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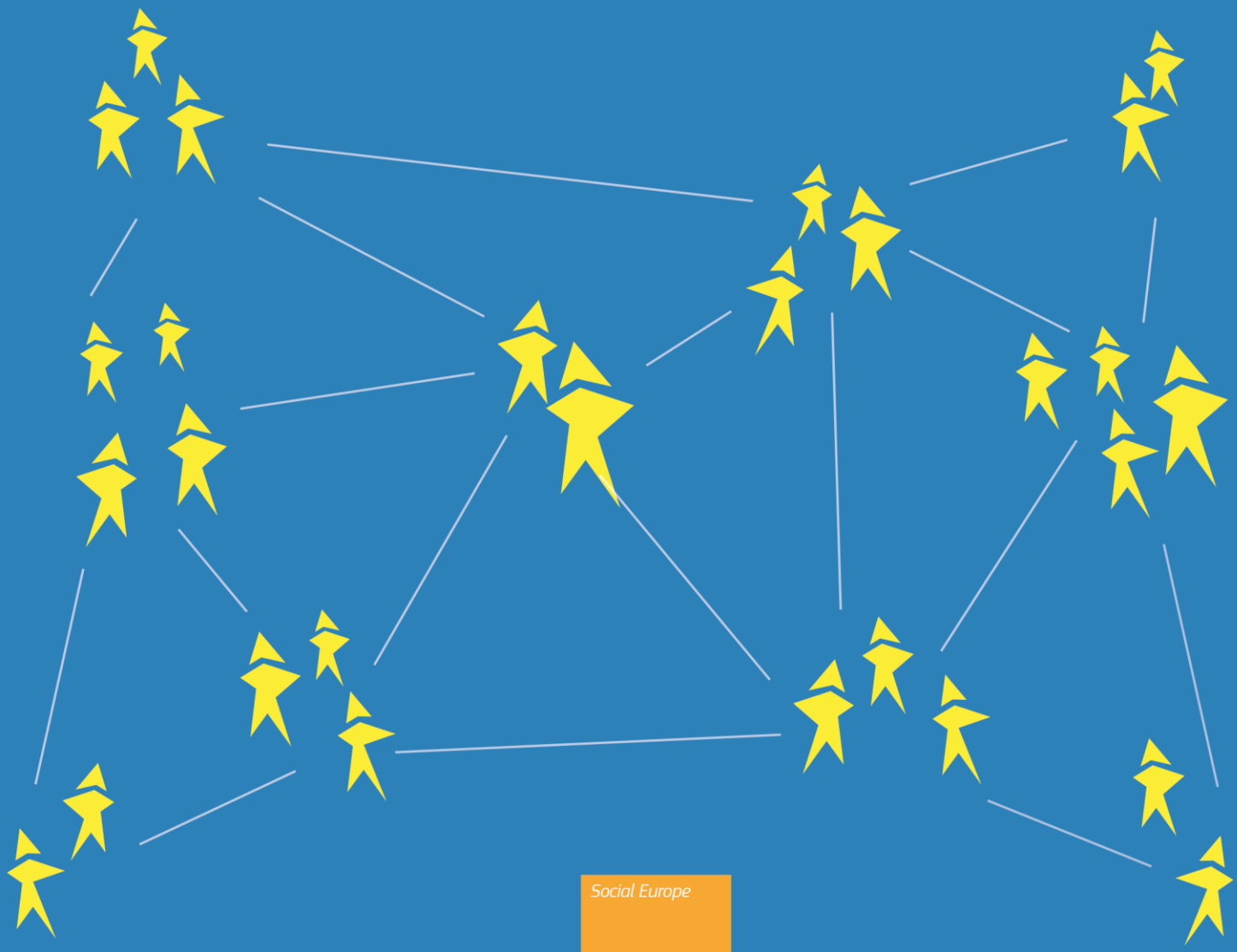
EUROPEAN SOCIAL POLICY NETWORK (ESPN)

Long-term care social protection models in the EU

Emmanuele Pavolini



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The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Contents

1 Introduction

Long-term care has become an increasingly salient topic in recent decades in EU Member States' policy and political agendas, for several reasons, ranging from population ageing to a lack of sufficient and/ or adequate services and the costs associated with adequate care. The COVID-19 pandemic has become a further proof of the necessity to reform and invest in long-term care systems.

At the same time, long-term care policies and structures are less developed in many countries than other social protection branches (e.g. pensions and healthcare). First, in some countries, it is not just the provision of formal long-term care which is underdeveloped, but also the concept of long-term care in itself is not well-established or used. Second, the boundaries between social care and healthcare, on the one hand, and long-term care, on the other, are often unclear and overlap. The result is that in many countries, firstly, social protection for long-term care needs is highly fragmented among different branches of social protection, which are not always integrated with one another, and secondly, public expenditure is too limited to cope with the multiple challenges in the area of long-term care.

The present report is organised in the following way. Section 2 provides an overview of the main studies produced over the last decades dealing with the classification of long-term care systems. Section 3 compares the Member States' long-term care systems in relation to four dimensions: overall organisation; the types of social protection provision for long-term care needs; the eligibility criteria for long-term care benefits; and how public long-term care is financed. Section 4 proposes an analytical framework and provides a typology of public long-term care models in the EU. Section 5 assesses the extent to which public long-term care models are able to respond to individuals' care needs, by using as a criterion their capacity to avert at least the risks of social exclusion and poverty. Finally, in the concluding section proposals are put forward on how to improve data collection in order to better assess how long-term care systems work in the EU.

Long-term care means a range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care[1]. In the present report, the focus is on social protection for long-term care needs for older people aged 65+.

2 A brief literature review: classifications of long-term care systems

In recent decades, several studies have proposed a classification of long-term care systems. As Ariaans et al. (2021) underline in the most recent publication on the topic, these studies fall into three major groups. The first focuses on care services and family policies in general (usually looking also at childcare), and long-term care is one of the observed policy fields (e.g. Alber, 1995; Anttonen and Sipilä, 1996; Kautto, 2002; Leitner, 2003; Bettio and Plantenga, 2004; Saraceno and Keck, 2010). The second group concentrates on specific aspects of long-term care systems – e.g. the role of migrant care workers and informal family care givers, or the role of specific schemes, such as care cash benefits or home care services (e.g. Burau et al., 2007; Simonazzi, 2008; Da Roit and Le Bihan, 2010; Di Rosa et al., 2011; Bettio and Verashchagina, 2012; van Hooren, 2012; Anderson, 2012; Da Roit and Weicht, 2013; Pfau-Effinger, 2014). The third and last group of studies focuses

[1] The daily living activities for which help is needed may be the self-care activities that a person must perform every day (Activities of Daily Living, such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling bladder and bowel functions) or may be related to independent living (Instrumental Activities of Daily Living, such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone).

on long-term care, including in some cases public provision in favour not just of older people but also of people with disabilities (e.g. Pavolini and Ranci, 2008; Pommer et al., 2009; Rothgang, 2009; Kraus et al., 2010; Colombo, 2012; Damiani et al., 2011; Ranci and Pavolini, 2015; Halásková et al., 2017; Ariaans et al., 2021).

Most studies on typologies incorporate the characteristics of public long-term care supply (e.g. financial resources, bed density in institutional long-term care, the percentage of people in ambulatory or residential care settings, the presence of cash benefit schemes), whereas fewer studies include information on access regulation (e.g. data on means-testing for benefits, entitlement to residential care, home care benefits, cash benefits).

Although the typologies in the above-mentioned studies are built on different methodologies and indicators, to a certain extent they yield partially similar findings, at least in relation to EU countries (Ariaans et al., 2021). First, they often identify a Nordic cluster, generally including Denmark, Finland, Norway, and Sweden, with some studies adding the Netherlands. Second, Central-Eastern European countries (including Baltic countries) tend to be clustered together, as are Southern European ones, with only Greece sometimes falling outside of this latter group. Conversely, Continental European countries are usually not clustered together, with France and Belgium, on one hand, and Germany, Austria and Luxembourg on the other hand, allocated to different long-term care models, mostly as a consequence of the different sources of funding and organisation adopted in these countries (for instance, since 1995 Germany has introduced specific long-term care social insurance, whereas France has not).

In general, these studies offer interesting insights, but they tend to suffer from one or two general shortcomings. First, most of them focus on only a limited number of EU countries (with Damiani et al., 2011 being the main exception). Second, they tend to be characterised by a lack of data on several dimensions of long-term care regulation. Therefore, their assessment of long-term care typologies is based on fragmented and limited information.

When compared to previous studies, the present report provides a broader and more complete picture on public long-term care provision and models in EU Member States, thanks to the sources on which it is based. In particular, the mapping has been built on: the country profiles of volume II of the 2021 long-term care report (European Commission, Social Protection Committee, 2021); the 2021 Ageing report and related country fiches (European Commission, Economic Policy Committee 2021); the 2018 ESPN synthesis report on long-term care (Spasova et al., 2018), and the accompanying country reports; the 2019 ESPN synthesis report on financing social protection (Spasova and Ward, 2019) and country fiches; the MISSOC database; the Eurostat online database. On specific issues, ESPN country experts have also been contacted for elucidations.

3 Comparative analysis based on four dimensions

Information and data have been collected and analysed taking into account four comparative dimensions: overall organisation of public long-term care systems; types of social protection provision; eligibility criteria; and financing.

Before describing the facets of these dimensions, it is important to underline that each EU state has to face a “long-term care” trilemma.

The first corner of the trilemma is how to ensure coverage of needs with formal long-term care services. Currently, many countries are not able to reach all their potential beneficiaries. Furthermore, coverage in long-term care has been mainly measured in terms of number of individuals who receive benefits, but not in terms of intensity (e.g. hours of care provided to beneficiaries). This latter dimension is particularly important at a time when most countries in the EU are increasingly willing to implement an “ageing in place” strategy, based on helping persons in

need at their homes rather than in residential care facilities.

The second corner of the trilemma deals with the extent to which long-term care systems should rely on and support informal family carers, mostly women, while avoiding placing on their shoulders the burden of daily care. The scientific literature cited above shows clearly that over-reliance on informal carers is not a farsighted strategy. Often informal family carers are individuals either still in the labour market or in their 70s and 80s and looking after frail partners. Inadequate support for informal carers fosters, on one hand, their early exit from the labour market or reduction of work hours, on the other hand, "burn-out" of these individuals, with potential consequences on their health and well-being. The fact that the majority of informal carers are women increases the risk of social inequalities based on gender, now and in later life.

The third corner of the trilemma is rising public expenditure at times when public budgets are already under pressure and cannot easily be expanded: long-term care expenditure is expected to increase substantially, albeit from a very low level, in many Member States in the next decades, due to several factors, population ageing being one of the most prominent (European Commission and Social Protection Committee, 2021; European Commission and Economic Policy Committee, 2021).

3.1 Overall organisation

The overall organisation of public long-term care provision has been analysed from two different perspectives. First, countries are classified as to whether they possess a dedicated public social protection branch for long-term care, which can be labelled an "integrated" system, or otherwise, which can be labelled a "split" system. Second, public long-term care provision is studied in terms of the level(s) at which social protection is organised (e.g. at regional level, national level, etc.).

Only 10 countries out of 27 have an integrated public long-term care system (AT, BE, DE, DK, ES, FI, FR, LU, NL, SE). However, out of these 10 countries, at least two feature either not totally integrated systems (AT) or a separation of responsibilities among sub-national levels (BE).

The remaining 17 have a public system, which is usually split, on one hand, between healthcare and social care/social assistance, and, on the other hand, between institutions in charge of providing cash benefits and institutions responsible for in-kind services.

In 12 countries, long-term care public provision is organised mostly at just one territorial level (AT, BE, CY, DE, DK, FI, FR, IE, LU, MT, NL, SE). This main territorial level in the Nordic countries is the municipal level (DK, FI, and SE), where municipalities are in charge of ensuring an integrated healthcare and social care long-term care system. The main territorial level in most Continental European countries (AT, DE, LU, NL) is the national level, where a specific branch of social protection for long-term care plays a pivotal role in the organisation of care. In this latter case, an important complementary role is played by local and regional authorities running services. Belgium, a federal state, is a specific case, given that long-term care organisation has been mostly devolved to the Regions (federated entities). Demographically small countries such as Malta and Cyprus organise their long-term care provision mainly at the state level.

In the remaining 15 countries (BG, CZ, EE, EL, ES, HR, IT, LV, LT, HU, PL, PT, RO, SI, SK), long-term care organisation responsibilities are allocated to different layers of government depending on the type of provision (healthcare services, social care services, and cash allowances).

3.2 Types of social protection provision for long-term care needs

In EU countries, long-term care social protection takes three forms: services, cash benefits for individuals with long-term care needs, and cash benefits for carers. In practice, all countries offer long-term care services. Provision includes residential care, semi-residential (day) care, different

types of home care (social and nursing home care), and other in-kind products (e.g. house adaptations, adult nappies, lifts to move the dependent). Member States do not differ as to the presence of these types of services. Differences stem rather from the level of service coverage. In particular, as Figure 1 shows, 12 countries offer home and residential care to less than 10% of their 65+ population (AT, BG, CZ, DE, EL, ES, HR, HU, IT, LV, PL, PT), whereas all others have higher coverage rates. There are also differences among countries in terms of proportions of home care and residential care. Residential care is still quite important in several countries (at least 5% of 65+ live in this type of facilities in 7 of them - BE, EE, LT, LU, NL, SI, SK) and coverage of home care still quite weak in many Member States (less than 5% of 65+ receive formal support at home in 11 Member States - AT, BG, CZ, DE, ES, HR, HU, IT, LV, PL, PT).

With reference to cash benefit schemes for individuals with long-term care needs, only 8 countries do not practically provide this type of support (DK, EE, EL, HU, IE, MT, RO). The remaining Member States have set up cash benefit schemes. Cash benefits are granted based on an assessment of long-term care needs and are funded from different sources (public long-term care system or via healthcare and social care/social assistance), depending on the overall organisation.

An important distinction among these schemes is between “bound” cash benefits (beneficiaries have to document how the resources that they received are spent) or “unbound” benefits (beneficiaries are free to use the resources as they prefer without any form of accountability). Most countries with cash benefits (12 out of 19) use “unbound” cash benefits (AT, BE, BG, CY, CZ, DE, FI, HR, IT, PL, PT, SI). Only 7 (ES, FR, LT, LU, LV, NL, SK) use “bound” ones. Opting for “bound” or “unbound” cash benefits has important consequences. Schemes based on “bound” cash benefits usually ensure coordination between the beneficiary and the long-term care public system (in terms of social workers and health professionals’ supervision, and in terms of integration with the provision of long-term care services). Schemes based on “unbound” cash benefits leave more freedom of choice to beneficiaries, allow for more flexibility in the way public resources are spent in comparison to “bound” schemes, but they do not often foster coordination.

While cash benefit schemes for individuals with long-term care needs are common in 19 countries, they cover at least 10% of older people in fewer than half of them (AT, CZ, DE, FI, IT, LT, PL, SE). In several Member States there is a correlation between the limited coverage through public services and the relatively high coverage through cash benefits (AT, CZ, DE, IT, PL), implying that these cash benefits essentially provide support to informal care and, to some extent, to provision by privately paid formal carers.

Table 1 provides information on the coverage and level of such cash benefit schemes in Member States. The level is measured as the percentage of the median monthly income of older people in each country. In most Member States (BG, CY, IT, LV being the main exceptions) the amount of cash benefits is not fixed, but depends on the level of care support required by the beneficiary. Therefore, the level can vary significantly depending on the assessment of the beneficiary’s needs (for example, as in the Austrian and German cases). In many Member States that offer cash benefits, the level of these benefits is relatively limited (being equal to maximum 36% of the median monthly income of older people): in BE, BG, CY, CZ, ES, FI, IT, LU, PL, PT, SE.

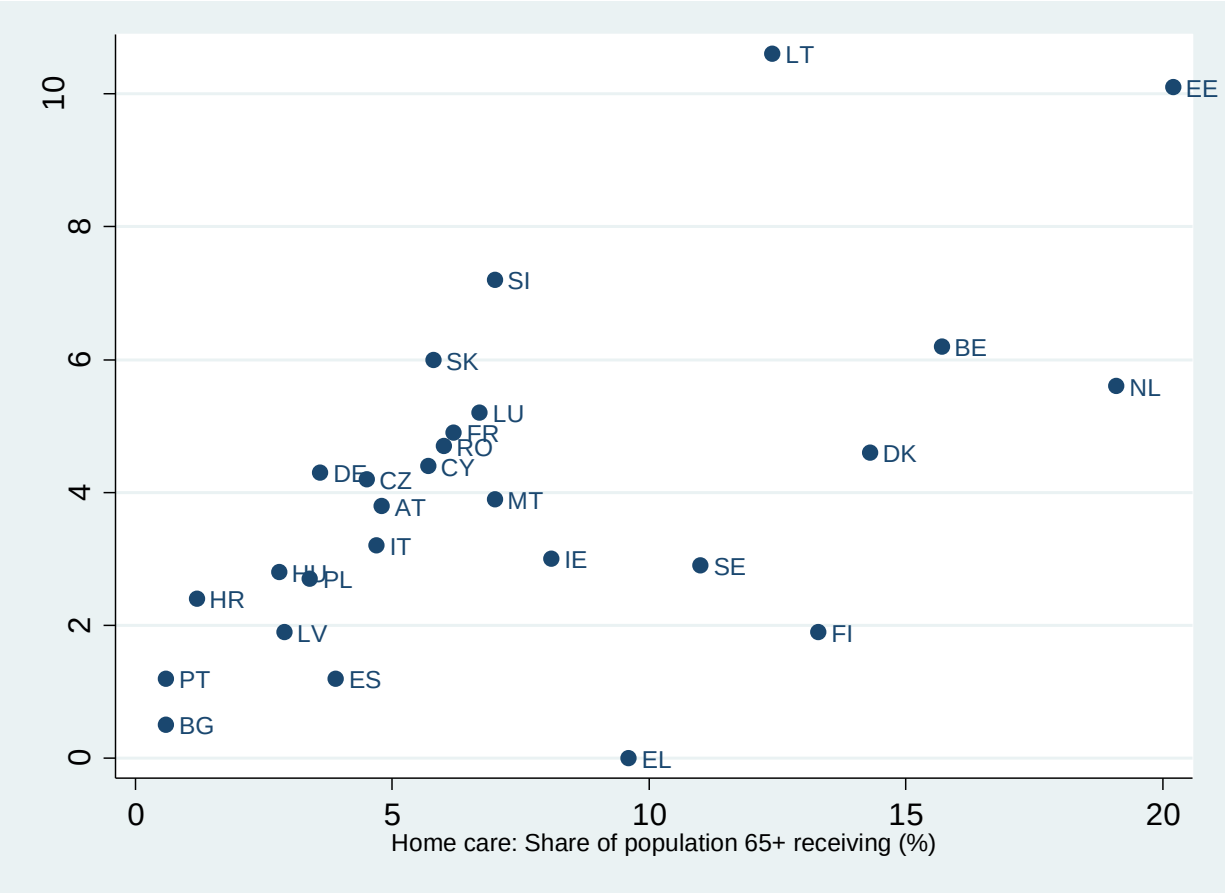
Table 1: The characteristics of cash benefit schemes in the EU: coverage rate and level (2019)

Country	Share of population 65+ receiving LTC cash benefits (%)	Level of cash benefits (as a percentage of the median monthly income of older people in the country)
Austria	21.6	8%-81%
Belgium	7.8	5%-36%
Bulgaria	3.1	20%
Croatia	7.5	14%-42%
Cyprus	9.4	36%
Czech Republic	12.0	5%-13%
Finland	13.9	4%-19%
Germany	11.3	40%-117%
Italy	10.9	36%
Latvia	1.3	51%
Lithuania	15.6	N.A.
Luxembourg	0.9	1%-30%
Netherlands	1.2	N.A.
Poland	37.2	20-25%
Portugal	0.3	14%-24%
Slovakia	8.7	80%-106%
Slovenia	7.1	8%-43%
Spain	4.3	12%-31%
Sweden	11.0	26%[a]

a): it can vary among municipalities
Source: ESPN elaboration on MISSOC data; European Commission, Economic Policy Committee (2021)

The large majority of EU countries (24 out of 27, apart from EL, NL, and RO) also offer cash benefits for carers, either through specific ad hoc programmes (DK, EE, HU, IE, MT), or by allowing informal carers to receive the cash benefit allocated to individuals with long-term care needs. In some countries where this type of provision is in place, beneficiaries and carers have the right to decide if cash benefits for the former can be received by the latter.

Figure 1: Public LTC systems in the European Union according to coverage ensured through home care and residential care, 2019



Source: European Commission, Economic Policy Committee (2021)

3.3 Eligibility criteria

In relation to the criteria for eligibility to long-term care social protection, EU countries differ as to whether they adopt a universalist approach (characterised by high social protection coverage for all residents, and universal publicly provided services and benefits) or a selectivist one (characterised by targeting or customising services and policies for particular groups). The mapping of EU Member States shows that there are also other approaches beyond the pure selectivist or universalist perspectives. In particular, the report has mapped four models that can be placed on a continuum, from selectivity at one end to universalism at the other:

- A "selectivist" model is present in ten Central-Eastern European and Southern European countries (BG, CY, EE, EL, HR, HU, PL, PT, RO, SI); in these countries, access to long-term care public provision, either cash benefits or in-kind services, is dependent not only on an assessment of care needs, but also on financial means testing (usually based on income, and in some cases property, often including close relatives' economic resources).
- A "mixed" model is adopted in six countries (BE, CZ, IE, IT, LT, SK), where, depending on the type of long-term care provision (cash benefits versus services), either selectivity in services or universalism in cash benefits is applied.
- A "quasi-universalist" model is present in three countries (ES, LV, MT), where access to provision is formally linked only to a care needs assessment and not to financial means testing, but where, at the same time, long-term care coverage rates are relatively low and

de facto the system is partially selectivist.

- A "universalist" model is adopted in eight (AT, DE, DK, FI, FR, LU, NL, SE), mostly Continental and Nordic European countries; needs assessment is the core principle in these Member States regarding long-term care provision (either through services or cash benefits).

Most countries use needs assessment criteria enabling them to differentiate among levels of long-term care needs. The number and the definition of care levels vary widely between countries.

In general, health professionals (GPs, gerontologists, or nurses) and social workers are responsible for the assessment, depending also on the type of provision offered (healthcare professionals for healthcare services and, often, cash benefits; social workers for social care in-kind services). Regulation of needs assessment is more or less centralised depending on: the presence or absence of an integrated long-term care system; the prevailing territorial level for organising long-term care public provision (see Section 3.1 above). In Nordic countries, for example, criteria and assessment are highly devolved to municipalities and their long-term care professional teams.

3.4 Financing

Member States finance public healthcare long-term care and social care long-term care mainly through three channels:

- Twelve countries use essentially taxation (AT, BG, CY, DK, ES, FI, HR, IE, IT, LV, RO, SE).
- Five countries use predominantly compulsory social contributions (BE in the Flemish Federated entity, DE, EL, LU, NL).
- Ten countries mix taxation (usually funding social care) and compulsory social contributions (usually funding healthcare) (CZ, EE, FR, HU, LT, MT, PL, PT, SK, SI).

Overall, compulsory social contributions are the core funding pillar in just a few countries, where insurance-based long-term care schemes have been set up, as the German case shows.

Countries adopting a mix of contributions and taxes do not usually have "integrated" long-term care systems; in these countries, healthcare and social care are funded by different institutions, and taxation finances the social care part of long-term care.

Practically all EU countries apply cost-sharing and long-term care fees. The very few countries that do not rely on fees, have high means testing thresholds that limit the beneficiaries' access to the public long-term care system. Usually fees apply to residential care, in order to cover accommodation costs more than care treatments. At the same time, all countries have introduced safeguards for those beneficiaries with limited economic resources: their fee is usually covered partially or in total by local authorities.

While it is difficult to summarise the regulations on users' fees and co-payments, given their complexity, there are two important indicators that proxy the role of households in funding public long-term care: the share of household out-of-pocket payment as a percentage of GDP; out-of-pocket long-term care payment as a share of public spending on long-term care. The former indicator provides information on how much households spend, whereas the second sets this information in relation to public effort in covering long-term care needs.

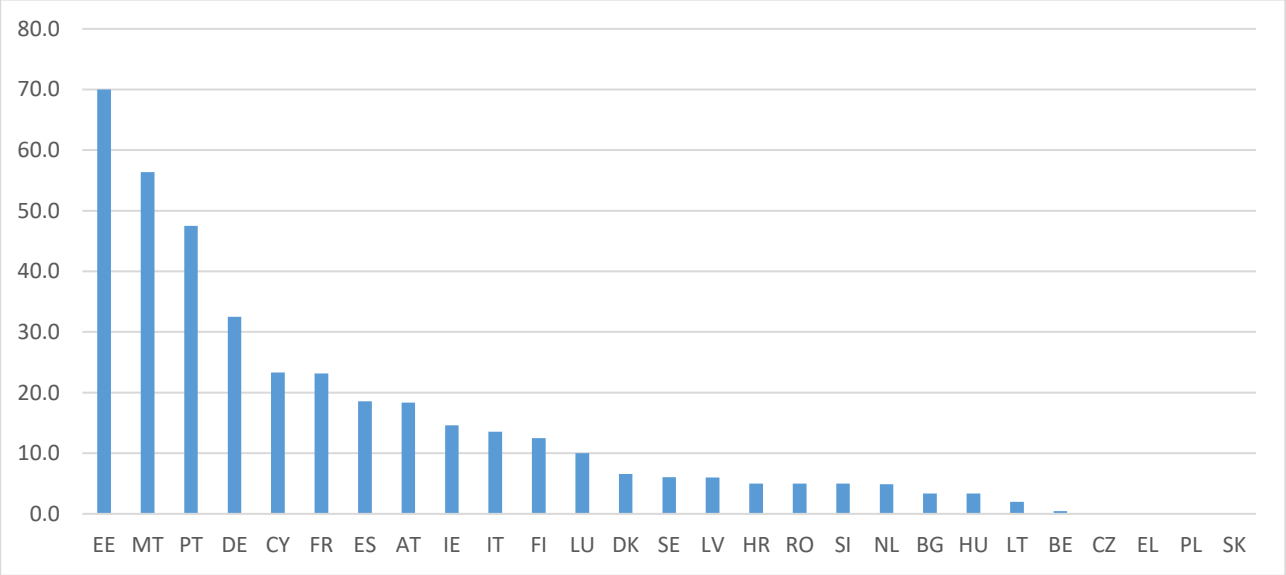
Unfortunately, the existing data have a major flaw: for most EU countries information is available on health long-term care out-of-pocket expenditure, but not on the social component of such expenditure.

The unweighted average out-of-pocket health long-term care expenditure in the EU is equal to 0.1% of GDP. However, there are six EU countries where this value is equal to at least 0.3% of GDP

(AT, DE, ET, FI, FR, MT).

The indicator on the role of household out-of-pocket long-term care payments as a share of public spending on long-term care offers further insights (Figure 2). There are eight countries where out-of-pocket health long-term care expenditure is practically insignificant (BE, BG, CZ, EL, HU, LT, PL, SK). However, most of the countries with very low out-of-pocket health long-term care expenditure are also those providing only very limited long-term care services. In another eight countries, this share is between 5 and 10% (DK, HR, LU, LV, NL, RO, SE, SI). In Ireland, Finland, Spain, Italy, and Austria, out-of-pocket payments account for 11-19% of total public spending. In the remaining six countries (CY, DE, FR, EE, MT, PT), this value is higher, especially in the three latter countries, where it accounts for at least 48% of the value of public expenditure[2].

Figure 2: Household out-of-pocket LTC payments (Health) as a share of public spending on LTC (2019)



Note: data for Malta refer to 2018
Source: Eurostat database (indicator: HLTH_SHA11_HCHF).

[2] Greece is not included in the analysis due to missing data.

4 How EU public long-term care systems cluster

4.1 The analytical and methodological approach

Most of the research on typologies presented in section 2 follows either a qualitative approach to mapping long-term care systems – based on a few variables that are considered pivotal (e.g. criteria for access) – or a quantitative approach – where several different dimensions and indicators are simultaneously introduced into the analysis (e.g. Damiani et al., 2011; Ariaans et al., 2021). The solution adopted in the present report is a mix between the two. Analysis and clustering are initially based on two dimensions, which can be considered as those defining the core functioning of long-term care systems; subsequently we consider if other indicators fit in with the resulting typology.

Therefore, adopting a stepwise approach, we start the clustering from two dimensions, and then add many other factors linked to institutional settings, provision of care, eligibility, and financing to the analysis. The two starting dimensions are:

- Public spending on long-term care as a share of GDP (%).
- Public spending on long-term care cash benefits as a share of total long-term care public spending (%).

These two dimensions provide major insights into the main decisions that countries make around long-term care: how much states should invest in public long-term care provision; should states prioritise services or social transfers as the main channel of intervention, knowing that in many countries social transfers do not necessarily need to be spent on formal services (Ranci and Pavolini, 2013). The simultaneous answer to both these questions reveals the core vision of long-term care public provision in a given country. In relation to these two decisions, Saraceno and Keck (2010) propose three different models of long-term care intervention:

a) *Familism by default* refers to a policy context in which the state does not offer publicly provided arrangements to take over or support family care, assuming the family will care for those who need help; familism by default is typical of long-term care with low expenditure levels; given the unbalanced division of care work by gender in most European countries, this model assumes implicitly that women have to bear the care burden.

b) *Supported familism* occurs when public policies aim at supporting family carers. The basic assumption is that the family, and not the state, is the main provider of care. However, supported familism policies often end up relying on female carers, and this clashes with policies aimed at encouraging greater female labour market participation and gender equality. Supported familism takes the form of relatively generous long-term care public expenditure through cash transfers, which, on the one hand, acknowledge the role that the family plays in care provision, and on the other hand, can be (partially) used to directly buy part of the provision on the care market;

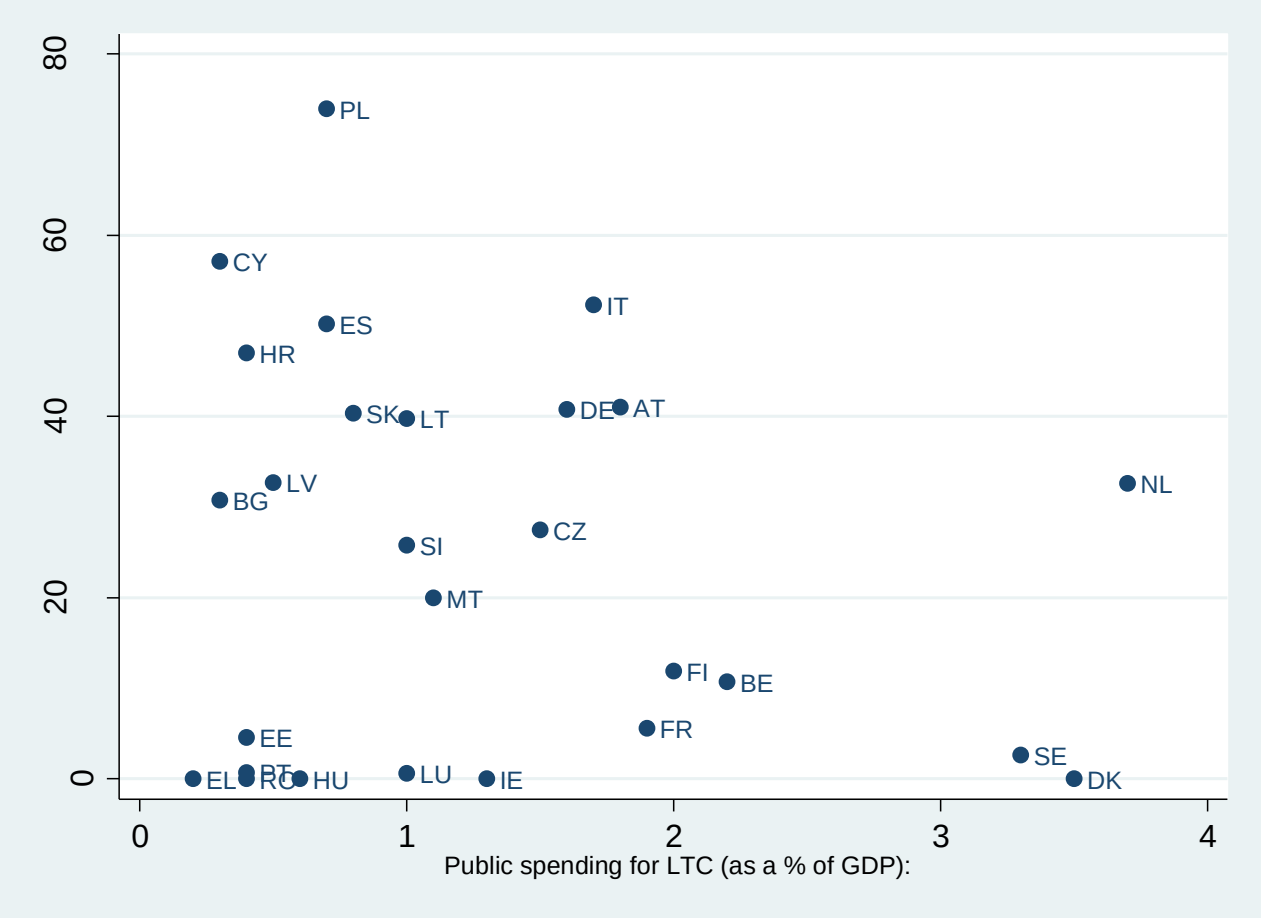
c) *Defamilisation* reflects the belief that the state should be the primary actor in charge of care provision, so that care users can autonomously decide how to meet their care needs without being excessively dependent on family members. Defamilisation requires at least a medium, if not high, level of long-term care public expenditure through services (home care and residential care). In this latter model, the state supports families (through services) and recognises their important role, but it does not consider them as the necessary main providers of care.

As the empirical analysis below shows, these three models can be analysed empirically in a more nuanced and detailed way. By doing so, a larger set of public long-term care systems emerge in the EU.

4.2 The results

Figure 3 shows how EU Member States fare on the two main core dimensions of the analysis. Significantly, these two indicators correlate to each other only to a very limited extent: the Pearson correlation coefficient between public spending on long-term care and public spending on cash benefits as a share of total long-term care spending is very low and negative (-.171). Therefore, they are based on two almost totally separate policy decisions.

Figure 3: Public LTC systems in the European Union according to their total level of expenditure on LTC and on the role played by LTC cash transfers (2019)



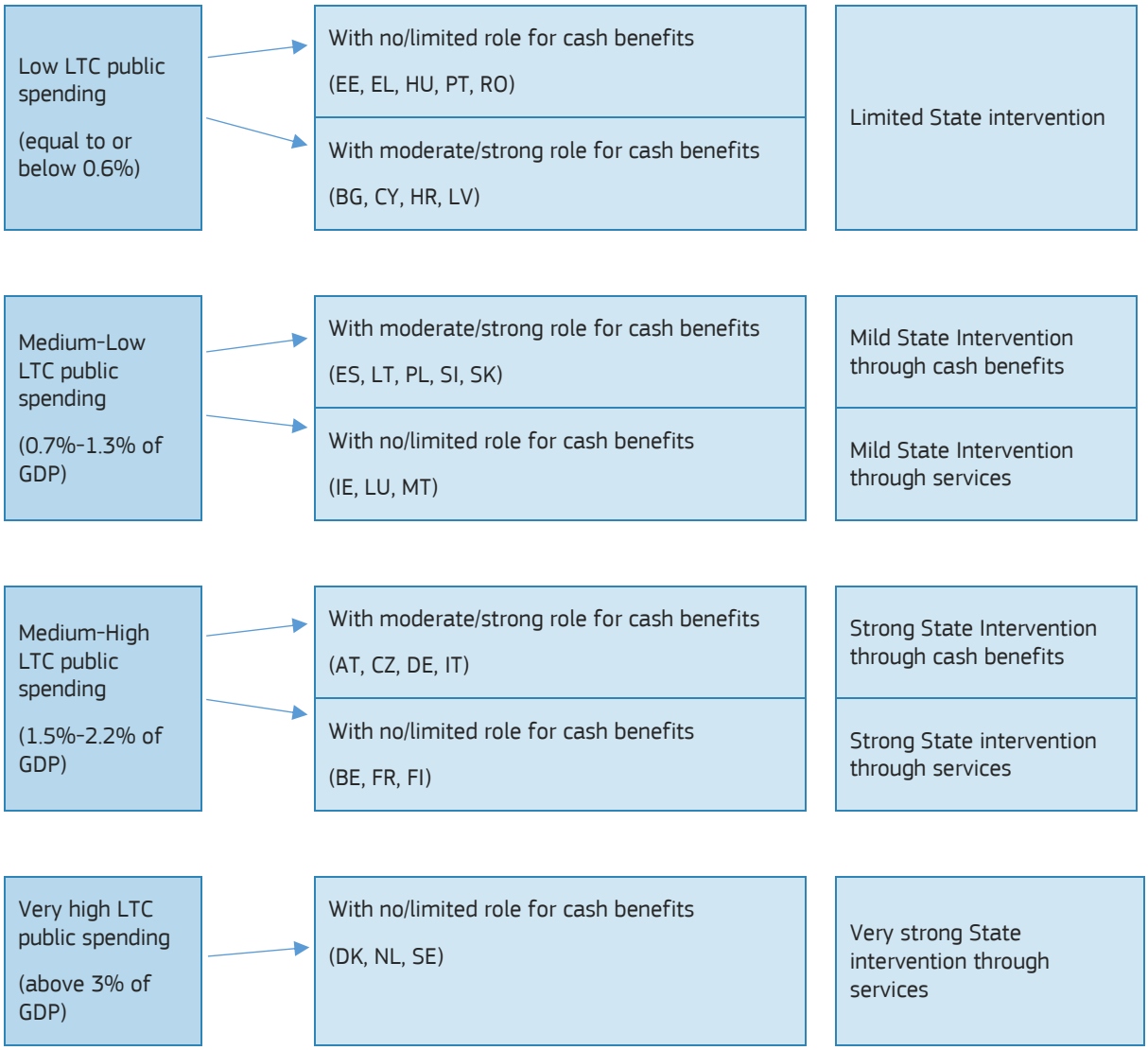
Source: European Commission, Economic Policy Committee

A cluster analysis conducted on these two dimensions yields six different models (see Box 1 and Table 2).

1. *A limited State intervention model*: one third of all EU Member States falls under this category, which is characterised by a very low level of public expenditure on long-term care (on average 0.4% of GDP). There are differences among the countries belonging to the cluster in terms of role of cash benefits, but the level of public intervention is so low that this latter facet appears to be the most important one; the countries belonging to the cluster are exclusively either Southern European (CY, EL, PT) or Central-Eastern European countries (BG, EE, HR, HU, LV, RO).

2. A *mild State intervention through cash benefits model*: almost one fifth of EU Member States belong to this second model, where GDP public expenditure on long-term care is higher than in the previous one (on average 0.8%), and almost half of this expenditure is channelled through cash benefits (46.0%); Spain and four Central-Eastern European countries (LT, PL, SI, SK) belong to this cluster.
3. A *mild State intervention through services model*: around one Member State out of ten belongs to this cluster, where countries invest more resources in long-term care than the previous models but still below the EU-27 average level; at the same time, funding goes essentially to home care and residential care services; while a geographical (Southern and Central-Eastern European) pattern was visible in the previous clusters, in this case countries are more heterogeneously distributed (IE, LU, MT).
4. A *strong State intervention through cash benefits model*: Austria, Germany, Italy and the Czech Republic share a model where financial support for long-term care needs is relatively consistent (1.7% of GDP), and often takes the form of cash transfers.
5. A *strong State intervention through services model*: Belgium, France, and Finland spend a relatively high share of their GDP on long-term care policies (2.0%), using mostly services as a tool of provision.
6. A *very strong State intervention through services model*: two Nordic countries (DK and SE), together with the Netherlands, are part of this last group investing a very high share of public resources in coverage of long-term care needs (3.5% of their GDP), and mostly counting on in-kind provision in order to support individuals and households.

Box 1: A typology of LTC models based on LTC public expenditure and on LTC cash benefit expenditure (2019)



Source: ESPN elaboration on European Commission, Economic Policy Committee data

While the first four models taken together account for approximately 78% of the Member States, the remaining countries (slightly over one fifth of all Member States) adopt a defamilisation model, which comes in two different versions, depending on the level of resources provided.

Table 2: The characteristics of the cluster typology of public LTC models (average values for each cluster) (2019)

	Share of GDP on public LTC expenditure (%)	Share of public LTC expenditure on cash benefits (%)	Share of EU Member States (%)
Limited State intervention	0.4	19.2	33.3
Mild State intervention through cash benefits	0.8	46.0	18.5
Mild State intervention through services	1.1	6.9	11.1
Strong State intervention through cash benefits	1.7	40.4	14.8
Strong State intervention through services	2.0	9.4	11.1
Very strong State intervention through services	3.5	11.7	11.1

Limited State intervention: 9 MS (BG, CY, EE, EL, HR, HU, LV, PT, RO)
Mild State intervention through cash benefits: 5 MS (ES, LT, PL, SI, SK)
Mild State intervention through services: 3 MS (IE, LU, MT)
Strong State intervention through cash benefits: 4 MS (AT, CZ, DE, IT)
Strong State intervention through services: 3 MS (BE, FR, FI)
Very strong State intervention through services: 3 MS (DK, NL, SE)
Source: ESPN elaboration on European Commission, Economic Policy Committee data

Building the typology on two variables makes it is possible to verify if the information on long-term care systems collected and described in the previous section fits in.

4.2.1 Overall public long-term care organisation

As Table 3 clearly shows, there is a strong association between overall long-term care organisation and the six models. A dedicated social protection branch for long-term care is present in all countries adopting a strong or a very strong model based on State intervention through services, and partially in those featuring the strong State intervention through cash benefits model, whereas it is less common in the other clusters, and totally absent in States with limited intervention.

The presence of a prevalent territorial/institutional level at which long-term care provision is organised follows partially similar lines but is also influenced by other characteristics of the Member States. A prevalent level is present in all countries with a very strong intervention through services model, it is often found in in countries with strong intervention through services, whereas it is very rarely typical in the other models.

Table 3: The characteristics of the cluster typology of public LTC models: the overall organisation of provision (average values for each cluster) (2019)

	Countries with a dedicated social protection branch for LTC*	Countries with a prevalent territorial/institutional level for organising LTC*
Limited State intervention	0.0%	11.1%
Mild State intervention through cash benefits	20.0%	0.0%
Mild State intervention through services	33.3%	66.7%
Strong State intervention through cash benefits	50.0%	50.0%
Strong State intervention through services	100.0%	66.7%
Very strong State intervention through services	100.0%	100.0%

** As the share of countries belonging to the same model (%).*
Limited State intervention: 9 MS (BG, CY, EE, EL, HR, HU, LV, PT, RO)
Mild State intervention through cash benefits: 5 MS (ES, LT, PL, SI, SK)
Mild State intervention through services: 3 MS (IE, LU, MT)
Strong State intervention through cash benefits: 4 MS (AT, CZ, DE, IT)
Strong State intervention through services: 3 MS (BE, FR, FI)
Very strong State intervention through services: 3 MS (DK, NL, SE)
Sources: ESPN elaboration on Spasova et al. (2018); Spasova and Ward (2019); MISSOC database.

4.2.2 Types of social protection provision for long-term care needs

Table 4 shows how the six models perform in terms of provision of different in-kind services (residential care and home care), cash benefits directly issued to the beneficiaries or to their informal carers, when present. The six-model typology holds relatively well, and further specifications can be added to the characteristics of these six models.

The *limited State intervention model* offers the lowest coverage rates for all kinds of provision, and reaches a very limited share of potential beneficiaries. Only in a minority of countries is there some cash support for persons in need (usually "unbound" schemes) and informal carers.

The *mild State intervention through cash benefits model* shows a higher coverage rate than the previous model, and it does so mainly through cash benefits, also for informal carers. However, given the limited resources devoted to long-term care, the level of such benefits is limited.

The *mild State intervention through services model* provides a higher coverage rate of needs compared to the previous two models, mostly through in-kind services, as expected, but also in some cases through cash benefits for informal carers.

A similar level of coverage is achieved by the *strong State intervention through cash benefits model*, thanks partially to service provision, but mostly to ("unbound") cash transfers.

The *two models based on strong or very strong State intervention through services* attain very high coverage rates through services. It is important to note that in both models, "bound" cash benefits are also offered, as a way of integrating rather than replacing the provisions of in-kind services, in order to make the latter more flexible and complete in covering beneficiaries' needs.

Table 4: The characteristics of the cluster typology of LTC models: provision (average values for each cluster) (2019)

	Residential LTC beds per 100 000 inhabitants 65+	Residential care coverage rate (%)	Home care coverage rate (%)	Cash benefits coverage rate (%)	Countries adopting an "unbound" cash benefits scheme among only those countries with a cash benefit scheme*	Countries with a cash benefit scheme for informal carers*
Limited State intervention	356	3.1	5.5	2.7	80.0	44.4
Mild State intervention through cash benefits	703	5.5	6.5	14.6	40.0	80.0
Mild State intervention through services	965	4.0	7.3	0.4	0.0	66.7
Strong State intervention through cash benefits	780	3.9	4.4	14.0	100.0	50.0
Strong State intervention through services	1150	4.3	11.7	7.2	33.3	33.3
Very strong State intervention through services	1170	4.4	14.8	4.1	0.0	66.7

** As the share of countries belonging to the same model (%).*
Limited State intervention: 9 MS (BG, CY, EE, EL, HR, HU, LV, PT, RO)
Mild State intervention through cash benefits: 5 MS (ES, LT, PL, SI, SK)
Mild State intervention through services: 3 MS (IE, LU, MT)
Strong State intervention through cash benefits: 4 MS (AT, CZ, DE, IT)
Strong State intervention through services: 3 MS (BE, FR, FI)
Very strong State intervention through services: 3 MS (DK, NL, SE)
Sources: ESPN elaboration on European Commission, Economic Policy Committee data; Spasova et al. (2018); Spasova and Ward (2019); MISSOC database.

4.2.3 The regulation of eligibility criteria

The six models also have very different eligibility criteria (Table 5). Countries belonging to the limited State intervention model do not take a universalist approach and most of them adopt a selectivist approach (not even a mixed one). In the case of the two mild State intervention models, again there is no universalist approach, but often a selectivist or mixed approach. Countries adopting a strong State intervention through cash benefits model tend to take a universalist or mixed approach. The two models based on strong and very strong State intervention through services adopt mostly a universalist approach. The quasi-universalist approach is common mostly among countries which adopt a model based on mild State intervention through services.

Table 5: The characteristics of the cluster typology of public LTC models: eligibility criteria (average values for each cluster) (2019)

	Countries adopting a selectivist approach*	Countries adopting a mixed approach*	Countries adopting a quasi-universalist approach*	Countries adopting a universalist approach*
Limited State intervention	88.9	0.0	11.1	0.0
Mild State intervention through cash benefits	40.0	40.0	20.0	0.0
Mild State intervention through services	0.0	33.3	33.3	66.7
Strong State intervention through cash benefits	0.0	50.0	0.0	50.0
Strong State intervention through services	0.0	33.3	0.0	66.7
Very strong State intervention through services	0.0	0.0	0.0	100.0

** The share of countries belonging to the same model (%).*
Limited State intervention: 9 MS (BG, CY, EE, EL, HR, HU, LV, PT, RO)
Mild State intervention through cash benefits: 5 MS (ES, LT, PL, SI, SK)
Mild State intervention through services: 3 MS (IE, LU, MT)
Strong State intervention through cash benefits: 4 MS (AT, CZ, DE, IT)
Strong State intervention through services: 3 MS (BE, FR, FI)
Very strong State intervention through services: 3 MS (DK, NL, SE)
Sources: ESPN elaboration on Spasova et al. (2018); Spasova and Ward (2019); MISSOC database.

4.2.4 Financing

Compared to all dimensions analysed so far (organisation, provision, eligibility criteria, etc.), the source of public long-term care funding is the only dimension which does not seem to be associated with the six models. As Table 6 shows, each model includes countries adopting different sources of funding. In other terms, the choice of how to finance public long-term care systems seems almost independent from the choice of how much to spend and on which type of provision. As previously stated, the source of financing seems highly dependent on the type of overall institutional regulation adopted by countries in relation to social protection, and in particular to healthcare.

The role of out-of-pocket long-term care expenditure in each cluster corresponds more closely with the differences among models than does the source of financing. With a few exceptions (EE, MT, PT), models that provide no or limited support to individuals with long-term care needs usually also involve low out-of-pocket expenditure. At the same time, the model with very strong State intervention through services, thanks to high levels of public investment, also requires very low levels of household contribution to financing long-term care.

Table 6: The characteristics of the cluster typology of public LTC models: financing (average values for each cluster) (2019)

	Countries funding LTC through taxation*	Countries funding LTC through a mix taxes-contributions*	Countries funding LTC through social contributions*	Household out-of-pocket LTC payment (Health) as a share of public spending on LTC
Limited State intervention	55.6	33.3	11.1	18.2 (1.2)**
Mild State intervention through cash benefits	20.0	80.0	0.0	5.1
Mild State intervention through services	33.3	33.3	33.3	27.0 (12.9)***
Strong State intervention through cash benefits	50.0	25.0	25.0	16.1
Strong State intervention through services	33.3	33.3	33.3	12.1
Very strong State intervention through services	66.7	0.0	33.3	5.9

** As the share of countries belonging to the same model (%).*
*** Value excluding Estonia, and Portugal.*
**** Value excluding Malta.*
Limited State intervention: 9 MS (BG, CY, EE, EL, HR, HU, LV, PT, RO)
Mild State intervention through cash benefits: 5 MS (ES, LT, PL, SI, SK)
Mild State intervention through services: 3 MS (IE, LU, MT)
Strong State intervention through cash benefits: 4 MS (AT, CZ, DE, IT)
Strong State intervention through services: 3 MS (BE, FR, FI)
Very strong State intervention through services: 3 MS (DK, NL, SE)
Sources: ESPN elaboration on European Commission, Economic Policy Committee data; Spasova et al. (2018); Spasova and Ward (2019); MISSOC database; Eurostat database (indicator: HLTH_SHA11_HCHF).

5 Public long-term care models, coverage of needs and protection against the risk of poverty and social exclusion

This report has provided a mapping and clustering of public long-term care in the EU. The last section has also analysed the interplay between the affordability dimension and the different models of social protection for long-term care. Further future analyses will be needed in this latter respect (see Conclusions). At the same time, in this section the issue of affordability and coverage can be assessed from two different perspectives: first, how many individuals with care needs are actually covered, either through in-kind provision or cash benefits; second, how many individuals with severe care needs risk becoming poor or socially excluded[3]. In relation to the latter issue, two elements have been used: the share of individuals aged 65+ having severe activity limitation, who run the risk of becoming poor or socially excluded; the percentage difference between individuals aged 65+ with severe activity limitation running this risk compared to those at risk but without activity limitation.

Table 7 shows how the six models perform in relation to the two dimensions.

The *limited State intervention* model has the weakest performance for older people: it provides the lowest coverage rate, has a very high share of older people with severe activity limitation who are at risk of poverty and social exclusion. Furthermore, having severe activity limitation, compared to not having such limitation, considerably increases the risk of being poor or socially excluded.

The model based on *mild State intervention through cash benefits* offers a higher coverage of potential beneficiaries than the previous model, but at the same time, being an older person with severe activity limitation is still a strong predictor of poverty or social exclusion compared to not having activity limitation.

The *mild State intervention through services* and the *strong State intervention through services models* provide a high coverage of potential beneficiaries through services and, in the latter case, also through cash benefits. At the same time, they help to strongly reduce the impact of activity limitation on the risk of poverty and social exclusion.

The model based on *strong State intervention through cash benefits* covers a large part of potential beneficiaries, more often through cash transfers rather than through services. At the same time, it produces relatively good results in terms of reducing the risk of those with strong activity limitation being poor or socially excluded. This latter result is very interesting as it shows that generous cash benefits schemes play a role not only in relation to care needs protection but also to maintain income levels among older people with disabilities.

The very *strong State intervention through services model* covers practically all potential beneficiaries, and can intervene and provide services also to individuals with medium-low levels of long-term care needs (as data on the share of potential beneficiaries covered by in-kind services above 100% show). At the same time, it helps to strongly reduce the impact of activity limitation on the risk of poverty and social exclusion.

[3] The present report could not adopt the same methodology or use the data provided in the recent OECD study on the effectiveness of L TC social protection in old age (Hashiguchi and Llena-Nozal, 2021) since important information is as yet still missing for some EU countries (see Conclusions); the OECD study covers only 19 EU Member States and for four of them it refers only to specific sub-national entities (in AT, BE, EE, IT), which might not be representative of LTC provision in the whole country (as in the case of Italy).

Table 7: The characteristics of the cluster typology of public LTC models: needs coverage and protection against the risk of poverty or social exclusion (average values for each cluster) (2019)

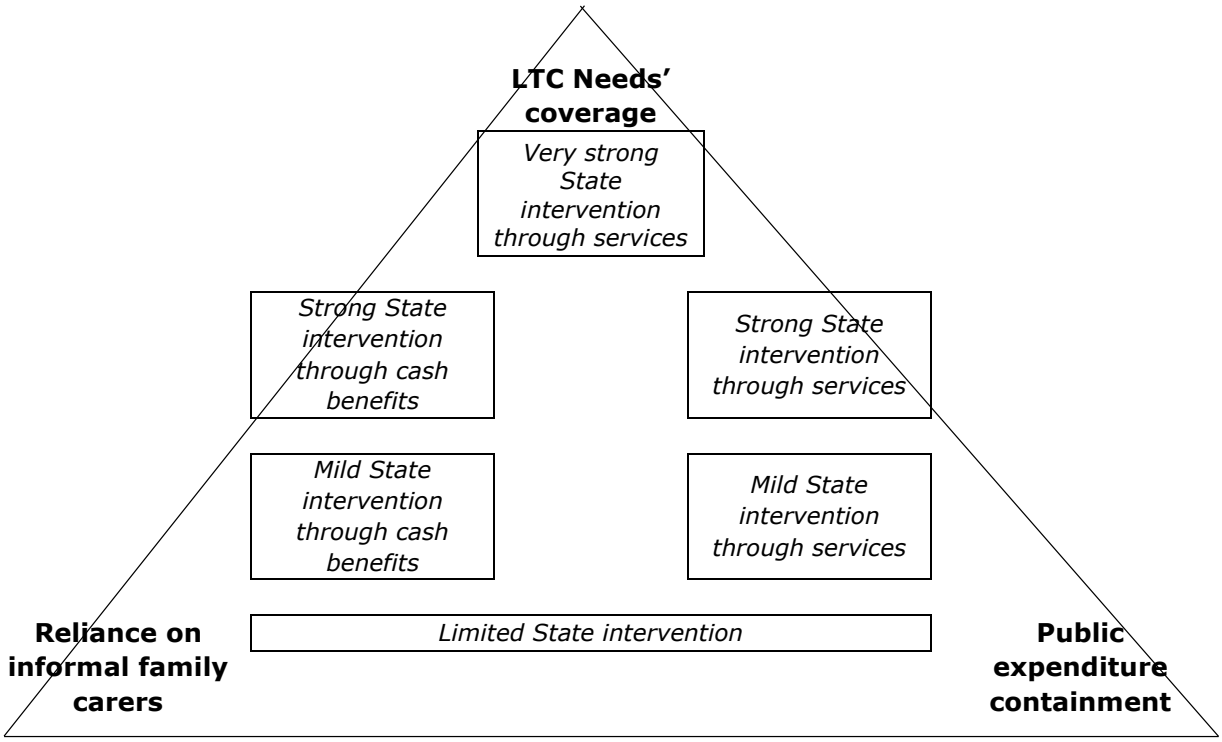
	Share of potential beneficiaries covered by in-kind services (%)	Share of potential beneficiaries covered by cash benefits (%)	People 65+ at risk of poverty or social exclusion with severe activity limitation (%)	Difference between People 65+ at risk of poverty or social exclusion with severe activity limitation and with no activity limitation (%)
Limited State intervention	33.0	12.4	41.7	15.4
Mild State intervention through cash benefits	49.3	66.2	28.5	12.0
Mild State intervention through services	76.5	1.4	25.3	7.9
Strong State intervention through cash benefits	43.7	71.2	21.9	6.5 (8.4)*
Strong State intervention through services	79.0	39.5	21.7	8.6
Very strong State intervention through services	155.0	39.8	19.3	7.7

** Data in parenthesis excluding Austria.*
Limited State intervention: 9 MS (BG, CY, EE, EL, HR, HU, LV, PT, RO)
Mild State intervention through cash benefits: 5 MS (ES, LT, PL, SI, SK)
Mild State intervention through services: 3 MS (IE, LU, MT)
Strong State intervention through cash benefits: 4 MS (AT, CZ, DE, IT)
Strong State intervention through services: 3 MS (BE, FR, FI)
Very strong State intervention through services: 3 MS (DK, NL, SE)
Sources: ESPN elaboration on European Commission, Economic Policy Committee data; Eurostat database (indicator: HLTH_DPE010).

6 Conclusions

The report shows that EU countries respond differently to the long-term care trilemma described at the beginning of Section 3. Six main public long-term care social protection models emerge from the analysis. Each of them focuses predominantly on one corner of the trilemma (see Figure 4). For instance, in the limited State intervention model, budget concerns dominate, but it also has the highest share of older people not covered by public support and experiencing the highest risk of poverty and social exclusion because of their care needs. The model based on very strong State intervention through services priorities needs coverage, but it requires a considerable amount of resources, well above the average EU expenditure in this policy field. The model based on strong State intervention through cash benefits attempts to find a balance between expenditure, coverage, and protection against poverty risks due to care needs, but it has to rely heavily on informal care support, which is not (and might not be in the future) always available; it also has often a gender-biased nature, with women bearing a large part of the care burden.

Figure 4: The typology of LTC models and the trilemma of needs coverage, reliance on informal carers, and public expenditure containment



The report shows that taking just a few criteria to cluster long-term care systems can be useful. Looking jointly at public expenditure on long-term care and the role of cash benefits within such expenditure also captures the distribution of a large part of the core institutional and organisational features of these systems. The only main feature that does not fit well using these two dimensions as a basis for classifying countries is the issue of how long-term care services are financed. Yet, as explained in the report, the source of long-term care financing is highly influenced by the general institutional set-up of social protection funding in each country.

One last note regards data availability. In recent years, the information available on public long-term care regulation and coverage in the EU has considerably increased and improved. The analysis presented in this report mirrors these developments. Considering the previously cited work by the OECD (2021), future efforts to improve data and information collection should proceed in at least two directions. First, information on long-term care in-kind services currently only shows coverage rates (how many individuals benefit from them), but there is no data on intensity of coverage, especially on home care. This information would be essential to assess to what extent an "ageing in place" strategy (based on home care services provision to older people) works without relying too much on informal care work. Second, information on long-term care out-of-pocket expenditure should be improved. Currently, data are available practically for all Member States on the health part of this expenditure. Therefore, in order to better assess the long-term care economic burden on individuals and households, it would be highly recommendable to increase the efforts towards systematic collection of data on social long-term care out-of-pocket expenditure.

References

Alber, J. (1995), "A framework for the comparative study of social services", *Journal of European Social Policy*, 5(2): 131–49.

Anderson, A. (2012), "Europe's care regimes and the role of migrant care workers within them", *Journal of Population Ageing*, 5(2): 135–46.

Anttonen, A. and Sipilä, J. (1996), "European Social Care Services: is it possible to identify models?", *Journal of European Social Policy*, 6(2): 87–100.

Ariaans, M., Linden, P. and Wendt, C. (2021), "Worlds of long-term care: A typology of OECD countries", *Health Policy*, 125(2021): 609–617.

Bettio, F. and Plantenga, J. (2004), "Comparing Care Regimes in Europe", *Feminist Economics*, 10(1): 85–113.

Bettio, F. and Verashchagina, A. (2012), *Long-term care for the elderly: Provisions and providers in 33 European countries*, Luxembourg: Publications Office of the European Union.

Burau, V., Theobald, H. and Blank, R. (2007), *Governing home care: A cross-national comparison,* Cheltenham, UK, Northampton, MA: Edward Elgar Publishing.

Cès, S. and Coster, S. (2019), *Mapping long-term care quality assurance practices in the EU*, European Social Policy Network (ESPN), Brussels: European Commission.

Colombo, F. (2012), "Typology of public coverage for long-term care in OECD countries", in Costa-Font, J. and Courbage, C. (eds.), *Financing long-term care in Europe: institutions, markets and models*, London, S.L. UK: Palgrave Macmillan, p. 17–40.

Da Roit, B. and Le Bihan, B. (2010), "Similar and Yet So Different: Cash-for-Care in Six European Countries' Long-Term Care Policies", *The Milbank Quarterly*, 88(3): 286–309.

Da Roit, B. and Weicht, B. (2013), "Migrant care work and care, migration and employment regimes: a fuzzy-set analysis", *Journal of European Social Policy*, 23(5): 469–86.

Damiani, G., Farelli, V., Anselmi, A., Sicuro, L., Solipaca, A., Burgio, A. et al. (2011), "Patterns of Long Term Care in 29 European countries: evidence from an exploratory study", *BMC Health Services Research*, 11: 316-328.

Di Rosa M., Kofahl C., McKee K., Bien B., Lamura G., Prouskas C., et al. (2011), "A typology of caregiving situations and service use in family carers of older people in six European countries", *GeroPsych*, 24(1): 5–18.

European Commission and Social Protection Committee (2021), *2021 Long-term Care in Europe*, Brussels: European Commission.

European Commission and Economic Policy Committee (2021), *The 2021 Ageing Report: Economic and Budgetary Projections for the EU Member States (2019-2070)*, Brussels: European Commission.

Halásková, R., Bednár, P. and Halásková, M. (2017), "Forms of providing and financing long-term care in OECD countries", *Review of Economic Perspectives*, 17(2): 159–78.

Hashiguchi, T. and Llena-Nozal, A. (2021), "The effectiveness of social protection for long-term care in old age: Is social protection reducing the risk of poverty associated with care needs?", *OECD Health Working Papers*, no. 117.

Kautto, M. (2002), "Investing in Services in West European Welfare States", *Journal of European Social Policy*, 12(1): 53–65.

Kraus, M., Riedel, M., Mot, E., Willemé, P. and Röhrling, G. (2010), *A typology of long-term care systems in Europe*, Brussels: ENEPRI.

Leitner, S. (2003), "Varieties of Familialism: the Caring Function of the Family in Comparative Perspective", *European Societies*, 5(4): 353–75.

Pavolini, E. and Ranci, C. (2008), "Restructuring the welfare state: reforms in long-term care in Western European countries", *Journal of European Social Policy*, n. 18(3): 246-259.

Pfau-Effinger, B. (2014), "New policies for caring family members in European welfare states", *Cuadernos de Relaciones Laborales*, 32(1).

Pommer, E., Woittiez, I. and Stevens, J. (2009), *Comparing care: the care of the elderly in ten EU-countries*, Amsterdam: Aksant Acad. Publ.

Ranci, C. and Pavolini, E. (eds.) (2015), *Reforms in Long-term Care Policies in Europe*, New York: Springer.

Ranci, C. and Pavolini, E. (2015), "Not all that glitters is gold: Long-term care reforms in the last two decades in Europe", *Journal of European Social Policy*, 25(3): 270-285.

Rothgang, H. (2009) *Theorie und Empirie der Pflegeversicherung*, Berlin: Lit-Verl.

Saraceno, C. and Keck, W. (2010), "Can we identify intergenerational policy regimes in Europe?", *European Societies*, 12(5): 675–96.

Simonazzi, A. (2008), "Care regimes and national employment models", *Cambridge Journal of Economics*, 33(2): 211–32.

Spasova S. and Ward T. (2019), *Social protection expenditure and its financing in Europe, A study of national policies*, European Social Policy Network (ESPN), Brussels: European Commission.

Spasova, S., Baeten, R., Coster, S., Ghailani, D., Peña-Casas, R. & Vanhercke, B. (2018). *Challenges in long-term care in Europe. A study of national policies*, European Social Policy Network (ESPN), Brussels: European Commission.

van Hooren, F. (2012), "Varieties of migrant care work: comparing patterns of migrant labour in social care", *Journal of European Social Policy*, 22(2): 133–47.

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