style-type: none"> • Thinking about the activities that you have problems with, does anyone ever help you with these activities? - Yes
13	Seeing	<ul style="list-style-type: none"> • Do you usually wear glasses or contact lenses? AND • How good is your eyesight for seeing things up close, like reading ordinary newspaper print – fair/poor
14	Hearing	<ul style="list-style-type: none"> • Do you have a hearing aid? – Yes

Note: Unless otherwise specified in the table, the SHARE respondents indicate whether they have any difficulty (yes/no) with the activities because of a physical, mental, emotional or memory problem, e.g. “Getting in or out of bed.”

Source: Decree on the detailed rules for examining and verifying the need for care and social need based on health status - 36/2007. (XII. 22.) SZMM rendelet, a gondozási szükséglet, valamint az egészségi állapoton alapuló szociális rászorultság vizsgálatának és igazolásának részletes szabályairól.
<https://net.jogtar.hu/jogszabaly?docid=a0700036.smm>.

LATVIA (Pabalsts cilvēkiem ar invaliditāti, kuriem nepieciešama īpaša kopšana)

Benefit awarded to those with very severe disabilities (disability group I).

Setting: 10 ADLs+iADLs are assessed. Each task is assigned a different scale of intensity of help needed to perform the tasks, either 0-1, or 0-1-2, or 0-1-2-3. The lower the assigned number, the more dependent the person is! The final number of points is an unweighted sum across the tasks.

Execution: As only those gaining less than 7 points are eligible for care, we assigned the highest dependency (=0 points) whenever the SHARE respondent indicated problems with performing the task independently.

	ADLs+iADLs	SHARE questions used
1	Eating	<ul style="list-style-type: none"> Eating, such as cutting up your food
2	Moving (from bed to chair and back)	<ul style="list-style-type: none"> Getting in or out of bed, OR Getting up from a chair after sitting for long periods
3	Mobility (walking or using a wheelchair)	<ul style="list-style-type: none"> Walking across a room
4	Using stairs	<ul style="list-style-type: none"> Climbing one flight of stairs without resting
5	Getting dressed	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks
6	Caring about appearance (e.g. shaving)	<ul style="list-style-type: none"> Bathing or showering
7	Washing	<ul style="list-style-type: none"> Bathing or showering
8	Controlling bowel movements	<ul style="list-style-type: none"> Do you use - incontinence pads? Yes
9	Controlling urination	<ul style="list-style-type: none"> Do you use - incontinence pads? Yes
10	Using the toilet	<ul style="list-style-type: none"> Using the toilet, including getting up or down

Note: Unless otherwise specified in the table, the SHARE respondents indicate whether they have any difficulty (yes/no) with the activities because of a physical, mental, emotional or memory problem, e.g. "Getting in or out of bed."

Source: Regulations of the Cabinet of Ministers No. 805. Rules for determining foreseeable disability, disability and loss of working capacity and issuing a document certifying disability. <https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu>.

SPAIN (Prestación económica vinculada al servicio = PEVS)

Setting: 10 groups of ADLs+iADLs are assessed. Each is specified by multiple subtasks. Each of these subtasks must be assessed. The 10 groups of ADLs+iADLs are not equally weighted. In addition, each subtask has its own weight within the group. The intensity of dependency is specified in four levels: supervision (=0.9), partial physical assistance (=0.9), maximum physical assistance (=0.95), and special assistance (=1).

Execution: Our analysis assumes the lowest levels of dependency (=0.9) whenever the SHARE respondent indicated problems with performing the task independently.

	Groups of ADLs+iADLs with subtasks	SHARE questions used	weight across/ within groups
1	Eating and drinking		16.8
1a	Recognising and/or reaching for the food served	<ul style="list-style-type: none"> Eating, such as cutting up your food 	0.25
1b	Cutting or breaking food into pieces	<ul style="list-style-type: none"> Eating, such as cutting up your food 	0.20
1c	Using cutlery to bring food to your mouth	<ul style="list-style-type: none"> Eating, such as cutting up your food 	0.30
1d	Bringing the drink container close to your mouth	<ul style="list-style-type: none"> Eating, such as cutting up your food 	0.25

2	Personal hygiene related to urination and defecation		14.8
2a	Going to a suitable place	<ul style="list-style-type: none"> Using the toilet, including getting up or down AND Walking across a room 	0.20
2b	Handling clothes	<ul style="list-style-type: none"> Using the toilet, including getting up or down 	0.15
2c	Adopting or abandoning the proper posture	<ul style="list-style-type: none"> Using the toilet, including getting up or down 	0.30
2d	Cleaning yourself	<ul style="list-style-type: none"> Using the toilet, including getting up or down 	0.35
3	Washing		8.8
3a	Opening and closing taps	<ul style="list-style-type: none"> Bathing or showering 	0.15
3b	Washing your hands	<ul style="list-style-type: none"> Bathing or showering 	0.20
3c	Accessing the bathtub, shower or similar	<ul style="list-style-type: none"> Bathing or showering 	0.15
3d	Washing the lower part of the body	<ul style="list-style-type: none"> Bathing or showering 	0.25
3e	Washing your upper body	<ul style="list-style-type: none"> Bathing or showering 	0.25
4	Performing other body care		2.9
4a	Combing hair	<ul style="list-style-type: none"> Bathing or showering AND Reaching or extending your arms above shoulder level 	0.30
4b	Cutting your nails	<ul style="list-style-type: none"> Bathing or showering AND Picking up a small coin from a table 	0.15
4c	Washing your hair	<ul style="list-style-type: none"> Bathing or showering AND Reaching or extending your arms above shoulder level 	0.25
4d	Brushing your teeth	<ul style="list-style-type: none"> Bathing or showering AND Picking up a small coin from a table 	0.30
5	Getting dressed		11.9
5a	Recognizing and reaching for clothing and footwear	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks 	0.15
5b	Putting on clothing and footwear	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks 	0.10
5c	Buttoning up buttons or similar	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks AND Picking up a small coin from a table 	0.15
5d	Putting on the clothes on the lower part of the body	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks 	0.30
5e	Putting on upper-body clothing	<ul style="list-style-type: none"> Dressing, including putting on shoes and socks 	0.30
6	Maintaining health		2.9
6a	Requesting therapeutic assistance	<ul style="list-style-type: none"> Taking medications 	0.15
6b	Applying the recommended therapeutic measures	<ul style="list-style-type: none"> Taking medications 	0.10

6c	Avoiding risky situations at home	<ul style="list-style-type: none"> • Can [he/she] be left alone for an hour or so? - No OR For the past six months at least, have you been bothered by - falling down? - Yes 	0.25
6d	Avoiding risky situations outside the home	<ul style="list-style-type: none"> • Leaving the house independently and accessing transportation services OR For the past six months at least, have you been bothered by - falling down? - Yes 	0.25
6e	Asking for help in an emergency	<ul style="list-style-type: none"> • Making telephone calls AND Do you use any of the items - personal alarm? - not selected 	0.25
7	Changing and maintaining body position		9.4
7a	Switching from lying down to sitting up in bed	<ul style="list-style-type: none"> • Getting in or out of bed 	0.10
7b	Staying seated	<ul style="list-style-type: none"> • Sitting for about two hours 	0.15
7c	Switching from sitting in a chair to standing	<ul style="list-style-type: none"> • Getting up from a chair after sitting for long periods 	0.10
7d	Standing up	<ul style="list-style-type: none"> • Getting up from a chair after sitting for long periods 	0.15
7e	Switching from standing to sitting in a chair	<ul style="list-style-type: none"> • Getting up from a chair after sitting for long periods 	0.10
7f	Transferring one's own body while sitting	<ul style="list-style-type: none"> • Sitting for about two hours 	0.10
7g	Transferring one's own body while lying down	<ul style="list-style-type: none"> • Getting in or out of bed 	0.10
7h	Changing the body's centre of gravity while lying down	<ul style="list-style-type: none"> • Getting in or out of bed 	0.20
8	Moving around the home		12.3
8a	Making movements to get dressed	<ul style="list-style-type: none"> • Walking across a room 	0.25
8b	Making trips to eat	<ul style="list-style-type: none"> • Walking across a room 	0.15
8c	Making trips to wash	<ul style="list-style-type: none"> • Walking across a room 	0.10
8d	Making trips unrelated to self-care	<ul style="list-style-type: none"> • Walking across a room 	0.25
8e	Making movements between rooms	<ul style="list-style-type: none"> • Walking across a room 	0.10
8f	Accessing all common home areas	<ul style="list-style-type: none"> • Walking across a room 	0.15
9	Moving outside the home		12.2
9a	Accessing the exterior	<ul style="list-style-type: none"> • Climbing one flight of stairs without resting 	0.25
9b	Making movements around the building	<ul style="list-style-type: none"> • Walking 100 metres 	0.25
9c	Making short journeys in familiar environments	<ul style="list-style-type: none"> • Walking across a room 	0.20

9d	Making short journeys in unknown environments	<ul style="list-style-type: none"> Walking across a room OR Using a map to figure out how to get around in a strange place 	0.15
9e	Making long journeys in familiar environments	<ul style="list-style-type: none"> Walking 100 metres 	0.10
9f	Making long journeys in unknown environments	<ul style="list-style-type: none"> Walking 100 metres OR Using a map to figure out how to get around in a strange place 	0.05
10	Doing housework		8.0
10a	Preparing meals	<ul style="list-style-type: none"> Preparing a hot meal 	0.45
10b	Going shopping	<ul style="list-style-type: none"> Shopping for groceries 	0.25
10c	Cleaning and caring for the home	<ul style="list-style-type: none"> Doing work around the house or garden 	0.20
10d	Washing and caring for clothes	<ul style="list-style-type: none"> Doing personal laundry 	0.10

Note: Unless otherwise specified in the table, the SHARE respondents indicate whether they have any difficulty (yes/no) with the activities because of a physical, mental, emotional or memory problem, e.g. “Getting in or out of bed.”

Source: Royal Decree 174/2011, of February 11, approving the scale for assessing dependency status established by Law 39/2006, of December 14, on the Promotion of Personal Autonomy and Care for People in Situations of Dependency. <https://www.boe.es/buscar/doc.php?id=BOE-A-2011-3174>.