Peer Review on "Financing Long-term Care"

Online, 22-23 September 2020

Synthesis report

Written by ICF

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1. Introduction

The Peer Review focused on challenges and solutions concerning sustainable financing of long-term care (LTC) across Europe. The Peer Review aimed to review effective and sustainable LTC financing by reflecting on different cost-sharing arrangements between the State, local government and service users; and to identify the impact of the marketisation of LTC services on the financing and quality of LTC.

The Peer Review was hosted by the Estonian Ministry of Social Affairs. It brought together government representatives from the Host Country (Estonia) and seven peer countries (Austria, Bulgaria, France, Malta, Portugal, Slovenia and Spain). Representatives of the European Commission, as well as a thematic expert who put the topic in the wider context of EU policy were also present.

Funding LTC has been described as a 'financial challenge'[1] and a 'sustainability challenge'[2]. In this context, projections represent a useful tool to identify immediate and future policy challenges, related to current and expected demographic trends. In the 2018 *Ageing Report* the European Commission[3] assumes a scenario where 'half of the projected gains in life expectancy' (i.e. extra years of life due to longer life expectancy) are spent in good health and without the need of LTC. In this scenario public LTC expenditure in the EU is projected to increase from 1.6% of GDP to 2.7% of GDP, i.e. an increase of 73% until 2070[4].

While LTC services and assistance can support people of any age, the older population (aged 65 years and over) constitutes the group with the highest risk of needing LTC, a risk which significantly increases after the age of 80. The current and predicted growth in the proportion of the population across Europe aged 80 years and over, together with the decline of the number of people of working age, as well as societal changes, present a challenge for the provision of LTC in EU Member States and for future public expenditure.

Debates around current and future LTC spending are tough, also in the context of shrinking economic growth as a result of the economic crisis related to COVID-19. However, shortcomings in LTC funding and provision came to the fore during the pandemic - especially with the high mortality rate of people living in residential care - highlighting that LTC systems need to be sufficiently resourced and monitored, and coordination with the health system is crucial.

As in other Member States, the challenges to fund the provision of LTC in a sustainable manner have become pressing in Estonia. While Estonians aged 65 and older are more likely than their peers in other European countries to require assistance with activities of daily living, public spending on LTC is lower than in many other EU Member States, leaving a big share of LTC to be financed by out-of-pocket payments of service users. Care homes, day-care services, home care and other personal care and social services are mainly financed and organised by municipalities.

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[1] SPC/ECS, 2014. Adequate social protection for long-term care needs in an ageing society Report jointly prepared by the Social Protection Committee and the European Commission. Accessed at: https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=7724

[2] Spasova, S., Baeten, R., Coster, S., Ghailani, D., Peña-Casas, R. and Vanhercke, B., 2018. Challenges in long-term care in Europe. A study of national policies, Brussels: European Commission, European Social Policy Network (ESPN). Accessed at: https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=9185

[3] European Commission, The 2018 Ageing Report. Economic & Budgetary Projections for the 28 EU Member States (2016-2070), 2018, https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf

[4] EPC-AWG/EC, 2018. The 2018 Ageing Report. Economic and Budgetary Projections for the 28 EU Member States (2016-2070). Brussels: European Commission Directorate-General for Economic and Financial Affairs (Institutional Paper 079). Accessed at: https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en

Whilst local authorities have the freedom and responsibility to define LTC provision locally, their capacity to fund and provide services depends significantly on their tax revenue, the age structure of the local population and political priorities. This results in differences and disparate access to LTC across the country, high out-of-pocket payments by service users and reliance on informal family carers.

The upcoming reform of the Estonian LTC system will create a new model that will provide more support from the State to local governments via the possibility to purchase some LTC services from the State and additional earmarked financial incentives. In addition, service users and their families will be supported by introducing limits to out-of-pocket payments for LTC service provision at local level by setting a minimum standard of living for service users that needs to be ensured and better coordination between the health and social sector.

1.1 Background and purpose of the Peer Review

Depending on the individual needs, LTC involves several activities. Whilst there are varying approaches across the EU, it is defined on EU level by the Social Protection Committee as follows:

"*Long-Term Care (LTC) encompasses a range of services and support for people who are dependent over a long period of time on help with their daily living. This need is usually the result of disability caused by frailty and various health problems and therefore may affect people of all ages. But the great majority of the recipients of long-term care are older people.*" [5]

LTC involves different types of activities, ranging from helping people with daily living activities (such as toileting, getting dressed and undressed, bathing or washing), to nursing, rehabilitation, and supporting social participation. In general, long-term care systems aim to reduce, lessen consequences of, or compensate for disability, cognitive impairment and loneliness and improve quality of life, as well as supporting family and other unpaid carers, and ensuring that the person is safe and treated with dignity.

The most predominant form of care in Europe is the one provided by informal carers[6] (usually family members or relatives). This can have long-term consequences on the informal carers themselves - in terms of their economic activity, their health and future social protection entitlements - and on the labour market. As regards formal care, services and facilities are generally categorised into residential care facilities (care homes, nursing homes, service housing), semi-residential facilities (day/night-care, short-term care), and community care/home care services (home nursing, home help, meals-on-wheels, etc.), including prevention, rehabilitation and counselling/case management.

The costs of LTC, particularly when people need intensive support for a long period of time, can be very high for the individuals and for their families. For this reason, an important aspect of how LTC is financed is the degree of protection against risk (or risk sharing) that is offered by the system. Since not everyone will need LTC, and some will need it only for a short period, sharing the risk collectively, through a large pool of insured individuals, protects people against catastrophically high costs of care.

While all European countries have some form of minimal public and non-profit LTC support for people with LTC needs who cannot access family support, the degree of protection provided varies. Some countries, such as Austria and France, have

[5] SPC/ECS, 2014. Adequate social protection for long-term care needs in an ageing society Report jointly prepared by the Social Protection Committee and the European Commission. Accessed at:: https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=7724

[6] G. Paat-Ahi, M. Masso, B., 2018. ESPN Thematic Report on Challenges in long-term care Estonia, European Social Policy Network (ESPN), Brussels: European Commission. Accessed at: https://ec.europa.eu/social/BlobServlet?docId=19845&langId=en (21.10.2020)

universal systems where everyone who has recognised LTC needs can access at least some form of publicly funded support. Other countries provide minimal public LTC support that is often means-tested, thus for people with LTC needs who cannot access family support and have insufficient income and assets to fund their care. There are also countries that provide a limited set of universal, needs-based support, such as vouchers or cash benefits which can be used to purchase services or remunerate formal and informal carers. In almost all countries there are co-payments for at least some services, but the extent of these out-of-pocket payments varies widely in the amount and may also depend on whether assets are included in the means-tests.

It is possible to distinguish between private insurance schemes and public sector schemes (i.e. publicly funded schemes). Voluntary private insurance schemes are long-term contracts that help paying for assistance, through cash benefits or in-kind assistance. While these products are available in many European countries, this approach is not the main form of LTC financing in any of them.

On the other hand, public sector schemes can be either financed through on social insurance or on taxes. In schemes based on social insurance, such as Germany, the Netherlands and Luxembourg, the costs of care are paid out of social contributions (usually coming from employees and employers). Tax-based schemes, such as Austria, Spain and Portugal are based on the general taxation

While different LTC financing mechanisms have different strengths and weaknesses, in practice most countries use a mix of approaches to finance LTC.

In almost all countries co-payments are required, for at least some services. extent of these out-of-pocket payments varies widely in the size of the co-payments and also whether assets are included in the means-tests (e.g. Austria excluded assets from the means-test in 2018, while in Ireland assets are included in means-testing for institutional care).
Member States follow different approaches, entailing different levels of spending.

1.2 The EU policy context

The European Pillar of Social Rights (hereafter the Pillar)[7] recognised for the first time the right to long-term care at European level (Principle 18), establishing that '*Everyone has the right to affordable long-term care services of good quality, in particular home-care and community-based services'*. In order to support the implementation of the Pillar, which is a non-binding initiative, and to prepare the ground for the upcoming Pillar's Action Plan, the European Commission launched a broad consultation with all EU countries, regions and partners. Other legislative measures to strengthen some of the aspects of the Pillar are underway. For instance, the EU Work-Life Balance Directive[8] (2019) introduced two measures relevant to carers: the entitlement to five days of carer's leave per year and the right to request flexible working arrangements.

preparation of the Country Reports prepared in the context of the European Semester and into the continuous dialogue with Member States throughout the year. Several EU Member States have already received country-specific recommendations (CSRs) related to health and LTC, including aspects linked to fiscal sustainability, access and quality of services.

[7] European Commission. The European Pillar of Social Rights in 20 Principle*s.* Accessed at: https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en#relatedlinks (05.10.2020).
[8] European Union, 2019. *Directive of the European Parliament and of the Council on work-life balance for parents and carers and repealing Council Directive 2010/18/EU.* Accessed at: https://data.consilium.europa.eu/doc/document/PE-20-2019-INIT/en/pdf (05.10.2020)

The European Commission is preparing, together with the Social Protection Committee (SPC), a report on long-term care preparedness of Member States, which is to be published in 2021. This will provide a horizontal analysis of the challenges faced by long-term care systems across the EU, including sustainability. The European Commission is also working with the *Indicator Subgroup* of the SPC to develop a portfolio of agreed indicators to monitor long-term care along the dimension of access, sustainability and quality[9].

The topic of the Peer Review relates also to issues recently addressed by the Ageing Report[10], which presented long-term projections of the budgetary impact of the ageing population, and by the Report on the Impact of Demographic Change by the European Commission[11]. The report presents the drivers of demographic change and the impact they are having across Europe, including challenges related to long-term care. The report kick-starts the Commission's work in this area and will help identify how people, regions and communities most affected can best be supported. It will also provide the foundation for the upcoming Green Paper on Ageing and Long-term Vision for Rural Areas[12], to be issued in 2021.

In the context of demographic change and ageing population, LTC has been an important strand of work for the European Commission for a long time; however, as the COVID-19 crisis tested the healthcare and welfare systems across the Union and cast a spotlight on existing shortcomings, LTC has become a renewed focus in last months.

1.3 The Peer Review: headline messages and policy implications

The key learning messages from the Peer Review are summarised below:

Key policy messages from the Peer Review can be summarised as follows:

Sustainable long-term care funding

- Ageing populations, a shrinking workforce and wider societal change, such as changing family structures **challenge Member States to fund LTC**, health care and other public services. While current funding for LTC varies significantly across Member States, even in countries with a relatively high level of public LTC expenditure, family care continues to be the most predominant form of care in Europe. In addition, there are also regional differences in terms of LTC organisation and funding in countries like Austria, Estonia or Spain. Especially very rural municipalities with an increasing ageing population are often in need of funding to provide accessible and quality LTC services.
- Sustainable LTC systems and reforms that aim to balance between increasing LTC needs and public funding are often supported by **long-term, wider public debates** around the need to LTC and intergenerational solidarity. This can lead to wider public awareness of the necessity to invest in LTC (similar to an awareness around pensions and the impact of not investing in LTC) and political consensus. These debates however often take years.

[9] https://ec.europa.eu/eurostat/web/employment-and-social-inclusion-indicators/social-protection-and-inclusion/health-long-term-care
[10] EPC-AWG/EC, 2018. The 2018 *Ageing Report. Economic and Budgetary Projections for the 28 EU Member States (2016-2070)*. Brussels: European Commission Directorate-General for Economic and Financial Affairs (Institutional Paper 079). Accessed at: https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en
[11] European Commission, 2020, *European Commission Report on the Impact of Demographic Change.* Accessed at: https://ec.europa.eu/info/sites/info/files/demography_report_2020_n.pdf (1/10/2020).
[12] See also here: https://ec.europa.eu/commission/presscorner/detail/en/IP_20_1056

- Another general point to address sustainable LTC funding is that policies and reforms should focus on delaying the need for long-term care **through prevention, rehabilitation and healthy ageing**. For example, in Scandinavia, were LTC is mostly provided formally at home, rehabilitation and prevention allows people to perform everyday tasks themselves for as long as possible, such as in the well-known Fredericia model in Denmark[13]. This is also in line with the planned law in France on reforming LTC which aims to prioritise home-care, so that residential care becomes an exception.

Cost sharing with service users

- Family carers (mostly women) are often supported by cash benefits. While these schemes reflect the wish of most service users to stay at home for as long as possible, cash payments need to be carefully balanced with the **potential impact on labour market participation and undeclared work**. However, in some countries or in certain areas cash benefits have been introduced as care services were not available and this is seen as the only way to provide a support to those in need of LTC.
- In all countries, users and/or their families contribute with **out-of-pocket contributions** to co-finance LTC costs, but they vary widely in the size of the co-payments. Whilst out-of-pocket payments aim to contribute to fiscal sustainability and limit moral hazard, they can also result in unmet LTC needs.
- Focusing on residential care, which usually implies higher costs for both the State and individuals, countries have a set of maximum contributions or a minimum amount of income that the service user is guaranteed. Similar to the current foreseen Estonian reform, there are also discussions in Slovenia to **reduce out-of-pocket payments of service users**. The proposed legislation on LTC from August 2020 foresees LTC as a new pillar of social security, which would include 1.47% of social contributions for both employers and employees, if the law is passed.
- **Means testing** is used to access publicly funded care and to set co-payments. However, it also may result in unmet needs of service users (especially those who have income/assets to pay and so do not qualify for support, but do not have sufficient resources to fully cover the costs for LTC) and high administrative costs. Here, considering income *and* assets has also the risk for service users to under declare assets and/or not to accumulate assets/savings for later life in order to reduce their contribution. It may also lead to unmet LTC needs, as they wish to keep their assets (e.g. when they live in their own property). As a result, only some countries take assets into account (recently, for example, Austria excluded assets from the means-test in 2018).

Cost sharing arrangements between the State and local governments

- While the decentralisation of LTC has the advantage to plan for and **address local needs**, a number of potential dysfunctionalities were pointed out. In some countries where municipalities or regions are expected to fund partially or totally LTC schemes (e.g. Estonia), the **access to and quality of LTC can vary substantially** as some municipalities differ in terms of their population size, their demographic composition, their infrastructure and their budget

[13] See also here: https://www.agefriendlyeurope.org/sites/default/files/Life%20Long%20Living_Description%20of%20initiative.pdf

(often generated from local tax). Here, the role of the national government was pointed out to adjust local differences by grants or equalisation payments. While equalisation schemes aim to balance different regional or local revenue (such as in Austria, France or Spain), it was pointed out that the allocation of funds should take into account wider age- or morbidity-adjusted indicators.

- In order to address regional inequalities, the Estonian reform aims to **incentivise municipalities to improve their provision of LTC services**. One example to do so is the Austrian LTC fund which aimed to improve home-based care. This fund is financed by the federal government (two thirds) and by the regions and municipalities (one third) and contributed to enhance common standards in LTC provision.
- **Transparency** might suffer with decentralisation. In Austria, for example, the regions have different systems for LTC provision resulting in different definitions, which makes comparisons across regions complicated and hinders a regulation of the sector at national level. The proposed law on LTC in Slovenia aims at recentralising the system to avoid fragmentation and to increase transparency.
- The Estonian reform also envisages a **better coordination of LTC services** that are governed under the health and social welfare system. This is an important aspect in terms of fiscal sustainability, effective service provision and quality LTC. The responsibility for community-based and institutional care needs to be coordinated or governed by one Ministry, so there are no incentives to cost-shifting. In Slovenia, the planned legislation on LTC foresees the establishment of the care coordinator to ensure services based on the service users' needs.

Impact of marketisation on long-term care quality

- In general, the provision of LTC by public and private providers, can contribute to competition which ideally impacts on the **quality of LTC** and gives the service user a **wider choice of services** (for example, private providers can offer additional services to public LTC services that individuals can choose from, if they can afford it). They can also help to fill in gaps of service provision. For example, in Malta, private-public partnerships with private service providers to administer government-owned homes aims to guarantee places for very frail and vulnerable groups.
- However, without efficient quality criteria, there is the risk that private providers are contracted based on the **lowest price** or on quality criteria that are not relevant. Moreover, prices established by private operators may not be affordable for everyone, especially those who find themselves in precarious financial situations. In addition, private operators may avoid certain geographical areas (for example, rural areas) or clients (those with more complex needs, such as those with dementia), so this does not necessarily improve the access to LTC services.
- Here, an important role of the national level is to set **common quality standards** applicable to LTC private, non-for-profit and/or public providers and to set up monitoring schemes. In Bulgaria, for example, a new regulatory agency was set up for registering and regulating private and public providers.
- Here, quality criteria or maximum prices can be used as criteria in **public procurement**. Municipalities could adapt these criteria based on local needs, but often also need capacity building in effective procurement processes.

2. Host country practice: Planned long-term care reform in Estonia

2.1 Overview of the current situation[14]

The Estonian population is shrinking and ageing. While life expectancy is increasing, this does not apply to healthy life years to the same extent. The number of elderly people is expected to grow from 19.8% to 30% by 2060[15]. The proportion of people with disabilities is increasing and currently represents 12% of the population. The demand for long-term care has significantly increased in the last years and is expected to keep following this trend in the coming years.

The organisation and financing of the Estonian LTC system is fragmented between the social and health care sector, as well as between the State and local municipalities. The fragmentation is multidimensional and can be observed at financial, organisational, professional and policy levels.

In Estonia there is no universal LTC organisation and no financing model that guarantees equal access to LTC services: as the capacity to fund and provide services is unequal, access to LTC services depends largely on the place of residence of people with LTC needs. The capacity of local governments to provide social benefits and services hinges on their local budget and resources available. Although local governments are required to follow legal obligations in providing LTC services, they have a high degree of freedom in defining the services packages, prices and volume of services provided. Moreover, currently every local government has their own needs-assessment tool which is not based on the same criteria, contributing to the inequitable access to LTC across Estonia.

Out-of-pockets payments are required for most LTC services and most elderly people finance social services from their state-funded pension, which is often insufficient to cover residential care. Moreover, home-based formal care service are still rare. Despite the Estonian long-term goal to increase the provision of home services and decrease the number of institutional service users, the organisation of LTC and provision of assistance is mostly institutionalised and there is an unmet demand for services supporting independent living at home.

The burden of LTC care therefore largely relies on, mostly female, informal carers (spouses, children, other relatives, or friends of the person in need of LTC). In Estonia approximately 65 000 people have care responsibilities. Of those, 8 800 persons are not engaged in the labour market and 5 000 work part-time due to their caring responsibilities.

In 2016, Estonia started to develop a policy framework for LTC organisation, including ways to finance LTC. In addition to complex policy proposals, immediate measures (i.e. the introduction of day and weekly residential care for adults with very high care needs and the establishment of a Dementia Competence Centre) to alleviate the care burden were approved by the Cabinet of Ministers in September 2017.

[14] For more detail, see Peer Review on "Financing Long-Term Care", Host Country Paper. Available at:
[15] Data from *Statistics Estonia* based on the data on Estonian Social Insurance Board. The number contains people who are officially granted disability by the Estonian Social Insurance Board. According the Estonian Social Benefits for Disabled Persons Act, disability is granted to a person who has loss of or an abnormality in an anatomical, physiological or mental structure or function of a person which in conjunction with different relational and environmental restrictions prevents participation in social life on equal bases with the others.

2.2 The new model of LTC in Estonia

In January 2020, a new needs-based local government and State partnership model was decided by the Cabinet of Ministers. The model will be based on the same management structure, a similar division of tasks between local governments and State, but a stronger role of coordination, guidance and supervision by the State.

The main principles of this model will be the following:

- The State will provide LTC services that are not reasonable for local authorities to develop, primarily due to the specificities of the services, the low number of qualified staff to provide them or the small size of the target group (e.g. personal assistance and personal support). This needs-based local government and State partnership LTC management and financing model also aims at increasing the provision of formal LTC services to people who receive informal care by family members because necessary LTC services are not available in their area of residence. This shall guarantee a more equal access to LTC.
- Minimum criteria for LTC services will be established by local governments. Guidance materials will help local governments to develop minimum criteria for LTC service provision. Counselling and training will be made available for local governments and service providers to increase their knowledge and encourage the exchange of good practices about needs-assessment methodology and practical provision of LTC services.
- The introduction of a care coordinator between the health and the social sector will be scaled across (see box below).

Box 1 The care coordinator's role in Estonia

In August 2018, a pilot project implementing a person-centred coordination model was launched in six areas in Estonia (in Saaremaa, together with Muhu and Ruhnu, Tartu, Rakvere, Tallinn, Tori and Tõrva, together with Otepää and Valga).

The care coordinator carries out a case manager's role, supporting service users with complex needs and receiving help from health and social care services.

The results of the pilot project highlighted that the role of care coordinator was not needed everywhere and that instead of adopting a one-size-fits all model, it is important to consider that different roles and functions are needed across different municipalities.

On the basis of this outcome, in 2020, a two-year implementation phase will start in eight Estonian regions to develop more targeted, local approaches. In this new phase, municipalities receive 'top-up innovation resources' and decide how to allocate them. In the regions where the project is implemented, local municipalities, social services centres and local hospitals need to decide together on their priorities and how to achieve their goals. In the longer perspective, the aim is to link the financing of LTC with the coordination agreement on local level.

The new financing model for LTC will establish the following new arrangements:

- A minimum standard of living for service users shall be established. It shall be defined as a minimum amount of income that a person must have after having paid for LTC services.
- The State shall grant additional earmarked financial incentives for the organisation of LTC to local governments through a support fund. Requirements to apply for additional financing, with the most important focus on increasing investments to develop accessible LTC services, shall be established.

- A standard methodology for local governments to assess the financial situation of service users will be developed to guarantee equal access to LTC services across the country.
- The principle of the welfare mix will be maintained. Local governments will have the possibility to purchase services from the State, from NGOs or from private providers or to organise these services in co-operation with other local governments. It is expected that this decentralised organisation shall support the effectiveness of LTC services, increase competition between service providers and boost innovation.

The necessary legislative arrangements, as well as implementation principles and evaluation criteria will be elaborated during 2020 to 2021 and implemented from 2022 at the earliest.

3. Key Peer Review discussion outcomes

This section recaps the discussions held during the Peer Review on the key issues related to the sustainability of LTC financing systems.

3.1 Sustainable long-term care financing

All EU Member States face demographic change characterised by a shrinking active population and by increasing numbers of old and very old people.[16] This means that countries need to balance the needs of services users, who will increasingly have complex needs, and the ability to sustain spending on government commitment, legislation and policies.

Member States need to invest in long-term policies that will address the rising future needs for LTC. This includes that LTC systems consider the needs of future service users and their expectations, today. For example, demands for quality LTC will impact on the unit costs of LTC, while there is also a much debated need to increase remuneration in the sector. All of these aspects need to be included in deliberations around intergenerational fairness, also in terms of access and trust amongst younger generations today to receive public LTC in the future.

Sustainability of LTC spending initially depends on the funding model chosen, its characteristics and implementation. Three models, that can serve as a source of LTC funding, their potential challenges to sustainability and potential solutions were discussed and are featured in the table below.

Table 1. Challenges and potential solutions to guarantee financial sustainability to fund LTC

Financing approach	Challenges to guarantee sustainability	Potential solutions
Social insurance	It is mandatory and based on employer and employee contributions. This subsequentially increases labour costs. Moreover, it is very dependent on employment fluctuations and on a (shrinking) workforce as contributors.	The system contributes to transparency by creating an explicit entitlement to benefit (less stigma) and earmarked financing. For example, in Germany's long-term care insurance there is a clear link between contributions and entitlements that makes it clearer for

[16] European Commission, The 2018 Ageing Report. Economic & Budgetary Projections for the 28 EU Member States (2016-2070), 2018, https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf

		(future) services users what to expect and plan for. This also requires a debate around what services are covered through the insurance. There are reliable and predictable revenues, that are nevertheless sensitive to cyclical or structural changes on the labour market. One aspect to consider could be to increase revenue through contributions that do not only depend on employment, but also other income such as capital gains. There is a need to ensure that the non-employed population is also covered.
Tax-based system	Although there is a broader tax base, this model is also affected by a declining workforce. In addition, there is no transparent link between the revenue and LTC funding. However, there is potentially a greater flexibility in the sources of funding for LTC and redistribution.	Less transparency in the allocation of benefits (which may ultimately depend on available budget). However, there is the possibility to earmark taxes. This could contribute to a debate around the increased demand for LTC and the willingness to share the burden via tax contributions.
Private insurance	Limited financing base. Younger people may be myopic in their assessment of LTC risks and opt out of buying insurance if voluntary. There are issues around the affordability of premiums, so it may require subsidies for low-income or inactive people (if mandatory). Adverse selection, so people who know they are more likely to need care are more likely to wish to buy premiums; this is a problem, in particular, when people buy premiums later in life. On the other side, there is a risk that people with a high risk of needing care or who already need LTC may be rejected, potentially leaving out the most vulnerable service users. Adverse selection can be addressed by making private insurance mandatory, but this would not address the issue of affordable premiums for everyone. This could be addressed by income-related social insurance (see above) There is little trust in private insurance schemes.	It can be a 'top-up' option next to the public funding model. The system combines a basic package of services provided by the State and the possibility for individuals to access the services provided by private LTC providers. This may also have the advantage of further risk pooling with the private sector, as private LTC insurance could be sold to employers. Out of the countries participating in the Peer Review, only France has significant voluntary private LTC insurance that primarily aims to cover the costs of care not covered by the public system.

Next to these three models, informal carers, mostly family members, still provide a substantial contribution to LTC across the EU[17]. Whilst the different models of LTC and the generosity of entitlements and access and affordability of services entails different degrees of reliance on informal carers to provide LTC, informal care provision can still be considered as an in-kind private contribution to the costs of LTC across Europe.

Informal care results in lower employment rates amongst those who provide care and subsequentially to lesser possibilities for the State to fund services via taxes. Moreover, reliance on informal care disproportionally falls on certain groups of the population, namely low-income groups who cannot afford out-of-pocket payments and women, who provide most informal care. Next to the economic costs, informal care responsibility incurs social costs associated with the psycho-social impact of providing care to family members.

Hence, a combination of different support measures that focuses on a shift to formal home-based care can have multiple positive impacts such as the following:

- Increased labour market participation, especially of women, preventing poverty in old age and increasing GDP and tax revenues (which can, in turn, be used to fund LTC);
- Conditional benefits (services in kind or cash benefits that need to be spent in a certain way) prevent undeclared work;
- Formal LTC provided by sufficiently staffed services and professional carers can enhance the quality of care;
- Formal care reduces care burden for informal carers, which has an impact on their health and well-being; and
- Promotion of gender equality, as informal care givers are still predominantly women.

Where formal LTC services are unavailable or family carers decide to provide LTC for their relatives, cash benefits can help. However, it is important to have wider support measures for these carers in place to mitigate their mental and physical stress and to increase their chances to remain or return to the labour market. Such support can include training for carers, career counselling, peer-to-peer exchanges and leave arrangements to remain in employment such as outlined in the French example below. One way to support (former) informal carers is to offer them professional training to reenter the job market in the area of LTC, building and recognising their skills, thus also further closing the gap in staff needed in this sector.

Box 2: Caregiver Leave in France

In France, there are around 8.3 million family carers and around half of them are employed. These 4 million people can suspend or reduce their professional activity to support a family member who suffers from a significant loss of autonomy. From October 2020, this includes a daily allowance for up to three months. This allowance will be €52 per day for a single person and €43 per day for people living as a couple. The leave is renewable up to a maximum of one year over the entire professional career. The carer is guaranteed the maintaining of their job.

[17] Spasova, S., Baeten, R., Coster, S., Ghailani, D., Peña-Casas, R. and Vanhercke, B., 2018. Challenges in long-term care in Europe. A study of national policies, Brussels: European Commission, European Social Policy Network (ESPN). Accessed at: https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=9185

The care receiver may be the spouse or partner, an ascendant (of the applicant or their spouse), an elderly person with whom they reside or with whom they have close and stable ties.

The caregiver leave was created by the law of 28 December 2015 on the Adaptation of Society to Ageing from the Ministry for Solidarity and Health. The daily allowance was created by the Social Security Financing Act for 2020.

Many countries emphasise home-based LTC provision; this is often less costly than residential LTC and corresponds to most service users' choice to stay in their own homes for as long as possible. However, formal and informal care provision needs to be carefully balanced at home. Next to the positive impact on labour market participation and gender equality, the shift to formal, home-based services may also trigger a positive change to LTC provision. This is done in Austria where the LTC fund incentivises local actors to invest in measures that support people to live independently (see Box 4 below) – a possible option for the Estonian reform that foresees support to municipalities.

In Scandinavia, formal, home-based LTC services focus on rehabilitation, which can delay the need for further LTC, improve people's quality of life and allow them to stay at home for a longer time, while reducing the need for LTC funding.

Box 3: Re-ablement or every day rehabilitation approaches in Scandinavia

This approach in formal home-based care provision relies on a rehabilitative approach to care, focusing on supporting the service user to perform everyday activities themselves (rather than undertaking them in their place). This is usually a short-term intervention (3-12 weeks) at home, complementing or replacing home care.

Together with the carers, the service users define important goals and the most important activities in their lives that they wish to strengthen. Care is then often provided with occupational therapists, physical therapist, nurses and 'home trainers'. There is everyday encouragement and celebration with service users who meet their goals.

This approach used in the Danish municipalities of Fredericia and Odense shows that reablement can reduce home-care expenditure.[18]

Another option to prevent the need for LTC is offering low-threshold support to people who enter the LTC system. For example, in Slovenia, if a person is not eligible to LTC public support, they receive information on what support services they can use instead. In France, a law on reforming LTC is currently discussed in Parliament; the law aims at providing home-based care for as long as possible and will also reflect on how to avoid or delay residential care as well as taking into account all the health and social consequences generated by the COVID-19 crisis.

In all LTC models, it is important to consider entitlement (*Who gets LTC? What does the service user need to contribute? Do they need to fulfil minimum contributory periods?*), the type of services covered in the public LTC model and if there are co-payments required. These are relevant aspects when deciding on cost sharing arrangements.

[18] See also here: http://www.ifa-copenhagen-summit.com/wp-content/uploads/2016/04/1.6-Rudi-Westendorp-The-Case-for-Reablement.pdf

3.2 Sharing costs for long-term care

3.2.1 Sharing costs between the national and regional level

LTC funding can come from both the central government or/and from local/regional governments. In general, a decentralised funding and organisation of LTC allows to address local needs. This can however also lead to a fragmentation of services, such as in Austria, where financing, provision and organisation of LTC in-kind benefits is different across regions. This results in different responsibilities, separate definitions of services, affecting also the comparability of statistics and a varying evaluation of the intensity of care needs. Moreover, municipalities and regions need to provide LTC services, but can hardly influence the money they have which further leads to regional disparities according to political priorities and the age structure of population. In some countries such as Estonia, municipalities or regions partially fund LTC. This can, however, create large disparities in the access to and the quality of LTC, which come about as a result of the differences in population size, demographic composition, infrastructure and budget (which is often generated from local taxes).

In order to tackle local inequalities concerning access and quality of LTC, the national level can provide grants or equalisation funds/payments which provides additional resources to regional/local governments to guarantee a minimum set of services. These equalisation payments are used in Denmark, Austria, France and Spain. However, it highly depends on how equalisation funds are designed and organised. For example, what criteria, such as infrastructure, demography, disability or morbidity, are taken into account.

Box 4: Equalisation funds and the LTC fund in Austria

In Austria, LTC is provided by the regions and municipalities in cooperation with non-profit organisations. Municipalities receive a fiscal equalisation payment which is based on the number of inhabitants only and does not consider age nor morbidity.

Next to this, there is also the earmarked LTC fund introduced in 2011. The purpose of this grant is to ensure the provision and sustainability of LTC services. The grant should primarily be used for funding home and community-based care, as it is one of the main principles of the fund to allow people to live at home as long as possible. For example, services funded mainly include day care, case and care management, participation and alternative forms of living in the community.

The fund is sourced from national tax revenues, amounting to 366 million EUR in 2018. Funding is divided between the national level (2/3) and regions and municipalities (1/3). For the national government, the LTC fund is a crucial instrument because it encourages some common standards in provision of services in kind across the different regions.

Other Member States are highly centralised in funding and providing LTC, such as Bulgaria and Slovenia. In Bulgaria, the State plays a bigger role by funding and regulating LTC services. In Slovenia, a reform aims to recentralise the system in order to avoid fragmentation and to increase transparency while enhancing access to and quality of LTC. Local authorities do not fund services but organise LTC providers.

The level of decentralisation depends on many factors, such as the population size, the established model to fund and organise services and governance arrangements in general. No matter if at national, regional or local level, a better coordination of LTC services between the different departments impacts on the sustainable provision of LTC, the effectiveness of service provision and the quality of LTC. For example, if the responsibility for LTC lies within a single Ministry, there are fewer incentives for cost shifting. On local level, care and case managers aim to coordinate different services, depending on services users' needs. For example, in Slovenia, the planned legislation

on LTC foresees the establishment of the care coordinator to ensure services based on the service users' needs.

Box 3: The LTC law proposal in Slovenia

In 2017, only 26.6% of the expenditure on LTC came from public sources and the LTC law proposal aims to reduce out-of-pocket payments by service users.

This would be funded through an increase of 1.47% of social security contributions for both employers and employees (this will introduce a fifth pillar in social security payments).

The LTC law proposal would also create the role of a 'care coordinator', tasked with assessing the needs of the service users (based on a common needs-assessment model) and to identify the right service. This would also promote the development of integrated care comprising health and social services.

3.2.2 Cost sharing between the service user and the State

LTC systems need to strike a balance between public funding to pool the risks of needing LTC with acceptable contributions of the individual and their family. Currently all LTC systems in Europe are also based on out-of-pocket-payments to keep LTC funding fiscally sustainable. However, the rules for out-of-pocket payments vary between Member States, in terms of what services need to be co-funded, who is co-paying (the service user or wider family members?) and whether access to publicly funded services should be based on means-tests or not.

However, especially in Member States with lower incomes, it is often difficult for the service user to save and cover additional costs by out-of-pocket-payments, resulting in further reliance on family members and/or grappling with unmet needs.

Residential care often involves high out-of-pocket-payments which may lead to limiting the use of such services to service users with a sufficient income and assets. In the Estonian system, limited access to formal home-based LTC services has per consequence that some service users rely on residential care that is more costly for the State as well as the service user, although this is not the preferred choice of most older people.

Means testing is a way to allocate long-term care resources and to determine out-of-pocket payments. Either the income or the total value of the assets owned by a person can be the object of means testing. In most LTC systems, people in residential or nursing care need to cover accommodation and lodging. Contributions to residential care often depend on income and, in some countries, on assets. For example, in Malta service users of residential care contribute 80% of their pension and 60% of their remaining net income with a cap of EUR 1,398 per year, including pension or other income. In Austria, service users of residential care need to disclose their income: any difference between income (minus specified amounts to cover some other needs) and actual costs of the care home is born by the State. In order to avoid co-payments and to stay at home as long as possible, formal 24-hour care by migrant carers has become popular. Moreover, since 2018, assets to contribute to the costs for residential care are no longer considered. This was also a political debate in Austria; whilst some may consider that the accumulated or inherited wealth of some older people should contribute to funding LTC, especially if in form of property, this is publicly unpopular and may depress savings over the life course or lead to under declaration and the transferring of assets to family members.

Some Member States also stress the reliance on children's financial contribution to LTC, such as in Estonia or Slovenia. In Estonia, ascendants and descendants related in the first and second degree are required to contribute to LTC cost of their relatives in need. However, in other countries like Austria this would meet severe resistance.

Obligations of children to pay for their parents' care seem very problematic, especially in view of families with only loose ties between (one) parent and the children, increasing geographical spread of families and also in view of adult children having to cater for their own future LTC needs.

3.3 Marketisation of care services

LTC can be provided by public and private providers (for-profit and non-profit), and the composition of providers varies across countries, depending also on the LTC model of welfare provision.

In general the provision of LTC in a 'welfare' mix, therefore by different types of providers, combined with the option to receive informal care at home with sufficient support for families, increases the choice for service users and their families, hence contributing to person-centred support as a variety of services can meet needs in a more tailored way.

In Estonia and Bulgaria, increasing choice and incentivising private providers to offer LTC services is seen as a way to ensure access to LTC, especially in regions that differ. For example, the Bulgarian Law on Social Services regulates that municipalities can contract LTC services and anecdotal evidence reveals that private providers were able to provide better quality care than public services. Hence, the competition between public and public providers ideally improves the quality of LTC and fosters innovation through new ways of service provision and cooperation.

Moreover public-private partnerships can incentivise providers to close gaps in provision. In Bulgaria, such schemes allow for extending service provision to areas of the country that would not have been profitable for private providers otherwise. In Malta private-public partnerships allow to fill the gaps of service provision by granting private service providers the management of government-owned homes aimed at ensuring LTC for vulnerable groups.

However, competition between LTC providers remains ambiguous, as private providers often gain little revenue from 'better quality' or innovative services, so the right quality/price ratio remains a key challenge. Across Europe, there have been reports of insufficient quality LTC in residential care, particularly in the support for people with very complex needs. Linked to this, providers may avoid certain areas (e.g. poorer or rural areas) or clients (e.g. people with more complex needs, such as those with dementia).

Therefore, appropriate and relevant quality criteria are crucial. Often regional or local contracting authorities define the services needed and set quality criteria. For example, in Portugal quality criteria are defined nationally, but regions may further refine them. When procuring LTC services, public authorities need a number of mechanisms, such as ways to define and assess the multi-dimensional quality in LTC, incentives to provide quality care, also for service users with complex needs, and relevant contractual design. To do so, the contracting authority needs to set a clear definition of exact services needed, minimum standards and monitoring arrangements.

There are different national quality assessment systems and regulators monitoring this. State-level regulations on LTC quality, which are applicable to all types of providers (e.g. private, non-for-profit and public providers), ensure minimum quality standards and give permission to providers to offer LTC. Such quality standards need to be monitored in order for them to be effective. In Bulgaria, a new regulatory agency was set up for registering and regulating private and public providers. All providers are required to prepare and submit quality development plans and on-the-spot inspections are carried out to monitor these.

4. Conclusions

Member States follow different LTC financing mechanisms and use a mix of approaches to fund LTC. In countries where LTC is provided by local governments, as it happens in Estonia, there is a risk of unequal provision of services. However, the State can intervene to mitigate these disparities, through equalisation mechanisms or providing support to local governments.

As resources are limited, it is essential to channel them towards the target groups who are most in need but also to delay future LTC needs. It is also important to adjust LTC financing to the real needs of the population as well as to individual needs via case management.

In general, the provision of LTC by public and private providers can trigger competition, which – ideally - impacts positively on the quality of LTC and gives the service user a wider choice of services. However, the balance between the quality of care and the price for services remains a challenge, as private providers often may find little revenue from 'better quality' or innovative services.

The main priorities identified to ensure sustainable financing of LTC provision are the following:

- Striking a balance between a mix of approaches to fund services, also in relation to governance models and the role of local and regional governments who organise or provide servicers.
- Investing on prevention policies and measures in order to mitigate and/or postpone the need for LTC.
- Focusing on early intervention and financing community-based services and professional care staff that can support independent living, helping people to stay out of institutions as long as possible.
- Providing the right incentives to make informal care compatible with employment, limiting the economic and social impact of informal care.
- Improving the coordination between LTC services that are governed under the health and social welfare system, as foreseen by the Estonian reform.
- Establishing national quality standards applicable to all LTC providers and setting up monitoring mechanisms.

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