sprint

Social Protection Innovative Investment in Long-Term Care

Social Protection

Innovative Investment in Long-Term Care

THE LONG-TERM CARE RESOURCING LANDSCAPE

Prof. Bent Greve (Ed.), Roskilde University

www.sprint-project.eu

The SPRINT Project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 649665.

Executive Summary

This report paints a portrait of the types of resourcing of long-term care (LTC) in Europe as seen in different welfare states. Resourcing is understood here as including not only classical ways of financing the welfare state, but also support from civil society. Examination of the framework of providers, which involves the state, the market and civil society, allows us to investigate the landscape of resourcing within selected EU countries.

The picture presented is varied and data is not always systematically collected or solely related to long-term care for elderly people. There are overlaps between health care and long-term care for elderly and for people with disabilities, which is one reason information available is not always very precise or coherent. The lack of systematic reliable data is a problem for our knowledge of LTC in Europe and our understanding of how different schemes of resourcing can have an impact on the lives of elderly people. Despite this, the data presented here give an indication of the welfare mix, and how state, market and civil society interact in the different welfare states.

The analysis shows that there is pressure on the long-term care financing in welfare states, due among other issues to demographic changes. The elderly population is growing; civil society and informal care plays an important role in most countries, and with increased labour market participation, this is likely to be reduced. The report mentions the possible impact on labour market attachment as regards carers but this also is an issue that needs to be further refined and discussed.

The report also argues that there is no clear and uniform depiction of what quality of long-term care is. This lack of a clear definition of quality implies a need to be very specific when looking into the possible impact of using a social investment perspective.

Finally, the report discusses the possible impact of using different ways of resourcing long-term care, including on issues such as well-being and inequality in care. Analysis of social investment in LTC will need to use a variety of techniques and approaches in order to be able to show its impact.

In this report, impact is mainly analysed in a theoretical way and summarised to indicate possible impacts (favourable and otherwise) by the various approaches to finance and resourcing long-term care. Social investment in different countries will have different impacts, dependent on the welfare state system and the country's approach to long-term care.

However, for all countries the expectation is that social investment in long-term care might help in reducing the pressure on long-term care spending due to ageing. It might further help in making it possible especially for younger informal carers to continue or stay in the labour market.

In systems today mainly relying on informal care – especially in eastern and southern Europe – social investment might also produce better quality of care. In northern welfare states similar

effects could be achieved, while at the same time overall spending might be reduced. In liberal and continental welfare states quality effects for informal care could be expected and there might be some reduction in state spending. Work package 2, of which this report is a part, focuses on principles and structures, and wp4 and wp5 will build on this work, discussing the issues of measurement and assessment, and developing instruments for use in future analysis of social investment in LTC.

Key messages

- Demographic changes are putting pressure on welfare states.
- Social investment can potentially reduce the pressure on public sector spending.
- Social investment has the potential to improve quality of care.
- More informal carers could be enabled to enter the labour market.
- Data is difficult to obtain and not always precise.
- The interaction and boundaries of social care with the health care system are important.

Table of contents

List of Tables

Acronyms and abbreviations

D	Deliverable
EU	European Union
LTC	Long-term care
SI	Social investment
SPRINT	Social Protection Investment in Long-Term Care
wp	Work package

1 Introduction

The aim of this report is to do the following, as described in the contract for the project (p. 14.):

> *Gaining an insight into the resourcing of long-term care schemes, by presenting a representative sample of different resourcing schemes, the status quo, characteristics, players, legal framework, as well as by analysing the individual performance and impact of the sample of LTC schemes in various countries.*

This deliverable will, in accordance with deliverable D2.1, use the following definition of social investment:

> **Social Investment within the context of long-term care is defined as welfare expenditure and policies that generate equitable access to care to meet the needs of ageing populations, improve quality of care and quality of life, increase capacities to participate in society and the economy, and promote sustainable and efficient resource allocation.**

Overal this contributes to the aim of the work package to determine the "current landscape of organization and resourcing" (contract p.12) of long-term care with an eye to the social investment perspective.

There can be different interpretations of the task as described above. One could discuss the traditional methods of financing welfare states (Musgrave and Musgrave 1976, Stiglitz and Rosengaard 2015) and show possible ways of financing public sector activities. However, this would leave out market and civil society. The report will be based on theoretical description of possible ways of resourcing, and where data is available will illustrate variations in approaches.

The report can also be seen in the light of the milestone aim for WP2 to "promote understanding and […] document how the growing presence of different actors in the supply and resourcing of long-term care programmes" can influence LTC (p.15 in the description of the project). Thus this deliverable will not present calculations and more detailed descriptions of the analysis, as these are planned for wp4 and wp5.

Long-term care is not a very precise concept, and not often well defined social policy branch in all nations. Long-term care services refer to the organization and delivery of a broad range of services and assistance to people who are limited in their ability to function independently on a daily basis. Besides services delivered by the state and the market, civil society (including families and the voluntary sector) often plays a central role in care (see also Annex 4).

A question is also how to interpret performance of long-term care system, especially given that it is not a very precise concept. Measuring performance of the systems is difficult regarding possible difference in quality, however, one can argue that the access to and equity in access to long-term

care could be an interpretation of performance. Thus how different ways of financing possibly influences equity in access will be seen as an indicator of performance.

An important question from the point view of social investment is what is quality in long-term care and how can we understand it? There are no simple answers, nor any common international agreement of measurement or definition. Quality of care based on different types of resourcing is outside the scope of this report (cf. Leichsenring *et al*. 2013, OECD 2013). This is also a consequence of that long-term care "aims at making the current condition (unwell) more bearable" (De La Maisonneuve and Oliveira Martins 2013, p.24). Albeit there are some instruments used, and the most used instruments is EuroQuol – 5 (EQ-5D), followed by ASCOT and Health Utilities Index (HUI2/3) (Bulamu *et al*. 2015). Whether or not the resourcing is sufficient to ensure high quality is also outside the scope of this report, although at a later stage quality will be an important parameter to analyze when looking into impact of social investment.

Division of responsibilities and financing of long-term care, the degree of means-testing and choice between in-kind and in-cash support are also central questions (Swartz 2013).

Finally, the report will discuss the possible impact of social investment in the different welfare states and long-term care systems in selected countries in Europe.

2 Aims and Objectives

With the aim of the deliverable, as described in section 1, as the starting point for the analysis, the research question to be answered is:

> How can one understand theoretically the impact of different ways of resourcing long-term care schemes?

This will as indicated above also include access to long-term care.

This report will, in accordance with deliverable D2.1, use the following definition of social investment:

> Social Investment within the context of long-term care is defined as welfare expenditure and policies that generate equitable access to care to meet the needs of ageing populations, improve quality of care and quality of life, increase capacities to participate in society and the economy, and promote sustainable and efficient resource allocation.

It will further explore the first column in picture 1 in D2.1 and thus help in presenting the investors and the resources in long-term care[2].

Overall the aim of this specific deliverable is to present a picture of the resourcing of long-term care schemes in the different welfare states in Europe, showing a variety of approaches, and present a first discussion of the possible impact of using a social investment perspective in the long-term care area.

3 Methods

3.1 Background and Scope of the Paper

We will first describe the existing patterns of providing financing and resources to long-term care (both formal and informal care), within the representative sample of countries selected for the project. These countries (shown in table 1) represent different welfare regimes, cover all regions of the EU – north, south, east and west – and the new and older EU members. The division into five regimes is in line with the main literature in the field (Castles *et al*. 2010, Greve 2013).They have different welfare traditions and different interaction between state, market and civil society

Table 1: Countries included in the analysis

Nordic	Denmark and Finland
Liberal	United Kingdom
Continental Europe	Germany and Belgium
Southern Europe	Italy, Portugal and Greece
Eastern Europe	Poland, Hungary and Lithuania

There is a growing number of publications in the area of welfare state clustering and regimes (see for example the *Oxford Handbook of the Welfare State* (2010) or the *Routledge Handbook of the Welfare State* (2013)) and it will not be possible here to acknowledge or cite exhaustively the large literature on welfare state typology. However as the focus of the project is on social protection investment this is not in itself a problem. Using regime typologies and welfare state analysis as an instrument to give an insight into resourcing is important as this can make comparison and analysis clearer. It is also a useful tool to analyze both development and why the different

[2] This is one of four deliverable in the work package 2 in the project. See http://sprint-project.eu/ for a more detailed description of the project and the other deliverables in the project. D.2.1. deals with conceptual issues related to the understanding of social investment within long-term care.

countries' systems are as they are, including the distinction of using state, market or civil society as agents to deliver long-term care. Civil society encompasses a broad set of actors, e.g. both family, voluntary organizations etc. (Greve 2015), and thereby outside the state and outside the production (Urry 1981).

The countries in this project also represent the different typologies of long-term care schemes, as depicted in the latest report from the European Commission (2016, p.173) – in brackets countries within SPRINT project in the group:

A) Formal care oriented provision, generous, accessible and affordable (Denmark)

B) Medium accessibility, some informal care orientation in provision (Belgium, Germany)

C) Formal care of medium to low accessibility, medium informal care orientation in LTC approach (UK Finland)

D) Low formal care accessibility, strong informal care orientation in LTC approach (Hungary, Italy, Portugal, Poland)

E) Rather low formal care accessibility, almost exclusive informal care orientation in LTC approach (Lithuania).

The sample of countries therefore includes all major types of welfare states, and five models of LTC within Europe.

A central problem is that it can be difficult to know what the need (and therefore demand) for care is, and need can change gradually over time. Care within the family is not necessarily reported and therefore there is often a lack of data for this. Given these limitations, the report will try to describe what the supply of care is and how this is financed. The main data available concern public welfare provision. The division of responsibilities between central, regional and local public bodies can have implications for who is able to get care. This division will be explored in the later work-packages.

The financial crisis has led to crisis for long-term care in several welfare states, given the restraints on the public purse (Waldhausen 2014). This makes knowledge on the financing and types of financing and the possible impact of different systems of financing (which will be covered in later papers) all the more important. It is also desirable to have an assessment of what other resources are available for care, despite the lack of reliable data.

Methodologically, the study has used a combination of existing studies, information from country experts in the project and data from OECD and Eurostat. Literature survey has been done on google scholar, social science citation index and input from other partners in the project, see also the literature list on the SPRINT webpage. Furthermore, the previous EU-project ANCIEN has been consulted.

Use of data from OECD and Eurostat has the advantage of being done internationally comparable and in a consistent way. These data are, as all other data, not better than the input from each country. Especially, the borderline between health care and long-term care might imply a risk of less precise data, and there might be difference in national reporting. Furthermore, the information on informal care is less strong here (see on the supply of informal care Pickard *et al*. 2011). However, given the focus on social investment, and, the expectation that this mainly will come from the welfare state, it is natural to look at the existing provision of long-term care.

The report thus overall builds on a review of existing documents and data on long-term care in the selected EU member states, as well as giving a broader picture related to the EU in general (using as argued above Eurostat and OECD data). It also builds on information from those participants involved in the SPRINT project in order to ensure that national reports and more detailed information on the situation in the different countries are also included in the report (see also Greve 2017). The report should be seen in relation to the other deliverables in wp2. Concepts will therefore be discussed and presented here in a more limited way. Naturally, there are limitations with data and the analysis should be read with those caveats in mind, including difficulties as to whether a cost is seen as health care or long-term care. Furthermore, public data only measures public welfare, and not fiscal or occupational welfare (Greve 2015).

Section 2 will empirically describe different and varied types of resourcing schemes, thereby presenting a framework for further analysis. Section 3 will briefly describe the legal framework and core characteristics of the various schemes, and Section 4 will touch on the possible impact of using different financing schemes on issues such as pressure on welfare state spending and access to long-term care.

Overall, the aim is as the opening quote indicates, to show the existing systems of resourcing (formal as well as informal) long-term care, and to present an overview of the systems and some preliminary discussion of the possible impact of various approaches to long-term care. Further, given the different countries involved in the analysis, using regime typology as a structuring device makes it possible to show differences and link them to welfare state approaches, including the different balances between the state, the market and civil society.

3.2 Limitations of the Current Paper

Naturally, there are limitations of a paper such as this given the focus as presented the introduction.

One is that there are possible options in shifting between in-kind and in-cash benefits. Nor will the issue of how the generosity of pension systems might have an impact on the ability to buy long-term care be covered here. For example countries with a more generous pension system could, in

principle, provide less formal long-term care and leave that to the individual to buy. As with other benefits, the individual might instead of buying long-term care buy other goods and services. Given that pension systems historically have had a focus on ensuring consumption possibilities, also after retiring from the labour market, this seems to be a reasonable delimitation as the general idea has not been to buy long-term care.

Given their diversity, it is difficult to benchmark the various financing schemes against each other. However, one way is to look into the balance between state, market and civil society in providing resources to long-term care. This balance naturally depends to a large degree on historical and normative traditions (Greve 2015) which still inform the way different welfare states deliver services, including in the long-term care.

Social investment and long-term care revolves around how social investment might be beneficial for society by either reducing the need for LTC and/or improve its quality. This will be part of future WPs in this project.

Given that the focus here is not how the market for care functions, but different financial arrangements and approaches, the possible option of recruiting low-wage carers, including migrant carers, to affordable prices around the clock (Billings *et al*. 2013) will not be explored. Naturally when using market providers there will be a need for quality assurance and a need for controlling that society gets what they have paid for – as is also a clearly a requirement for public provision. There will also be a need to avoid "cherry-picking" by market providers.

A problem for the analysis is the possible overlap between health care and long-term care given that different institutional arrangements have implications for which sector is responsible for care, and also the issue of what is measured as long-term care. The boundaries between, for example, rehabilitation in hospitals and other types of rehabilitation or re-enablement also influences the distinction between and understanding of what kind of resources are available for long-term care. This also includes the possible different cost incentives built into the various systems (Costa-Font and Courbage 2011).

Data on long-term care do not always distinguish between the age group receiving the benefit, so while this project focuses on those above the age of 65 there is a risk that some of the data includes support to those in other age groups in need of long-term care, such as, for example, people with disabilities. However, we believe that the main part of the expenditure will be related to elders, given the strong relation between age and need of care.

The issue of how to make choice and ways to do this in long-term care is not central for this report, although it is touched on given that in some systems there might be a choice between providers (Pavolini and Ranci 2008, Greve 2010, Rodriques and Glendinning 2015)

Finally, possible generational issues related to payment for care will not be included. This includes whether a change in financing from one type towards another type will have different implications for the consequences of who will have to pay for long-term care (Colombo and Mercier 2012).

4 State of the Art

In order to answer the questions set out above this section will focus on types of resourcing schemes seen today and outline the legal framework and core characteristics of the systems.

4.1 Types of Resourcing Schemes

There are many and varied types of resourcing long-term care. For an overview of the logic and rationality of using public financing (see Barr 2010); a central argument being that private savings and/or insurance for the purpose would be inefficient and unequal. Here the focus is on describing the varieties of resourcing existing in selected European countries, as mentioned above in section 1. Resourcing is understood not only as tax, social security contributions or user charges, but also possible private insurance or through the user's own or family expenditures or informal support. Thus, classical concepts of financing are too limited here as resources can also consist of different kinds of informal support. Voluntary support and provision by NGOs can also be, in principle, a type of resourcing, although here data is scarce. Use of own capital, for example, through savings or by reverse mortgage is also an option. Resourcing is understood not only in monetary value, but also non-monetary terms, for example a relative supporting a dependent person. Informal care is measured, for example, using the available information on the number of informal care workers, most frequently working to support relatives in need of care. However, the size and use of informal care is barely documented in most available international statistics. Care can be supported directly or indirectly, through different types of benefits or payments to a relative for taking care of a dependent person.

The way resourcing happens in the selected countries is very different. An overview is shown in appendix 4, and this also indicates that not all countries have a single discrete type of scheme. This further underlines the risk that data is not precise.

In principle the focus could be on ex-ante as well as ex-post financing. Costa-Font *et al*. (2015, p.49) show that private-long-term care insurance only covers 2% of total long-term care expenditure in Europe. In this report, the central issue is how expenditures are financed in practice and this type of boundary between public and private is less important given the size of private insurance. In addition, LTC is still a fragmented area, lacking a shared definition (Billings *et al.* 2013) and is often observed to overlap with health care. However, this also illustrates the plethora of approaches different nation states have taken to this issue. The statistics provided below should thus be taken with some caution. However, they give some indication of the variety in approaches, including differences in the use of the welfare mix between state, market and civil society (civil

society understood in the broad sense of the concept). Care mix information can be found in the SHARE data for some of the countries analysed here (Tinios and Georgiadis 2016).

There are, as mentioned, many and varied approaches to resourcing. The welfare state can help in ensuring access to all, and insurance is in principle also a risk sharing device (Claid Dale *et al*. 2013), but the latter can have a negative, or perhaps more precisely, an unevenly distributed impact on the possibility of broad LTC coverage (Barr 2010). The possible distributional impact of private insurance-based systems will, for example, depend on the ability to take-up insurance in the given system, whereas obligatory social insurance might cover all on the labour market, and sometimes with derived rights for spouses and children.

The section is structured so that in order to get an overview, existing approaches to financing and the size of funding are presented in section 4.1.1, which leads to formulating a typology of financing as presented and illustrated in section 4.1.2.

4.1.1 Size of welfare state spending on long-term care

There is great variety in different welfare states' proportion of spending on long-term care, as shown in table 2.

Table 2: Expenditures on long-term care in selected countries as a percentage of GDP for the years 2000, 2005, 2010 and 2013

Country/Year	2000	2005	2010	2013
Nordic Europe:				
Denmark	1.89	2.2	2.55	2.50
Finland	1.7	2.01	2.44	2.58
Continental Europe:				
Belgium	-	1.71	2.14	2.29
Germany	1.3	1.43	1.53	1.58
Liberal:				
United Kingdom	-	-	-	1.20
Southern Europe:				
Greece	-	-	0.06	0.11
Italy	-	-	-	1.80
Portugal	0.09	0.09	0.15	0.89
Eastern Europe:				
Hungary	0.14	0.31	0.64	0.30
Lithuania	-	0.64	1.13	0.91
Poland	-	0.43	0.43	0.45

Source: OECD (2015a) and European Commission (2015)

Notes:

1) Annex 1 gives information for all EU member states. Annex 2 presents some more detailed information for the selected countries. For Poland in 2013 the data used are from Eurostat.

2) It is important to bear in mind that the table primarily describes in-kind expenditures on long-term care, and as illustrated in table 5, a large portion of cash expenditure is not included. Furthermore, those data might not always include all information specifically related to long-term care for the elderly.

3) Data for the United Kingdom and Italy are based on the 2015 European Commission Data Report (European Commission 2015). Methodological differences are explained in annex 5.

Table 2 shows the development in the spending in the selected countries on long-term care from 2000 until 2013. The table illustrates the differences and development in LTC expenditures across the selected countries. The Nordic welfare states, roughly speaking, have the highest level of expenditures, closely followed by countries of continental Europe. Although data availability for the liberal, southern and eastern European countries is sparser, and more fragmented, these countries, especially the southern European, have a relatively low level of state LTC expenditure. This might reflect (as discussed later) a different balance between state, market and civil society and underlines that considering state spending alone does not indicate the quality and the overall level of LTC resources in the different welfare states.

Demographic changes with an ageing population are not reflected in the data and the picture of spending after the financial crisis starting in 2009 is also blurred, not indicating any specific impact. Hungary and Lithuania are the countries where there seems to have been the most dramatic changes in a downward direction (see OECD 2013a). Debate and argument about the need for social investment in long-term care needs to be informed by an awareness of the pressure from demographic changes and the extent of them.

A problem for comparative analysis using the data in this field is the great variation in the boundaries between health- and long-term care. Different accounting practices also make direct comparison difficult. Additionally, it is not possible, based on existing information, to set a value on the informal care delivered..

One issue is the welfare states spending on long-term care; another is the split between public and private spending, including possible user charges. Table 3 shows overall spending on LTC and the split between public and private spending in the field in the latest year available.

Table 3: Overall spending on LTC – including the split between public and private spending for selected countries in 2013

Country	Overall spending as % GDP	Public spending as % GDP	Private spending as % GDP	Public spending as a % of overall spending
Nordic Europe				
Denmark	2.50	2.28	0.21	91
Finland	2.58	2.21	0.37	86
Continental Europe				
Belgium	2.29	1.87	0.42	82
Germany	1.58	0.99	0.59	63
Liberal:				
United Kingdom	1.20	-	-	-
Southern Europe				
Greece	0.11	0.10	0.01	91
Italy	1.80	-	-	-
Portugal	0.89	0.52	0.37	58
Eastern Europe:				
Hungary	0.30	0.25	0.05	83
Lithuania	0.91	0.81	0.08	89
Poland	0.45	0.43	0.02	96

Source: OECD (2015a) and European Commission (2015)

Notes:

1) Private spending consists of private insurance, private out-of-pocket expenditure and various types of co-payments, including co-payments to both public and private insurance. It does not include accommodation payments as this would not be seen, in general, as an extra cost.

2) Numbers from the United Kingdom and Italy are based on the 2015 European Commission Data Report (European Commission 2015). Methodological differences are explained in annex 5. For Poland, EU only in the long-term estimates of development use a starting point of 0.8. The data for Poland are taken from Eurostat HC3 and HCR1.

Table 3 shows clearly that the state is the main provider and financer of formal long-term care in all the welfare states, with Germany having the lowest relative share level. The data do not include the level of informal care and who is delivering this as informal care is difficult to measure in monetary terms. The absolute level of state funding is lowest in Greece, Poland and Hungary.

Therefore, in the analysis of resourcing long-term care one specific issue is the support from civil society. Table 4 shows LTC support with regard to informal care as shown by the availability of long-term care workers per 1000 population.

Table 4: Resources measured as workers in the formal and informal sector and real numbers per 1000 population for latest available year

Country	Formal long-term care workers*	Formal LTC workers per 1000 population*	Informal long-term care workers**	Informal LTC workers per 1000 population**
Nordic:				
Denmark	82,679	14.8	19,613	3.6
Finland	-	-	40.492	-
Continental Europe:				
Belgium	-	-	420,231	39.8
Germany	791,855	9.8	3,468,928	43
Liberal:				
United Kingdom	-	-	5,550,000	89.1
Southern Europe:				
Greece	-	-	273,234	24.6
Italy	406,669	7.1	4,034,696	70.4
Portugal	14,681	1.4	-	-
Eastern Europe:				
Hungary	40,484	4,1	-	-
Lithuania	-	-	-	-
Poland	-	-	1,214,331	31.8

Source: OECD 2015b

Notes:

*1) *Portugal: 2014; Germany and Hungary: 2013; Denmark: 2012; Italy: 2003.*

*** Germany: 2013; UK: 2009; Denmark: 2008; Belgium, Greece, Poland: 2006; Italy: 2003.*

2) Informal long-term care workers include: "individuals providing LTC services on a regular basis, typically at home, for example spouses/ partners, family members, neighbors and friends. The category 'informal caregivers' also comprises caregivers that are undeclared to the social security" (OECD, 2015b). The data for Finland covers family carers with care allowances is from 2012 and has been provided by Linnosmaa Ismo, and might not be directly comparable with the other data

3) Data across the various countries are the latest retrievable. The same goes for the number of formal/informal workers, and as such, these cannot be combined to account for the exact number of overall workers across formal and informal LTC.

Naturally, it is difficult to estimate the proportion of informal care workers although the existing data does provide some information. In particular the United Kingdom and Italy have a relatively high number of informal workers, compared to population size. Denmark, again, seems to be

unusual compared to the remaining countries, having by far the lowest quantity of informal care workers per 1000 population, presumably because of its larger state involvement.

Data is difficult within this area – they can be very imprecise or exclude support and care within the family – but those presented here are the best available. Imprecise data is especially a consequence of limited information about families which are not in contact with the welfare state's administration. Further, there is not necessarily a clear boundary between informal care or other normal household activities, such as cooking and cleaning for example. It is thus very difficult to infer whether this should be classified as LTC or just continuation of normal activities, with another split and division of responsibilities in the individual household. Comparative data on informal care is thus of a diverse nature and not necessarily comparable. But given that informal care, including family care, is highly important in many welfare states in Europe it is important to have at least some information on its level. It is also important because one of the consequences of a high level of informal care might be reducing labour market availability, especially when children are supporting their parents.

In summary, resources for long-term care are various and come from a variety of sources, not all well documented or precisely defined. For this reason the next section, on typologies of resourcing schemes, has a mainly economic background. Informal care is partly included in the analysis by using informal long-term care workers per 1000 of the population as an indicator of the importance of civil society in the delivery of long-term care.

4.1.2 A typology of resourcing schemes

This section presents the varieties of resourcing schemes existing in the selected countries from the different welfare regimes, with additional information in annex 4. This shows a large variety in the approaches to resourcing long-term care. First, as indicated above, there can be differences in the size of the public and private sector's contribution to the financing of long-term care. Before embarking more on the question of how to understand this variety it is important to be aware that there is also a variation in the way these benefits can be delivered. They can be provided in cash or in-kind with different implications for the user. If provided in cash the user is enabled to buy the necessary support, but with a risk that the user is not able to make an informed choice, or chooses to spend the money on other items than care. If in-kind this might give less flexibility, but on the other hand be more directly related to enabling necessary activities in daily living. One way of providing support is not necessarily better than the other: this will to a large degree depend on the specific way the system is developed (Greve 2015). In-kind benefits, for example, range from in-home care for elderly people to outside-home support in daily life, including different help-remedies and new welfare technology if provided by the welfare state.

There are many and varied approaches to financing long-term care and many combinations. France, for example, combines third-party coverage with a "steeply income-adjusted universal

program for people 60 or older" (Doty *et al*. 2015, p.359). Thus, a combination of an individual type of insurance market with, for those not covered, a strong means-tested long-term care system is one way. Germany has a social insurance program that cannot be publicly supported (although it is mandatory so that the social insurance contributions resemble an income tax) while some buy long-term care insurance from private insurers (Nadash *et al*. 2012). There are few long-term care systems that are primarily organized by private insurances. The central reason for so little private insurance seems to be: "excessive costs, social assistance, trust in family solidarity, unattractive rules of reimbursement, ignorance and denial of heavy dependence" (Pestiau and Ponthiere 2011).

Thus, in the following discussion private long-term care insurance will be left out. However, co-insurance can be interpreted as a kind of user charge (Missoc 2014) and a way of financing long-term care.

Overall, and without taking informal care into consideration, it can be argued that there are three systems of resourcing (Colombo 2011, p.26):

- Universal coverage within a single programme
- Mixed systems
- Means-tested systems.

This partly mirrors the welfare state models and long-term care models as presented at the beginning, however at the same time it points to classical divisions of financing arrangements in the welfare states.

There has been, over the last 15-20 years, at least a quasi-marketization in elderly care. Over time also an institutionalisation of care has taken place, so that "elderly care became subject to top-down (vertical) regulation (public norms, state funding) while being simultaneously based (in horizontal dimension) on a division of work between informal carers and formal service provision, on the one hand, on non-profit service delivery, often in collaboration with local authorities, on the other" (Bode *et al*. 2011 p.223). The impact of and use of the market also changes the balance between state, market and civil society provision in the area. Even in previously very universal and encompassing welfare states, there has been a marketization at least regarding delivery (Meagher and Szebehely 2013). Whether this influences access and quality of care depends on financing; the structure and the method of financing of the welfare state remains very important.

Table 5 gives information on the type of public support available in the chosen countries.

Table 5: Types of support in the different welfare states

Country	Public in cash spending as a percentage of GDP in 2010[1)]	Public in-kind spending as a percentage of GDP in 2010	Total number of beds in residential LTC facilities in latest year available	Beds in residential LTC facilities per 1000 aged +65 years in latest year available
Nordic:				
Denmark	2.04	2.47	45,460	48.7
Finland	0.31	2.20	61,575	60.5
Continental Europe:				
Belgium	0.45	1.9	137,069	71.2
Germany	0.45	0.98	902,882	53.1
Liberal:				
UK	0.56	1.42	543,897	48.3
Southern Europe:				
Greece	0.35	1.01	-	-
Italy	0.86	1.04	224,136	18.1
Portugal	0.0	0.39	-	-
Eastern Europe:				
Hungary	0.58	0.26	83,216	48.9
Lithuania	0.23	0.99	18,893	34.8
Poland	0.37	0.37	98,292	17.3

Source: OECD, 2015b and Lipszyc, Sail and Xavier (2012).

Notes:

1) UK: 2014; Finland, Germany, Lithuania, Poland, Hungary: 2013; Belgium, Italy: 2012; Denmark: 2011; Greece: 2000.

2) The data might include expenditures to long-term care for people below the age of 65; however for sake of comparison no correction of the data for age-composition has taken place.

3) It should be noted that the numbers on public cash and in-kind expenditures are based on data from European Commission's report: "Long-term care: need, use and expenditure in the EU-27" (Lipszyc, Sail and Xavier, 2012). Besides the numbers from 2010, data as regards to these two categories has not been obtainable or replicable.

In-cash and in-kind support for long-term care can be supplementary, substitutes or alternative ways of achieving the same goals. Table 5 only includes cash benefits that are benefits directly connected to long-term care, so the possible impact of a generous pension system is not included in the analysis as also argued earlier. In-kind support can also be of many varieties, for example welfare technology, changes in the private home or different kind of leave allowances for a

dependent relative. If there are specific systems within the collective agreement to take care of dependent relatives this is also not included in the data in the table.

Table 5 shows that the amount of different varieties of in-kind support is the most important aspect of the long-term care system in all welfare states. The table does not necessarily show the overall impact and size of the in-kind support, however. The cost is expected to be within the limits set by overall spending as described in table 2, with allowance for differences in the way the data is measured and differences in boundaries between the different sectors.

Table 5 shows that the Nordic welfare states spend more overall, although Finland spends only more limited in cash, and in this respect is below many of the other welfare states in the analysis. In-kind benefits are higher in the Nordic countries than in the other welfare states. Beds available (measured by the number of elderly people above the age of 65 in residential care), an indicator of how many can be taken care of outside private homes, do not vary to the same extend as spending. Belgium has the highest proportion and the difference among countries in the various clusters is not remarkable, except for a lower level in eastern and southern Europe. This indicates that the size of the difference in long-term care and variation in the level of care is not dependent on institutional access, but more on the impact of overall level of spending and the influence of the civil society's involvement and support for those in need of care. Furthermore, it might also be influenced by the use of enablement and rehabilitation and the availability of welfare technology.

Using the information from the previous tables, this can be interpreted as a way of describing the difference in approach to resourcing long-term care between state, market and civil society's involvement in the delivery of long-term care.

Table 6: Differences in approach between state, market and civil society in 2013

Country	State	Market	Civil Society
Nordic Europe:			
Denmark	+	0	-
Finland	+	0/+	-
Continental Europe:			
Belgium	0	+	0
Germany	0	+	0
Liberal:			
UK	0	+	+
Southern Europe:			
Greece	0	-	0
Italy	0	?	+
Portugal	0	0	(+)
Eastern Europe:			
Hungary	-	-	+
Lithuania	0	0	+
Poland	0	-	+

Source: Based on the previous tables

Note: + denotes high degree of importance, 0 neutral, and – limited importance. The ranking is based on +/- standard deviation. The mean is for all 11 countries, see also the table below with the boundaries used for denoting the position of the different countries.

State = Public expenditures on LTC in percentage of GDP
Standard deviation: 0.93208
Means: 1.31333

Market = Private spending on LTC in percentage of GDP
Standard deviation: 0,19788
Means: 0,23556

Civil society = Informal long-term care workers per 1000 population

Standard deviation: 26.4638

Means: 43.18571

Governance component	+	0	-
State	≥ 2.2 (2.24)	<->	≤ 0.4 (0.38)
Market	≥ 0.4 (0.43)	<->	≤0.05 (0,04)
Civil Society	≥ 69.6	<->	≤15 (14.6)

Table 6, to a certain extent, mirrors the picture from some of the previous tables with a stronger state influence in the Nordic countries, and with a weaker use of the civil society as central

provider compared to other countries. The tradition in eastern and southern Europe relies more on civil society, with continental Europe and the UK in between. Overall, this can be depicted in the following way:

a) Primarily state: Denmark and Finland

b) State and market: Belgium and Germany

c) Market and civil society: United Kingdom and Italy

d) Primarily civil society: Portugal, Hungary, Poland, Greece and Lithuania

Naturally, this is mainly pointing out some overall trends using the available data, and, given the focus is on the welfare mix, should not be seen as an argument that welfare regimes should look different. The above can be used as an indication of the variations, but further more detailed studies need to be done. Nevertheless, it highlights that within Europe there are very diverse ways of providing LTC; not all attempts to systematize countries into different clusters give the same results. This has also been the case in welfare state analysis (Greve 2013), but also indicates that there are some similarities in analysis of clustering. Here group A is the one which fits the Nordic welfare state pattern B, C and D are close to the clustering presented at the beginning, although with some variation. It has, further to be taken into account the mentioned issued regarding data availability, and as an indication of the diversity in the way resourcing of long-term care is within a selected number of countries in Europe. The data collected in the SHARE project should also allow the care-mix for some of the countries involved in the SPRINT project to be further explored (see also Tinios and Georgiadis 2016).

Legal framework and core characteristics

This section will probe into and describe the legal framework with regard to long-term care, including actors involved in allocating long-term care and whether or not there are formal rules related to decision on rights to care. This has mainly been done by summarising the information from the Missoc-Information System, supplemented by national information. It will especially focus on issues regarding resourcing of long-term care, however in order to do this information on the system as a whole is needed. The framework description also gives some indication of which level is responsible for different parts of the long-term care system. A more detailed analysis of the legal framework of LTC will be presented in wp3. Annex 6 shows basic principles.

Annex 6 indicates the great variety of approaches among systems in the chosen countries. It is not always clear how and to what extent there is a split between long-term care for the elderly and for people with disabilities. With these caveats in mind, the table still provides a picture of how long-term care is structured and financed in Europe. There are formal universal systems financed out of general taxation, but also through insurance, including mandatory social insurance (Germany), and to varying degree user charges. Only two countries has benefits for informal carers (Hungary and

Finland). The organisation is very diverse, but often with a focus on a decentralised and local provision of benefits and services. There is a mix of in-kind and in-cash benefits.

In general, taxes (or obligatory social insurance) in combination with user charges is the most common form of resources for LTC. The information also indicates that the boundaries between long-term care and health care are not always very precise or illuminating. In Table 7 some specific issues related to long-term care are presented, including cash benefits and user charges.

Table 7: Legal framework and core characteristics of long-term care systems on 1 July 2016

Country	Providers	Home Care	Residential care	Cash benefits	User Charges
Nordic:					
Denmark	Mainly municipalities, but private care can be chosen by elderly people eligible for cleaning and personal care	Yes, if eligible	Only for the very frail elderly	Only when taking care of a dying relative and on the labour market	Yes, for meals on wheels, living in residential care, but not for home help and certain help remedies
Finland	State, but mainly provided by the local municipality	Yes, if eligible	Only for very frail elderly	Municipalities may use vouchers to finance some care especially short-term care offered for those receiving informal care.	Yes, although with regulation of what should be left to the individual
Central Europe:					
Belgium	Municipalities are the main provider	Yes, home nursing care and home care service	Yes, some as part of social assistance package	Some means tested cash-benefits for elderly with severe need for care	Yes; those not eligible for home care have to buy it privately
Germany	Social and long-term care insurance	Yes, by professional providers	Yes, in nursing homes if needed	Yes, a care allowance in order to take of a person in	There are user charges as the long-term care

	central			need. Statutory LTC is complemented by social assistance for uncovered expenses	insurance do not cover all costs
Liberal:					
UK	Mixed public, private and informal sector	Some by local authorities	Yes, some by local authorities	There are some types of allowances	Can vary. In UK people with assets above a threshold have to pay, and may vary around the country
Southern Europe:					
Greece	No, universal statutory scheme	Some home care based on need and means-tested	Some public nursing homes paid by the state, and also non-profit homes mainly run by the church	No	Unclear – however those not eligible due to the means test are expected to pay themselves
Italy	State, but limited	Limited – focus on cash	Very limited in residential care	Mainly cash-benefits – often financing migrant care	Yes, on top of the provision of cash-benefits
Portugal	Family is central, but some state formal provision	Very limited	A few institutions available	Some cash-benefits for those in need	User has to pay part of the costs
Eastern Europe:					
Hungary	Integrated into the health and social care system, but	Different types, including meals on wheels, alarm	Limited number of places	Limited	In some cases such as personal social care (social

	main part household or informal market	system			services) co-payments are required.
Lithuania	Mainly state, including with health care, municipality for home care	Home care from municipalities. Home nursing is also available from primary health care institutions via health care system (since 2008)	Some full and semi-residential care	Option for special compensation for nursing or care expenditures	On top of public provision
Poland	Family the main provider	Some specialist nursing services	Some day centres and homes	Nursing voucher	Some for medical spending; informal care is also paid/delivered on a private basis

Source: Own summary based on European Commission and the Social Protection Committee (2014) and information from the Sprint network.

Note: See annex 3 for more detailed information.

Table 7 paints a very varied picture, but with some clear tendencies. The Nordic and continental countries have formalized types of systems where the state (or municipalities) are dominant regarding financing and delivery of services. This applies to a lesser extent in the UK – although with devolution, there are differences between, for example, England and Scotland (Rodriques and Glendinning 2015; and for more on UK Devolution, *Social Policy & Administration*, vol. 46, no. 2). Eastern and Southern Europe relies much more on family and informal care and thus there is seemingly a north/west east/south divide. This is perhaps not surprising; however it underlines that formulating approaches for further looking into the possible impact and use of a social investment perspective can be difficult across countries.

5 Findings

Long-term care expenditure is expected to create pressure on welfare states' financing in the years to come (European Economy 2012), due among other things to demographic changes. However, it is not only cost implications that is important; there will be impacts on well-being for elderly people and their relatives, and also on employment in the care sector. Delivery of long-term care is often a mix, and examining the welfare mix between state, market and civil society, as in the previous section, is thus a good starting point for analysing this area (Daly 2012).

Many and varied reasons are given for the possible size of the pressure on long-term care cost. They include: demographic drivers (dependents), life expectancy at birth, health expenditure, non-demographic drivers, income, "cost disease", informal care supply (De La Maisonneuve and Oliveira Martins 2013). To this could be added trends in welfare states towards rehabilitation and enablement of elderly people that may reduce pressure on public sector spending in the longer run, but can be more expensive at the beginning. There are also issues in relation to measuring the impact of social investment. Below we present tentative possible impacts of different kinds of resourcing, including what needs to be analysed in order to achieve more detailed knowledge about the impact of using different approaches to deliver long-term care.

It is possible to list a set of expectations from the different varieties of delivery of long-term care; table 8 shows possible pros and cons of different ways of financing long-term care, based on received understanding of how different ways of financing welfare states can have an impact (Musgrave and Musgrave 1976), and how welfare mix influences access. As this schema makes clear, whatever solution is chosen there will always be positives as well as negatives.

Table 8: Possible impacts (pro and con) of a set of varieties of financing long-term care

	Pro	**Con**
Universal tax-financing	Can ensure universal access based on decided criteria; the individual elderly person is not dependent on family/friends	Might be difficult to finance and be limited in provision
Social insurance	Ensures that those in the social insurance can collectively finance long-term care	Only those covered by social insurance get care. Risk of insufficient financing
Individual insurance, including reverse mortgage	Ensures that individual preferences for care is reflected in the size of insurance	Only those who can afford to take out insurance or own a house will be covered. Risk of high inequality in access to

		care. Risk of adverse selection and moral hazard
Delivery by civil society, including family (informal care supply)	Close; the individual knows the carer; no need of administration	Some may not receive care; reduction in labour supply (especially of women); inequality in level of care
User charges/self-based financing	Might reduce need for financing from other sources and better reflect preferences among users	Risk of inequality in access and high burden on those specifically in need of long-term care (compared to for example, health care) as not all will be able to fully or partly finance their care

Source: Own summary following Greve (2010a)

Table 8 reflects the many and very diverse theoretical approaches. They can further be interlinked considering fiscal welfare, when expenditures for long-term care are deducted within the tax–system, reducing the tax to pay, and thereby indirectly supporting long-term care. This underlines the large variety in the way long-term care is financed, and in access to care.

The quality of the delivery of different kinds of long-term care can also have an impact on care. However, this will need a more specific analysis of the concrete delivery of service and in principle, this can be an impact on service from state, market or civil society. Thus financing *per se* need not have an impact on quality, but might have also depend on how quality in long-term care is defined and understood. Furthermore, it is often so that "evidence of validity and reliability of these instruments is often lacking" (Leichsenring *et al*. 2013, p.173). Thus a specific issue besides the choice of financing instruments is how to measure and evaluate quality of the specific provision (see for example Bulamu *et al*. 2015) (OECD 2013). This, as mentioned above, is not the focus here, but in a broader framework needs to be taken into consideration. Other studies confirm that many interventions have limited or no evidence-based information (Billings 2013).

The possible impacts on well-being and quality of life of elderly people will also need further and more detailed analysis given that there is no simple way to compare and measure quality of life or assess the interaction between, for example, family support and welfare state support. However, it seems clear that there is a possible risk of a negative impact on well-being dependent on the size and impact on the quality of life on those delivering the informal care (Verbakel 2014). The possible impact of welfare states' delivery of long-term care on quality of life is difficult to measure as we would need to have data both before and after the welfare state intervention, and a proper study design with both a treatment and control group. However, there is a risk of lower level of labour market attachment and reduced productivity especially for those between 45 and 65 years of age (often women) who take care of or help in the care of a dependent relative (Prieto

2011). Taking care of a person with dementia might further imply a strong negative impact on the quality of life for the carer (Triantafillou *et al*. 2010). Care-giving can be more stressful in that it is not seen as volunteering, but embedded in social norms of what a family member should do (Heger 2014).

Informal care appears to be one of the areas with the largest differences among the EU-member states and there are also differences in the reliability and validity of data in the area, including what type of support is delivered and also interactions with LTC professionals (Triantafillou et al., 2010). Those with few children, or living a long distance from parents, for example, might get less support than others.

Most people in need of care prefer to stay at home where possible and this invites debate on how then to deliver the best long-term care to meet this preference. Ethical issues related to the delivery of informal care also arise (Leichsenring *et al*. 2013). Part of the attempt to support people staying at home has been an increase in the use of rehabilitation, enablement and prevention (Kümpers *et al*. 2010). These need to be further analysed in the context of social investment in long-term care.

Voluntary support appears not to be matching the increasing demand for long-term care and it has become more difficult to attract volunteers into the field (Angermann and Sittermann 2010).

An increasing concern is the possible opportunity cost of long-term informal care, "the impact on labour market and productivity, as well as on carers' health status itself" (European Economy, 2012, p. 197). This report also foresees a decline in informal care and consequent possible increased pressure on the support of welfare states for long-term care.

Overall, it seems that stronger state involvement with universal funding systems would ensure more equality, and, that reliance on market provision less (Fernandez, J. et.al. ,2009), this being a further good reason for the use of macrodata on the financing of long-term care. Furthermore, that reliance on family support might not be available for all. Thus performance, understood of equity in access (Barr 2010), of the universal welfare states with higher level of spending can be expected to be better than in countries within the other welfare state regimes, albeit with differences also between the other regimes.

Social investment in LTC might thus alleviate possible shortfalls in care and improve its quality, and also reduce pressure on public sector spending. This will be part of further work and exploration in wp4 and wp5.

However, based on the existing approaches in the varied welfare states one can argue that for all countries social investment in long-term care might help in reducing the future pressure on long-term care due to ageing. Investment in prevention, rehabilitation and re-enablement can be one way of reducing dependency among older people.

Social investment might help further by making it possible for younger informal carers in particular to continue or stay in the labour market, by reducing the need for them to spend time in caring.

In current systems relying on informal care – especially in eastern and southern Europe – social investment is likely also to result in better quality of care and better well-being for elderly people.

In northern welfare states the same will apply, and at the same time overall spending might be reduced. In liberal and continental welfare states we could expect the similar effects on informal care and therefore the possibility of some reduction in state spending.

6 Conclusions

Long-term care is an area with growing pressure on financing, and one of the areas with the largest differences among the European welfare states, ranging from universal financing and state influence to systems with a high focus on the family and informal care.

Some of the differences are historically determined by an approach to care and some are due to difference in the state's role in the financing and delivery of goods and services in the different welfare states. The many and very varied approaches discussed here implies that analysis of the impact of using different ways to support and deliver long-term care must take into account these differences of availability and use of resources. A possible impact on carers' labour market attachment is also raised as an issue.

How to measure quality and how to measure different kinds and types of intervention in order to provide long-term care has not been discussed in detail in this report given the focus on financial structures. However, in order to be able to understand the social investment perspective it will be necessary to be clear about how to define and measure quality. This also includes the aspects of rehabilitation, re-enablement and prevention.

Social investments for long-term care will include new ways to cope with the pressure on long-term care due to demographic changes, including the use of welfare technology.

Performance, in the different LTC-system, using equity in access as benchmark, can be expected to be better in the more universal and comprehensive welfare states, than in welfare states relying mainly or more on informal care. This still, do not imply that informal care is not important, it can, especially for women, be at the risk of low level if at all any care.

7 References

Angermann A. and Sittermann, B. (2010), Volunteering in the member states of the European Union – Evaluation and Summary of Current Studies. Working paper no. 5, of the Observatory for Sociopolitical Developments in Europe.

Barr, N. 2010. Long-term Care: A Suitable Case for Social Insurances. Social Policy and Administration 44(4): 359–374.

Billings, J. (2013), Improving the Evidence Base in Leichsenring, K. Billings, J and Henk, N., Long-Term Care in Europe: Improving Policy and Practice, Palgrave, Macmillan pp. 299-324

Billings, J. Leichsenring, K. and Wagner, L. (2013), Addressing Long-Term Care as a System – Objectives and Methods of Study in Leichsenring, S. et al. (eds), *Long-Term Care in Europe. Improving Policy and Practice*, Palgrave, MacMillan.

Bode, I, Gardin, L. and Nyssens, M. (2011), Quasi-Marketisation in domiciliary care: varied patterns, similar problems?, International Journal of Sociology and Social Policy, vol. 31, iss. 3/4, 222-235.

Bulamu, N. Kaambwa, B. And Ratcliffe, J. (2015), A systematic review of instruments for measuring outcomes in economic evaluation within aged care. Health and Quality of Life Outcomes, 13:179, pp. 1-23, DOI 10.1186/s12955-015-0372-8.

Castles, F. et. al. (eds) (2010) *The Oxford Handbook of the Welfare State.* Oxford: Oxford University Press.

Claid Dale, M. et al. (2013), Financing of Long-term care and Long-term Care Insurance for the Aged: A Literature-based comparison of Seven OECD-countries, RPRC Working Paper 2012, 2.

Colombo, F. (2011), Typology of Public Coverage for Long-Term Care in OECD Countries in Costa-Font, J, Courbage, C. Christophe, J. (eds) (2011), Financing Long-Term Care in Europe: Institutions, Market, Basingstoke, Palgrave Macmillan.

Colombo, F. and Mercier, J. (2012) Help Wanted? Fair and Sustainable Financing of Long-Term Care Services, Applied Economic Perspectives, pp. 1-17.

Costa-Font, J and Courbage, C. (2011), Financing Long-Term Care: New and Unresolved Questions in Costa-Font, J, Courbage, C. Christophe, J. (eds) (2011), Financing Long-Term Care in Europe: Institutions, Market, Basingstoke, Palgrave Macmillan.

Costa-Font, J. et al. (2015), Financing Long-Term Care: Ex Ante, Ex Post or Both? Health Economics, vol. 24, pp. 45-57.

Daly, M. (2012), Making policy for care: experience in Europe and its implications in Asia. International Journal of Sociology and Social Policy, vol. 32, no. 11/12, pp. 623-635.

De La Maisonneuve, C. and J. Oliveira Martins, 2013: "A projection method for public health and long-term care expenditures", Economics Department Working Papers No. 1048, OECD, Paris.

Doty, P., Nadash, P. and Racco, N. (2015), Long-Term Care Financing: Lessons from France. The Milbank Quarterly, vol. 93, no. 2, pp. 359-391.

European Commission and the Social Protection Committee (2014), Adequate social protection for long-term care needs in an ageing society. Brussels, European Union.

European Commission (2015), "The 2015 Ageing Report: Economic and budgetary projections for the 28 EU Member States (2013-2060)", Annex 1: "Statistical Annex - Cross-country tables", Brussels, European Commission: http://ec.europa.eu/economy_finance/publications/european_economy/2015/ee3_en.htm.

European Commission (2016), Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability. Volume 1, Luxembourg, Publication of the European Union.

European Economy (2012), The 2012 Ageing Report: Economic and Budgetary projections for the EU27 Member States (2010-2060). Brussels, European Commission.

Fernandex, J. et. al. (2009), How can European States design efficient, equitable and sustainable funding systems for long-term care for older people? Copenhagen, WHO.

Greve, B. (ed.), (2010), Choice. Challenges and Perspectives for the European Welfare States. Oxford, Wiley-Blackwell.

Greve, B. (2010a), Taxation, equality and social cohesion European experiences in Zupi and Puertas (eds.), Challenges of social cohesion in times of crisis: Euro-Latin American Dialogue. Madrid, FIAPP.

Greve, B. ed. (2013), The Routledge Handbook of the Welfare State. Oxon, Routledge.

Greve, B. (2015), Welfare and the Welfare State, Oxon, Routledge.

Greve, B. (2017), Long-term care for the Elderly in Europe. Oxon, Routledge.

Heger, Dörte, (2014), Work and well-being of informal caregivers in Europe. Ruhr Economic Papers 512.

Johansson, E. (2010), The Long-Term Care System for the Elderly in Finland, Ancien, European Network of Economic Policy Institutes.

Klavus, J. et al. (2011), Governance and Financing of Long-Term Care for Older People – National Report Finland, Interlinks, Helsinki.

Kümpers, S. et.al. (2010), Prevention and rehabilitation within long-term care across Europe. Interlinks.

Leichsenring, K. Nies, H, Veen, R. v. (2013), The Quest for Quality in Long-term Care in Leichsenring, S et al. (eds), Long-Term Care in Europe. Improving Policy and Practice, Palgrave, MacMillan.

Leichsenring, K. Billings, J. and Henk, N. (2013), Improving Policy and Practice in Long-Term Care in Leichsenring, K. Billings, J and Henk, N., Long-Term Care in Europe: Improving Policy and Practice, Palgrave, Macmillan pp. 325-336.

Lipszyc, B., Sail, E. and Xavier, A. (2012): "Long-term care: Need, use and expenditure in the EU-27". European Commission, Directorate-General for Economic and Financial Affairs. Economic Papers 469 | November 2012.

Meagher, G. and Szebehely, M. (ed) (2013), Marketisation in Nordic eldercare: a research report on legislation, oversight, extent and consequences, Stockholm, University of Stockholm.

MISSOC (2014), Cost Sharing for Health and Long-Term Care Benefits in Kind, Missoc.

MISSOC (2015), MISSOC Comparative Tables Database, "Table III.1.113":

http://www.missoc.org/MISSOC/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTableSearch.jsp.

Musgrave, R. and Musgrave, P. (1976), Public Finance in Theory and Practice, 2nd Edition, London, McGraw-Hill.

Nadash, P. et al. (2012), European Long-Term Care Programs: Lessons for Community Living Assistance Services and Supports? Health Service Research, vol. 47, no. 1 pp. 309-328.

OECD (2013), A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care, OECD Health Policy Studies, Paris, OECD.

OECD (2013a), Public spending on health and long-term care: a new set of projections. OECD Economic Policy Papers no. 6, Paris, OECD.

OECD (2015a): "Health Expenditure and Financing". Data extracted on 16 Oct 2015 08:11 UTC (GMT) from http://stats.oecd.org/

OECD (2015b): "Long-Term Care Resources and Utilisation". Data extracted on 16 Oct 2015 08:11 UTC (GMT) from http://stats.oecd.org/.

Pickard, L. et. al. (2011), The Supply of Informal Care in Europe. ENEPRI Research Report No. 94. ENEPRI and Ancien.

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

Pestiau, P. and Ponthiere, G. (2011), Long-Term Care Insurance Puzzle in Costa-Font, J, Courbage, C. Christophe, J. (eds) (2011), Financing Long-Term Care in Europe: Institutions, Market, Basingstoke, Palgrave Macmillan.

Prieto, C. (2011), Informal Care, Labour Force Participation and Unmet Needs for Formal Care in the EU-27, Croatia and Turkey, Enepri Research Report no. 97.

Rodriques, R. and Glendinning, C. (2015), Choice, Competition and Care – Developments in English Social Care and the Impacts on Providers and Older User of Home Care Services. Social Policy & Administration, 49: 649–664.

Swartz, K. (2013), Searching for a balance of Responsibilities: OECD countries changing Elderly Assistance Policies. Annual Review of Public Health, vol. 34, pp. 397-412

Stiglitz, J.E. og J.A. Rosengard (2015) Economics of the Public Sector, 43. udg. New York: W. W. Norton & Company.

Tinios P, Georgiadis T (2016) *Benchmarking Long Term care in Europe: Exploring the SHARE Data*, SPRINT Working Paper 1, University of Piraeus Research Centre, Brussels and Piraeus.

Triantafillou, J. Et. Al. (2010), Informal care in the long-term care system, Athens, Vienna, Interlinks.

Urry, J. (1981), The Anatomy of Capitalist Societies, the Economy, Civil Society and the State, London, Macmillan.

Waldhausen, Anna (2014), Care services in crisis? Long-term care in times of European economic and financial crisis, Observatory for Sociopolitical Developments in Europe (www.socipolitical-observartory.eu)

Verbakel, E. (2014), Informal caregiving and well-being in Europe: What can ease the negative consequences for caregivers? Journal of European Social Policy vol. 24(5), pp. 424-441.

8 Annexes

Annex 1: Development in spending on long-term care in all EU-countries since 2000

GEO/TIME	2000	2005	2010	2013
Belgium	-	1.71 (1.87)	2.14 (2.34)	2.29
Bulgaria	-	(0.16)	(0.01)	-
Czech Republic	0.21	0.22 (0.23)	0.26 (0.27)	0.29
Denmark	1.89	2.20 (2.26)	2.55 (2.61)	2.50
Germany	1.30	1.43 (1.35)	1.53 (1.44)	1.58
Estonia	0.00	0.15	0.27 (0.28)	0.31
Greece	-	-	0.06	0.11
Spain	0.13	0.82 (0.84)	1.08 (1.12)	-
France	1.06	1.31 (1.42)	1.19 (1.23)	1.30
Croatia	-	-	-	-
Cyprus	-	(0.16)	(0.19)	-
Latvia	-	0.18 (0.38)	0.36	0.06
Lithuania	-	0.64 (0.65)	1.13 (1.15)	0.91
Luxembourg	1.14	1.60 (1.57)	1.42 (1.50)	-
Hungary	0.14	0.31 (0.32)	0.64 (0.65)	0.30
Netherlands	0.80	3.38 (3.38)	3.83 (3.74)	4.29
Austria	1.21	1.28	1.50 (1.53)	1.48
Poland	-	0.43	0.43	0.37
Portugal	0.09	0.09	0.15 (0.16)	-
Romania	-	(0.52)	(0.76)	-
Slovenia	-	1.04 (1.10)	1.18 (1.29)	1.30
Slovakia	-	0.03	0.03	0.02
Finland	1.70	2.01 (2.10)	2.44 (2.54)	2.58
Sweden	0.60	3.34 (3.54)	3.38 (3.59)	3.36
Ireland	-	-	-	-
United Kingdom	-	-	-	-
Italy	-	-	-	-
Malta	-	-	-	-

Source: OECD 2015a, Eurostat.

Note: The data in parenthesis is from 2012 Joint OECD-Eurostat-WHO SHA questionnaire rather than from the more recent version from 2015 (which OECD uses).

Annex 2: Health care expenditure on long-term care as percentages of GDP

ICHA_HC * Services of long-term nursing care

Country/Year	2005	2010
Belgium	1,87	2,34
Denmark	2,26	2,61
Germany	1,29	1,38
Greece	:	0,06
Lithuania	0,24	0,62
Hungary	0,32	0,32
Poland	0,40	0,41
Portugal	0,09	0,16
Finland	1,01	0,96
UK	:	:

ICHA_HC Social services of LTC (LTC other than HC.3)

Country/Year	2005	2010
Belgium	:	:
Denmark	:	:
Germany	0,06	0,07
Greece	:	0,00
Lithuania	0,41	0,53
Hungary	:	0,33
Poland	0,03	0,03
Portugal	:	:
Finland	1,09	1,58
UK	:	:

ICHA_HC Long-term care (HC.3 and HC.R.6.1)

Country/Year	2005	2010
Belgium	1,87	2,34
Denmark	2,26	2,61
Germany	1,35	1,44
Greece	:	0,06
Lithuania	0,65	1,15
Hungary	0,32	0,65
Poland	0,43	0,43
Portugal	0,09	0,16
Finland	2,10	2,54
UK	:	:

Special value: : not available

Source: Eurostat, hlth_sha_ltc

Note: * See Annex 5 for category abbreviations and definitions of long-term care expenditures

Annex 3: More detailed information on important elements in the national systems

Country	Providers	Home care	Residential care	Cash benefits	User charges
Nordic:					
Denmark	Primarily municipalities, but private companies can also provide cleaning and personal care to eligible elderly people, if the recipient chooses.	Yes, if eligible. Includes personal hygiene, domestic help, "meals on wheels" (food service) and assistance to a person to maintain his/her capacities (rehabilitation).	If the recipient cannot be sufficiently supported by home care, the municipalities must provide them with temporary or permanent residential care, dependent on the need of the recipient.	No specific cash benefits. Furthermore, if employed, the relative of a person in terminal situation, can receive in-cash benefits for up to six months (can be extended for three months).	Some for meals on wheels, living in a residential care, but not for home care and certain help remedies
Finland	Municipalities are responsible for services, which can be provided by the municipality itself, by joint municipal authorities or based on a contract with a private service provider, by service voucher	Home services and services for the disabled, as well as support for informal care. Includes home help and home nursing, meals on wheels, cleaning services, transport services, day centres etc. and personal assistance.	Statutory institutional care services include services provided in homes for elderly people, in inpatient wards and in care units for people with intellectual disabilities.	Pensioners' care allowance, Pensioners' housing allowance and Disability allowance. All in-cash benefits dependent on the financial situation and severity of the recipient's situation.	Some services are free of charge (for example services related to disabilities), others require a user fee (max 85% of the costs and the recipient must have €97 left (Klavus et. al., 2011, p. 10)). Fees vary depending on the user's type

					of care, household size, family composition and income (including spouse's income) (Johansson, 2010 p. 5).
Central Europe:					
Belgium	Organized by insurance primarily orchestrated via the government	Nursing care at home for heavily dependent patients. Insurance covers part of the fixed cost of this care according to the state of the patient. The state of the patient also determines the duration of the service.	Sickness and invalidity insurance provides rest and nursing homes, psychiatric nursing homes and rest homes for the elderly.	Several of types of in-cash benefits: Sickness and invalidity insurance (€20 per day, after four months without work). Care insurance (fixed monthly amount of €130 for community-based and home care), Integration allowance and allowance for assistance to the elderly (both yearly allowances dependent on which category the recipient belongs to).	Primarily no participation, besides payment of annual insurance contributions. Possible increase in fee if beneficiary of the increased reimbursement scheme.
Germany	Local, non-profit or private enterprises, as well as informal caregivers provide the	Monthly benefits in kind (basic care, domestic help and care by outpatient care	Lump-sum payment of the costs for care, medical care treatment and social care	Statutory long-term care insurance for recipients, who provide the care	Not all costs relating to care are covered under the statutory LTC insurance. If

	actual care. The insurance fund must ensure proper LTC quality and coverage for its beneficiaries.	centres or individual carers) corresponding to the recipient's dependency category.	expenses as a monthly benefit in kind corresponding to the recipient's dependency category.	themselves. Dependent on the recipient's category of need. People with special needs can get additional benefits.	the total expenses of long-term care of a single person exceed the covered amount, the person pays the difference as participation. Only about half of the costs relating to care are covered under the statutory LTC insurance. AN individual has to pay the excess costs or apply for special social assistance benefits.
Liberal:					
UK	Organized through a mixture of the public, private, voluntary and informal sector.	Local authorities can provide homecare, meals on wheels and special aids and equipment. .	Local authorities can arrange admission to residential and nursing homes..	Attendance Allowance (€68-102 a week), Disability Living Allowance (€27-102 a week), mobility needs (€27-71 a week) and Personal Independence Payment (€68-102 a week).	For residential care in England, people with assets (including the value of the family home) over €29,075 receive no financial state support and have to fund their own care. The level and type of state support for people with assets below this threshold depends on

					their needs and income. People who receive non-residential care from the local authority have to pay reasonable charges, depending on ability to pay and at the discretion of the local authority..
Southern Europe:					
Greece	State-operated units for long-term care, for-profit and non-profit units of private sector, as well as the informal sector.	Part of the primary social care services, providing nursing care, social care services and domestic assistance to older people who cannot take care of themselves sufficiently.	Three types of residential care: 1) Social Welfare Centres for people with disabilities or under rehabilitation, hospitalization and medical services. 2) Elderly Care Units, often provided by charitable associations, the church or local authorities. 3) Supported living houses for people with disabilities and help to reintegrate them.	Two main types of benefits: 1) Non-residential care, which is a benefit in the form of rental fee, paid to uninsured and financially weak elderly people over 65 years who live alone or in a couple and do not own a house). 2); Invalidity benefit for people with various forms of disabilities.	The user primarily pays for elder care units privately. The beneficiary also covers a part of the cost in regards to nursing homes for the chronically ill.

Italy	Public actors such as doctors and paramedical professionals, as well as institutions for residential or semi-residential care and informal caregivers (household members or other people close to the beneficiary).	Home care … include[s] home help, meal delivery, medical treatment and nursing care. No limits to the duration of home care.	Residential care is provided for in the most serious cases. The length of the stay varies according to the seriousness of the situation of dependency. An alternative is day care centres, only open during daytime.	Benefits for various types of disabled people.	Contribution of the beneficiary takes the form of a co-payment, the amount of which varies according to the type of the benefit and the degree of invalidity.
Portugal	Professional providers from organizations such as hospitals, health centres, district social security centres, private social solidarity institutions, NGOs, local authorities and for-profit organizations, as well as informal caregivers.	Daily care, personal comfort, cleaning, meal delivery, accompaniment during medical visits etc. is provided without time limitation. Temporary or permanent integration of elderly persons or disabled adults in foster families, which ensure that their basic needs are met.	Residential facilities for elderly people who are or risk becoming severely dependent, as well as other institutions for various types of patients in need of LTC. Various forms of day and night care centres also exist.	Various forms of cash benefits, primarily through social insurance, to guarantee sufficient resources to recipients in need of permanent assistance from a third party. The recipient must receive less than €600 via pensions. Allowance for assistance by a third party to people with various forms of disabilities, survivors or parents of children in need of	Participation varies in regards to the services provided by the social security system and National Health Service according to the income of the recipient or their family and the level of care and dependency.

				assistance.	
Eastern Europe:					
Hungary	Informal caregivers, NGOs, local government and churches.	Home care is provided to persons being unable to care for themselves in their home and there is no one to care for them.	Residential care is provided in four types of institutions: a) care facilities providing nursing and care, b) institutes of rehabilitation, c) residential care homes, d) institutes providing temporary placement, as well as through e) supported living.	No cash benefits for recipients of LTC. However, there is a nursing fee - payable to persons who provide long-term care to a disabled or permanently ill relative.	In some cases such as personal social care (social services) co-payments are required. This is determined individually, but must not exceed a percentage of the user's income
Lithuania	Family, foster family members, volunteers, other relatives and persons. Professional providers such as social workers, community nurses and nurses for general practice.	Provided by primary health care institutions; people in need of care at home are regularly visited by social workers from local social assistance administration and they determine the need for social care.	Residential care is provided for children without parental care, children and adults with disabilities and elderly people, in foster families and social care houses (old-age homes, housing for disabled, specialised social care homes, etc.).	Benefits in support of disabled children with a severe degree of disability, to disabled persons with a reduction in capacity for or to the persons of retirement age if they have a need for permanent care. The amount is limited to a certain percentage of the social	All long-term care recipients have to contribute with co-payments. The amount depends on the kind of long-term care and the financial situation (income and property) and dependency conditions of the recipient.

				insurance basic pension depending on the category of the recipient.	
Poland	Especially informal caregivers, but also various professional providers.	Bedridden and patients with chronic conditions who stay at home and who require systematic nursing services due to existing health problems may receive long-term nursing care at home.	Various forms, especially support centres and social assistance houses.	Various benefits for disabled children, special attendance, as well as for adults incapable of work due to age or disability, fulfilling an income criterion. Also earmarked allowance (to cover expenses, very individually based) and Periodic Allowance, awarded to chronically sick, fulfilling an income criterion.	Social assistance house requires co-payment by recipient and (if willing) family (max 70% of income). The family is liable if the recipient cannot make the payment. Care services from social assistance centres are paid. The amount of payments depends on the income per person in the family. Partial or total exemption from such payments is possible in exceptional cases. People whose income is equal to, or lower than the income criterion are exempted from payments.

Source: MISSOC, 2014 is the main source, however also information from partners in SPRINT.

Annex 4: Financing arrangements for long-term care for selected countries in the EU

Belgium No single, discrete long-term care scheme.

Denmark No single, discrete long-term care scheme. Financed by local authorities as a part of health care and social services. State pays a subsidy to municipalities for their social and health services.

Finland No single, discrete long-term care scheme. Financed by local authorities as a part of health care and social services.

Germany Contributions (insured persons and employers) and taxes. Since 1 January 2013, state support for private long-term care provision contracts to supplement the statutory long-term care insurance; payment of max. €60 per year for supplementary long-term care insurance.

Greece No single, discrete long-term care scheme.

Hungary No single, discrete long-term care scheme. Benefits in kind financed by (general and local) taxes.

Italy No single, discrete long-term care scheme.

Lithuania No single, discrete long-term care scheme. Financed by the municipalities and state as a part of health care and social services.

Poland No single, discrete long-term care scheme. Financed by state budget as part of health care and social security.

Portugal Tax-financed.

United Kingdom No single, discrete long-term care scheme. Social care for the elderly and disabled provided by local authorities, private and charitable organisations. Full cost of care benefits for severely disabled people (Attendance Allowance, Disability Living Allowance and Personal Independence Payment) financed by the state.

Source: Based on MISSOC. Source: Commission services (DG ECFIN), here from European Commission, 2016.

Annex 5: Information on definition of long-term care expenditures

Organization	Reference	Definition of long-term care expenditure
Organisation for Economic Co-operation and Development	(OECD, 2015a)	*HC.3; HC.R.6.1 Total long-term care expenditure:* Expenditures on long-term care (total, public, private). The sum of "Expenditure on long-term nursing care" and "Expenditure on social services of LTC". *HC.3 Expenditure on long-term nursing care:* Long-term health care comprises ongoing health and nursing care given to in-patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. In-patient long-term care is provided in institutions or community facilities. Long-term care is typically a mix of medical (including nursing care) and social services. Only the former is recorded in the SHA under health expenditure. *HC.R.6.1 Expenditure on social services of LTC:* This item comprises services of home help and residential care services: care assistance which are predominantly aimed at providing help with instrumental activities of daily living (IADL) restrictions to persons with functional limitations and a limited ability to perform these tasks on their own without substantial assistance, including supporting residential services (in assisted living facilities and the like). Home help or, more generally, help with IADLs (such as help with activities of home making, meals etc., transport and social activities) may be provided and remunerated as integrated services with long-term nursing and personal care services. In these cases, an effort should be made to estimate expenditure on these items separately. When disaggregation of these spending items is not possible, experts should decide – based on the dominant character of the particular programs – whether these cases are reported under HC.3.3 or HC.R.6.1. When it is not possible to judge the dominant character of the programs concerned, it is proposed to report this expenditure under HC.R.6.1. However, when a country has already established a practice of reporting this expenditure

		under HC.3.3, it is proposed not to change this practice until the envisaged revision of the ICHA-HC. Includes: subsidies to residential services (including costs of accommodation) in assisted living arrangements and other kinds of protected housing for persons with functional limitations (including residential services to people with mental retardation, mental illness or substance abuse problems and homes for the physically and mentally handicapped); services of housekeeping, social services of day care such as social activities for dependent persons; transport to and from day-care facilities or similar social services for persons with functional limitations. Excludes: all services which are predominantly related to providing assistance with activities of daily living (ADL) included in the function HC.3: Long-term nursing Care. Also excludes: Services of surveillance of persons with mental deficits such as dementia patients; medical and services of assessment, case management and co-ordination between health and long-term care services (included under HC.3). Also excludes: meals on wheels. The reason for excluding meals on wheels is more practical than theoretical: difficulties in separation of spending on meals on wheels for persons with functional limitations from spending on meals on wheels due to other reasons. Excludes: services that aim predominantly to combat social isolation rather than protecting persons with functional limitations (body/mental functioning). This is the case in particular for services and/or living arrangements where eligibility criteria explicitly require recipients to be without health impairing chronic conditions, which would require substantial help with IADL or ADL restrictions. Expenditure on these services should be excluded even from HC.R.6.
Eurostat	-	*Current expenditure on long- term care (HC.3 plus HC.R.6)* Long-term health care comprises ongoing health and nursing care given to in-patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. In-patient long-term care is provided in institutions or community facilities. Long-term care is typically a mix of medical (including nursing care) and social services. Only the former is recorded in the SHA under health expenditure. *HC.3.1 In-patient long-term nursing care* This item comprises nursing care delivered to in- patients

		who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. In-patient long-term nursing care is provided in institutions or community facilities. Long-term care is typically a mix of medical and social services. Only health care services are recorded in the SHA under personal health care services. *Includes:* long-term health care for dependent elderly patients. This includes respite care and care provided in homes for the aged by specially trained persons, where medical nursing care is an important component. This type of care can be provided in combination with social services that should, however, be recorded separately, as they are not part of expenditure on health in the SHA. This includes hospice or palliative care (medical, paramedical and nursing care services to the terminally ill, including the counseling for their families). Hospice care is usually provided in nursing homes or similar specialised institutions. Also included is in-patient long-term nursing care for mental health and substance abuse patients where the care need is due to chronic or recurrent psychiatric conditions as defined by the list provided in ICD-9-CM, code 94. *HC.3.2 Day cases of long-term nursing care* This item comprises nursing care delivered to day cases of patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. Day-care nursing care is provided in institutions or community facilities. *Includes:* day cases of long-term nursing care for dependent elderly patients. *HC.3.3 Long-term nursing care: home care* This item comprises ongoing medical and paramedical (nursing) health care provided to patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of in- dependence and activities of daily living. This type of home care can include social services such as homemaking and “meals on wheels” which should, however, be recorded separately, as they are not part of expenditure on health.

		HC.6 Prevention and public health services Prevention and public health services comprise services designed to enhance the health status of the population as distinct from the curative services, which repair health dysfunction. Typical services are vaccination campaigns and programmes. Note: prevention and public health functions included in the ICHA-HC do not cover all fields. Maternal and child health in the ICPM public health in the broadest sense of a cross-functional common concern for health matters and public actions. Some of these broadly defined public health functions, such as emergency plans and environmental protection, are not part of expenditure on health. The most important of these public health functions are classified under various health-related functions in the ICHA-HC. A cross-classification of public health functions according to a broad WHO list of Essential public health functions (EPHFs, see Bettcher (1998)) with ICHA-HC and COFOG (United Nations, 1998b).
European Commission	(Lipszyc, Sail and Xavier, 2012)	The notion of long-term health care services usually refers to services delivered over a sustained period of time, sometimes defined as lasting at least six months. Public expenditure on long-term care is defined, according to the System of Health Accounts classification, as the sum of the following publicly financed items: • Services of long-term nursing care (HC.3) (which is also called "the medical component of long-term care" or "long-term health care", and includes both nursing care and personal care services), and • Social services of long-term care (HC.R.6.1), which is the "assistance services" part, relating primarily to assistance with IADL (instrumental activities of daily living) tasks. These components mainly represent the in-kind benefits allocated to dependent people. In addition, projections on long-term care also cover public spending on cash benefits. The cash benefits include social programmes offering care allowances, addressed to persons with long-

European Commission	(European Commission, 2015)	term care needs who live in their own homes. However, the design of these programmes varies widely across countries, which reduces the comparability between them. Illustrating this variety of systems, it is noteworthy that some countries account for nursing allowances in the HC.3 category. Yet, while the total public expenditure on long-term care comprises both in-kind and cash benefits, public expenditure on cash benefits is projected separately from expenditure on long-term care services provided "in kind" – at home or in the institutions. As agreed, and detailed in European Commission (2011), the data from the two databases (SHA and ESSPROS) have been combined as follows: 1) *In-kind public expenditure on long-term care* For the 23 EU Member States using SHA joint questionnaire data, public expenditure on LTC is computed as the sum of the above-mentioned SHA categories: long-term nursing care (HC.3) and related social services in kind (HC.R.6.1). Data by category are available on both the OECD Health Data and Eurostat Cronos. Most recent data by category refers to 2009. For those countries not using the SHA joint questionnaire or not reporting HC.R.6, proxies have been calculated on the basis of ESSPROS data. 2) *Long-term care related cash benefits* Long-term care related cash benefits are reported within two ESSPROS functions: "Disability" and "Old Age". Thus, both periodic and lump-sum parts of care allowances and economic integration in the Disability function, as well as periodic care allowance in the Old Age function are generally added, as cash benefits, to the HC.3+HC.R.6.1 sum or to the correspondent ESSPROS sum as calculated above. Moreover, the SHA joint questionnaire data by sub-categories of long-term nursing care (HC.3) – i.e. inpatient, day cases, and home care – and ESSPROS data by type of benefits in kind are used to identify the two components of total public expenditure: home care and institutional care. We then proceed to calculate the part of HC.R.6.1, which constitutes home care, and the part, which constitutes institutional care, through proxies calculated on the basis of the ESSPROS data.

Annex 6: Basic principles in LTC for elderly people in selected EU countries, January 2016

Country	Basic principles
Nordic:	
Denmark	Universal separate and tax-financed scheme. Every resident is entitled to in-kind personal and practical assistance if s/he cannot perform the basic personal and practical activities autonomously, regardless of ability to pay. The system of care services is decentralised: the responsibility for the provision of personal and practical assistance and necessary accommodation rests with the local authorities. They must consider all requests for personal and practical assistance. The decisions of the local authorities must be based on a specific and individual assessment of the need for assistance. Complaints about decisions on personal and practical assistance must be addressed to the National Social Appeals Board. Benefits for informal carers exist.
Finland	There is no single long-term scheme. Long-term care is provided through general social welfare and health care legislation which is supplemented by special legislation (for example on services for older people and on services for people with disabilities). Universal schemes financed by taxes and client fees depending on scheme, provided to all residents, irrespective of their economic status. Both benefits in-kind and cash benefits available. Municipalities are responsible for arranging the social and health services (including support for informal care) that their population requires and as stipulated by legislation. Specific benefits exist for informal care.
Continental Europe:	
Belgium	Sickness and invalidity insurance: Compulsory social insurance scheme for employees. Care insurance (Zorgverzekering/Assurance soins): The Flemish care insurance was created by the Flemish government in addition to the existing social security system. The care insurance confers entitlement to have a care insurance fund take responsibility (in the form of a monthly benefit) for the paying of certain costs connected with the provision of assistance and services of a non-medical nature. Affiliation is compulsory in the Dutch speaking regions and voluntary in the bilingual Brussels-Capital region. Social assistance scheme organised at a federal level.
Germany	Statutory long-term care insurance (Gesetzliche Pflegeversicherung): Since 1995 risks concerning the need for long-term care have been protected against by long-term care insurance (Pflegeversicherung), which has been created as an independent social security and exists alongside the social securities to protect against the risks of sickness, accident, unemployment and

	old age. The long-term care insurance (Pflegeversicherung) was codified in the Social Code (Sozialgesetzbuch) Eleventh Book. The long-term care insurance is in its basic idea and its legal form only a "core protection system", which is liable for any care-related expenses. The service guarantee of nursing care lies with the insurance funds. The federal states are responsible for infrastructure, planning and promotion tasks. It is a contribution financed compulsory independent social insurance scheme, in accordance with compulsory affiliation and sickness insurance limits. As from 2015, any funds equivalent to 0.1 contribution rate points, will be saved in one of the retirement funds managed by the federal bank. This will stabilize the contribution rate from 2035 onwards, when the baby boom generations grow into age groups with an increased risk of nursing care. Furthermore the option to take out private supplementary insurance plans for long-term care is given to every citizen. Since 1 January 2013, taking out a voluntary private supplementary long-term care insurance plan is subsidised by the state. There are uniform procedural rules concerning the state support for private long-term care provision which have to be complied with by the private insurance companies. Alongside these, there are industry-wide general insurance conditions for state-supported supplementary long-term care insurance, which have been approved by the Ministry of Health. The statutory long-term care includes two independent parts next to each other – social (SPV) and private long-term care insurance (PPV), which are both compulsory insurances with identical benefits. No financial compensation between the two compulsory insurance schemes, there is a financial compensation regulated by law only within the respective schemes (SPV, PPV). Benefits in cash and in kind, or a combination of both, are mainly available to those in need of care. There are also specific measures to support carers, which are legally consolidated. Social assistance (Sozialhilfe): Tax financed. Beneficiaries incapable of work in need of care, who cannot help themselves and do not receive assistance from other persons, are entitled to care assistance.
Liberal:	
UK	Long-term health care provided through non-contributory, state-financed system providing cash benefits and benefits in kind (social care) for elderly or disabled persons and their carers. Information in this table relates to England only. Competence for social care (benefits in kind) is devolved to Scotland, Wales and Northern Ireland. Social care: Local authorities are responsible for identifying the needs of their local population and commissioning services to meet them. Services are delivered through the public, private and voluntary sector. Benefits are provided for informal carers.
Southern Europe:	
Greece	No special scheme. Certain benefits and measures are provided by the invalidity

	and old-age schemes, which are compulsory social insurance schemes financed by contributions. Other benefits (in cash or in kind) are provided by social welfare schemes to individuals who are in need of care. These welfare schemes are organized centrally. No specific benefit for informal carers.
Italy	Long-term care is provided under other parts of the social security system, namely health care and social assistance. Both civilian invalidity benefits and the constant attendance allowance are special non-contributory benefits. They are administered at both national and regional levels. Benefits are granted both as benefits in kind and cash benefits. No specific benefits for informal carers.
Portugal	The system of long-term health care includes the following items: Social insurance: Public compulsory insurance scheme. Contributory cash benefits depend on contributions managed centrally. Guaranteeing sufficient resources: Non-contributory means-tested cash benefits which are managed centrally. Social security system and National Health Service: Network of long-term health care organised according to two operational territorial levels: regional and local. Benefits in kind provided through the integrated and continued intervention of social assistance and health care. No special benefits for the carer.
Eastern Europe:	
Hungary	There is no separate long-term care system; the long-term care services are supplied within the healthcare and social service system. Professional policies (and basic principles) pertaining to long-term care are shaped by the Ministry of Human Capacities (Emberi Erőforrások Minisztériuma). In case of long-term care services, personal social care (social services) is provided by the state, which has the obligation to provide such services. However, NGOs and churches can also provide long-term care services. Long-term care services are based on social assistance and financed by the state budget. Both cash benefits and benefits in kind are provided. A specific benefit for informal carers exists.
Lithuania	Central system is supplemented by regional schemes: • Government sets long-term national programs, strategies, requirements and standards; • Municipalities prepare and implement municipal programs of disabled social integration. They are directly responsible for the organisation of provision of social services; for determination of the needs for social services; for supervision of common and special social services; and for the organisation and provision of primary health care. Long-term care is organised in day centres, home care services, residential social care institutions and

	hospitals. There is no separate legislation for long-term care, which is provided under several branches: social services, invalidity and sickness. Social services are granted for all residents in need. Health care is based on social insurance. Financed by the state, local budgets and Health Insurance Fund, payment by the recipient (family). Benefits in-kind are provided for long-term care. No specific benefits are provided for informal carers.
Poland	Central system supplemented at the regional level. Long-term care is provided piecemeal through legislation on a number of other risks including old-age, invalidity, survivors, health care and also through the legislation on social assistance. Long-term care is based on: social assistance (Pomoc społeczna, benefits in kind); social insurance (Medical Care Supplement, dodatek pielęgnacyjny); universal coverage (Medical Care Allowance (zasiłek pielęgnacyjny), training and rehabilitation of disabled child supplement (dodatek z tytułu kształcenia i rehabilitacji dziecka niepełnosprawnego), nursing benefit (świadczenie pielegnacyjne), Special Attendance Allowance (specjalny zasiłek opiekuńczy), Permanent Allowance (Zasiłek stały), Earmarked Allowance (Zasiłek celowy) and Periodic Allowance (Zasiłek okresowy). The long-term care provides benefits in-kind and cash benefits – both financed from the state budget. Specific benefits exist for informal carers.

Based on: Comparative tables long-term care, general principles, MISSOC, 2016, http://www.missoc.org/MISSOC/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTableSearch.jsp, accessed 14 November, 2016.

Acknowledgment

Thanks to partners in the SPRINT projects, and also internal and external reviewers whose valuable comments have helped in improving the report.

The SPRINT Project has received funding from the European Union's Horizon 2020 research and innovation programme under Grant Agreement No 649565