



Paying for Long-term Care*

Ricardo Rodrigues and Andrea Schmidt

Ricardo Rodrigues is Research Fellow and *Andrea Schmidt* Research Assistant at the European Centre for Social Welfare Policy and Research, Vienna.



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Policy Briefs are a publication series providing a synthesis of topics of research and policy advice on which European Centre researchers have been working recently.

This Policy Brief aims to present information on the current picture of (public and private) expenditure on long-term care (LTC) for older people and discuss the challenges of financing care. It also reviews the rationale for public funding of long-term care needs, since the funding is currently relatively low in most European countries when compared to other social protection areas. Also, funding schemes are skewed towards institutional care, even though most older people are cared for at home and age-adjusted nursing home usage rates have been falling. Contrary to health care user payments for long-term care can be quite high as a percentage of an individual's income, especially for institutional care. This can raise questions about which income groups contribute the most to finance care, as users of long-term care are expected to be disproportionately concentrated in poorer income groups. Using SHARE data, some initial results on the potential redistribution effects of home care benefits are also discussed.

This Brief is structured in three main sections, framed by some background information on the context of long-term care policies. While the first and the second sections provide an overview of – respectively – public and private funding arrangements and expenditure on long-term care, with a focus on Europe, the third section explores the potential inequalities resulting from long-term care policies. Finally, some conclusions will be presented.

Background: an ageing society

In the present context of demographic ageing the overall concerns over the fiscal sustainability of social protection systems have rapidly caught up with long-term care (see e.g. European Commission ECFIN, 2009). Concerns over the sustainability of long-term care systems have arisen in the face of an ageing society because for most people health deteriorates with age (Kerkhofs and Lindeboom, 1997). As more people survive to later ages the share of those in need of care in the older population is likely to rise, requiring specially trained carers to deal with the symptoms of disease. The predicted increase in care needs hinges on the hypothesis that patterns of health in old-age in the future will at least mirror those of today. This is far from being a consensual hypothesis (see Lafortune et

al., 2007), but policy-makers would be wise not to rule out the possibility that the number of dependent older people will increase in the future.

Demographic ageing could also impact long-term care systems by reducing the availability of carers. With the working-age population expected to shrink in most European Union (EU) countries, the availability of informal care – performed to a great extent at present by women and people of working age (Hoffmann and Rodrigues, 2010) – may further decrease unless there are major migratory labour inflows, while the formal care sector can expect existing labour shortages to continue and widen.

With respect to informal care, given falling fertility rates today, the burden of care will be on increasingly older and fewer adult children. Spouses might substitute part of the informal care provided today by children of working age, especially as male life expectancy is catching up with that of women. However, with more people living alone in old-age (Eurostat, 2001 Census data), new types of solidarity beyond responsibilities of kinship would be needed to support this trend of sharing care responsibilities. At the same time, public employment policies are trying to deal with a generally shrinking labour force and aim at increasing labour market participation rates of older workers and women, by that on the one hand shrinking the available pool of informal carers, but also possibly leading to the extension of formal care services and a further commodification of long-term care.

The factors mentioned above give reason to call for active policy approaches addressing current and future challenges for financing long-term care.

Public funding of long-term care

The rationale behind public funding

As pointed out by Fernandez et al. (2009) there are strong arguments in favour of public intervention in long-term care. The risk of needing long-term care is associated with potentially catastrophic individual costs for the individual (for the use of long-term care services), which makes the case for pooling risks across individuals. One way to pool risks would be through voluntary private insurance. However, for several reasons a private insurance market for long-term care has so far failed to develop and it may even be argued that this solution is not really well-suited to address the nature of this risk (Barr, 2010). The reasons range from myopic behaviour of individuals (there is a particularly high uncertainty regarding both the probability of needing care in old-age and the future costs as-

sociated with it), to problems of moral hazard (individuals are more likely to demand for care if fully insured against its costs) and adverse selection (whereby only those with a high risk of needing care would actually buy insurance).

Collective public funding arrangements have therefore been set up to offer basic protection against the risk of needing long-term care in old-age. These funding arrangements can be universal, i.e. public support is provided on the basis of assessed care needs,¹ or be means-tested, i.e. public support is provided to those deemed to be in need of care whose income or wealth falls below a certain threshold. Existing long-term care systems in Sweden, Denmark, Austria or Germany would be closer to universal, while England would be an example of means-tested systems.

Present collective funding arrangements include both elements of universalism and means-testing.

In practice, however, most long-term care systems combine elements of universalism and means-testing, as care needs are seldom covered completely by public systems, leaving individuals to pay for the remaining needs. In Lower Austria, for instance, a person assessed as needing 120 hours of care is only entitled to 60 hours of subsidised care (Leichsenring et al., 2009). More public resources are available if users lack the financial means to pay, but these are subject to means-tests. On the other hand, even in predominantly means-tested systems some services may be provided on a needs base only. In England, many health care services fall under the scope of the National Health Service (NHS), which aims to be universal in its coverage and has therefore limited financial barriers to access.

As most long-term care systems are found at the interface between health care and social care, they often combine elements of targeting (which are characteristic of social care, e.g. in social assistance) and universalism (which are characteristic of health care, mostly free for the user at the point of delivery and financed through social contributions), by that reflecting the lack of integration of care services as well as the resulting shortcomings due to cost-shifting between stakeholders (Glasby et al., 2010).

The current picture of public expenditure

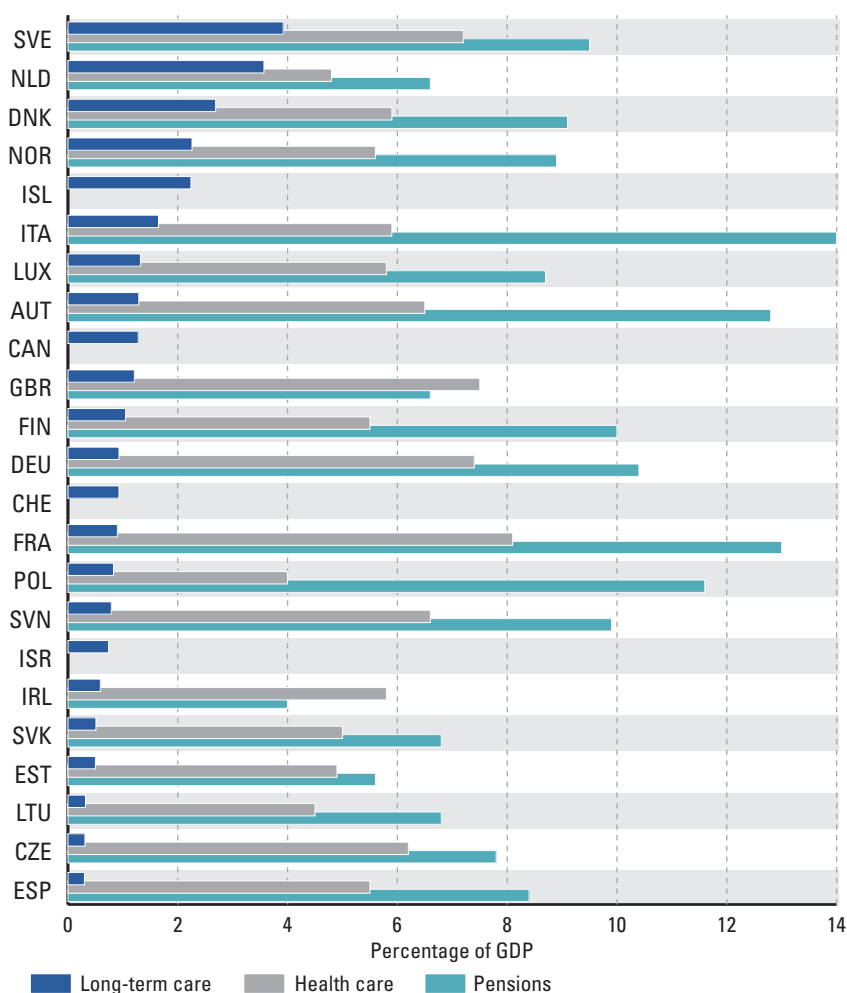
Accounting for public expenditure on long-term care remains difficult. Most countries do not have dedicated budgets for long-term care, and the division of responsibilities between stakeholders regarding governance and finance (e.g. between the state, regional administrations and municipalities) adds to the difficulties in accounting for public expenditure (Glasby et al., 2010). Even in countries with relatively well-established

long-term care systems, e.g. figures on what is spent on dependent older people under the health budget remain an estimate at best.

Figure I:
Public expenditure in long-term care, old-age pensions and health care in % of GDP

Note:
Expenditure data for long-term care in the United Kingdom refer to England only.

Source:
European Commission, ECFIN (2009),
Więckowska (2010), Huber et al. (2009)
adapted from table 7.1.
For original sources on expenditure on long-term care (except Poland) see Huber et al. (2009).



When looking at total public expenditure on long-term care as a percentage of the Gross Domestic Product (GDP), it becomes apparent that relatively few public resources are devoted to long-term care. This becomes especially obvious when compared to pensions or health care – as displayed in Figure I.

Current levels of public expenditure are still relatively small and diverse among countries.

Sweden and the Netherlands are by far the highest spending countries, but even these do not devote more than four percent of their GDP to long-term care. On the other hand, the very low levels of public expenditure exhibited by some countries stem from the very low availability of long-term care services or public support to secure adequate care. Among the latter group of countries are most of the new EU Member States as well as Spain. It is realistic to expect that for many low and

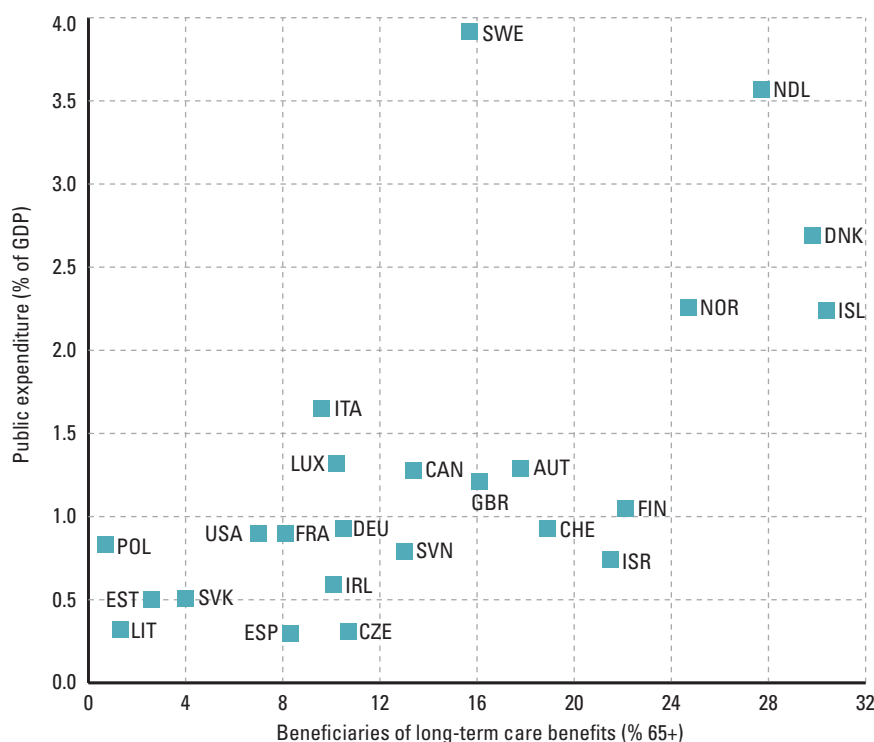
medium spending countries public expenditure levels are bound to increase, as expectations for more and better care are likely to lead to more public resources being channelled to this area.

Although the highest spending countries seem to be countries with a predominantly universal approach to the funding of long-term care, it would be too simplistic to conclude that this approach to fund long-term care necessarily leads to higher public expenditure. Many other factors are likely to influence spending ratios, such as: the share of old-age people accessing care, the private-public mix of expenditure, the quality of care, the type of care provided (institutional vs. home care) and reliance on informal care.

Figure 2:
Public expenditure and beneficiaries of long-term care (2007 or latest available year)

Notes:
Beneficiaries of in-kind and cash benefits. Data refer to old-age beneficiaries (60+ or 65+), except for Spain, Czech Republic and Slovenia, which may include younger users. Data for Austria and Germany include also those receiving cash benefits.

Source:
Huber et al. (2009) adapted from tables 5.1 and 7.1, Wiecekowska (2010). For original sources on expenditure (except Poland) and beneficiaries of long-term care see Huber et al. (2009).



Countries with the highest public expenditure levels are also those where a higher share of their old-age population accesses professional care services (formal care) – either at home or in institutions – or cash benefits (Figure 2), which means that securing care to a wider share of the old-age population comes at a price. For some of the new EU Member States, the current low expenditure levels are simply linked with very low availability of formal care. Still, several countries have a similar share of older people accessing care, while the corresponding expenditure levels and main funding rationale (universal or means-test) are quite different – see e.g. Italy, Germany and Ireland.

Several factors, such as quality standards, reliance on informal care and public-private mix of care are likely to explain expenditure differences.

Expenditure levels may also be influenced by quality standards or policy options regarding the provision of care. For example, higher spending countries such as Norway and Sweden have a higher share of single rooms when compared to other countries (see OECD, 2005; Marin et al., 2009). In Sweden, the total number of beneficiaries of formal care has continuously dropped over the past decade without a similar reduction in expenditure levels since policy has shifted towards targeting more and sophisticated care to older people with higher care needs.

The formal-informal care mix is also substantially different between countries. Thus, the degree of (de)familiarisation of care may explain part of the differences in expenditure (see Jensen, 2008). For instance, Nordic countries and the Netherlands seem to favour the provision of professional services, whilst at the same time having higher female employment rates. While a high share of the population remains involved in informal care duties, these are mostly performed by non-resident relatives and limited to lighter chores (Huber et al., 2009). Germany and Austria, on the other hand, set up their long-term care systems as a way to supplement and support care that was already being provided by family members, while slowly increasing formal care services. In any case and in all countries, informal care has always been expected to fill the gap of the limited availability of formal care services. Indeed, cash allowances provided in more and more European countries have partly been able to compensate for informal carers' efforts. However, in Austria, Germany, Italy as well as in Greece and Spain they have contributed to the creation of new 'markets' of informal care provided by migrant care workers from Central and Eastern European countries – due to the wage differentials it has become affordable to employ persons providing 24-hours care within the family to replace adult children who cannot afford to quit their job in order to care for their older kin (Di Santo and Ceruzzi, 2010; Bettio et al., 2006).

Undoubtedly, the public-private mix of financing may also explain part of the differences in expenditure as users and/or their families contribute quite heavily, but to different degrees to long-term care costs; not to speak of opportunity costs and indirect costs of informal care provision that are not even partially taken into account.

Although most people are cared for at home, public expenditure is mainly allocated to institutional care.

Finally, a most important driver of costs is the way in which long-term care services are provided. Policy papers in all countries promote 'ageing in place', and users and their families prefer to be cared for at home as long as possible (see Eurobarometer, 2007). Available figures confirm that indeed only a minor percentage of older people live in institutional

care facilities. Even in the country with the highest percentage (Iceland) only 9.3% of all people aged 65 and older live in institutions and the un-weighted average for the EU countries is only 3.3% (Huber et al., 2009). Still, it is for institutional care rather than for home care that most public expenditures are reported. In most cases, it appears to be the case that public resources have thus far failed to follow the policy discourse and expectations of the public.

Figure 3:
Distribution of beneficiaries and expenditure between home and institutional care (2007 or latest available year)

Notes:
Data refer to old-age beneficiaries (60+ or 65+), except for Spain, the Czech Republic and Slovenia, which may include younger users.
Data for Italy refer only to users of in-kind benefits.
Data for Austria and Germany include also those receiving cash benefits.

Source:
Huber et al. (2009). For original sources on expenditure and beneficiaries of long-term care, see Huber et al. (2009).

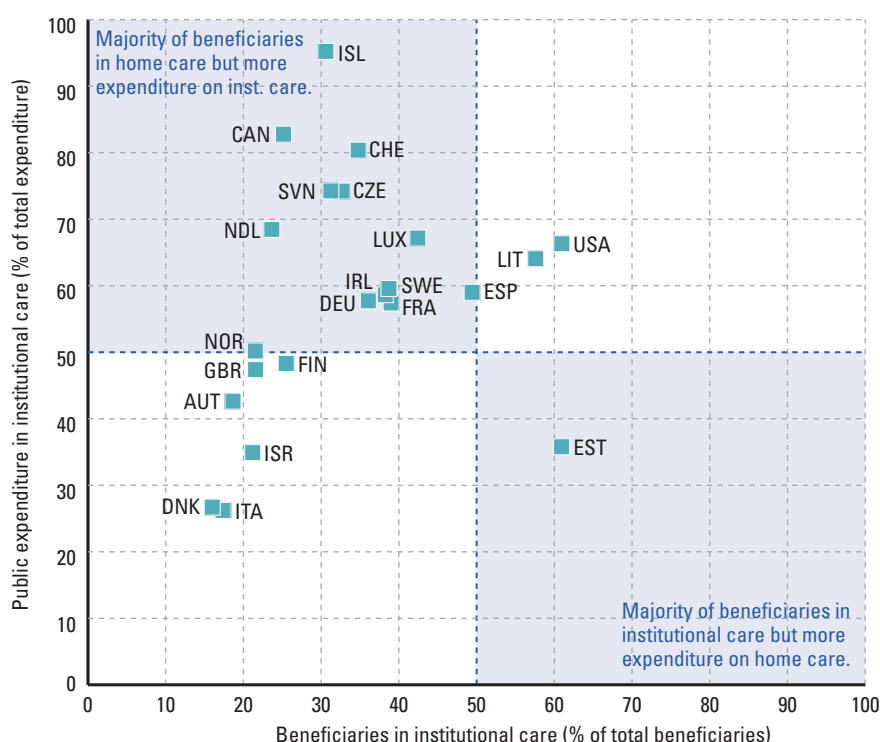
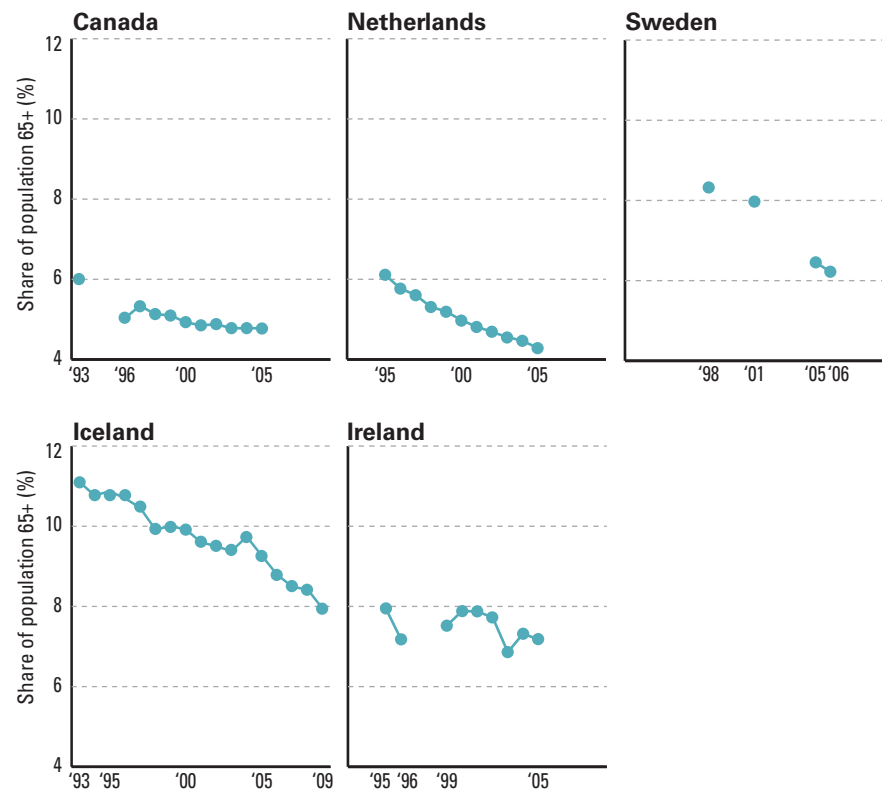


Figure 3 provides an illustration of this by plotting the share of beneficiaries of long-term care² that is cared for in institutions (horizontal axis), i.e. the balance of care settings used, against the share of all expenditure that is allocated to institutional care (vertical axis), i.e. the balance of funding according to care settings.

One potential concern regarding the sustainability of long-term care systems is that due to population ageing the prevalence of those too frail to be cared for in their own homes, and therefore requiring institutional care, will increase. Furthermore, this could be further exacerbated by changing living arrangements leading to more people living alone in old-age. For example, in the most recent Ageing Report (European Commission, ECFIN, 2009) the scenario that could potentially cause the highest increase in public expenditure on long-term care was the one where a

part of informal care was replaced by institutional care. The degree to which demographic ageing is thus associated with increased institutional care usage may have an important role in shaping future public expenditure on long-term care.

Figure 4:
Age-adjusted rates of people aged 65 or over in nursing homes in selected countries over time (Standard population: 2005)



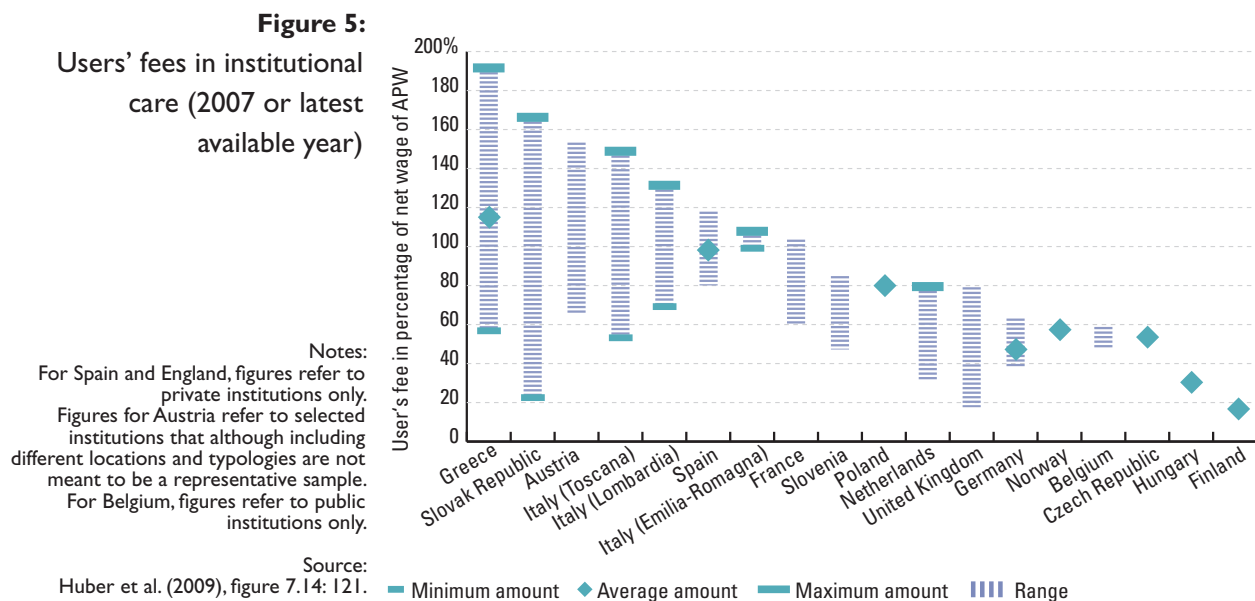
Source:
Own calculations based on
Eurostat; Statistics Iceland; Statistics
Canada; National Board of Health and
Welfare, Statistics – Social Welfare
(Sweden); CBS Statline (Netherlands);
Department of Health and Children,
Annual Survey of Long Stay Units (Ireland).

Population ageing does not necessarily mean that usage rates of nursing homes will increase in the future.

Studies in the United States have shown that population ageing does not necessarily translate into higher nursing home usage rates once the ageing of the population is taken into consideration (OECD, 2005; Redfoot, 2005). The same conclusion seems to hold true for five OECD countries (Ireland, Canada, the Netherlands, Iceland, Sweden) for which age-adjusted rates of nursing home usage³ were calculated (Figure 4). In most countries a downward trend is revealed, except for Ireland where the pattern is less clear. In all other countries, nursing home usage rates have declined continuously over the past decades, with a higher proportion of people aged 65+ remaining in their own homes. Thus, population ageing may not necessarily translate into higher nursing home usage in the future, which means that expenditure scenarios based on higher nursing home usage rates are less likely to occur.

Private expenditure: How deep are the users' pockets?

Users of long-term care services and their families may also be called upon to contribute to finance their care. These contributions may result from a voluntary decision to acquire more or better-quality care (e.g. residing in a single room while in a nursing home), or may arise from the fact that public benefits only cover for part of the care needs or are subject to means-tests. Thus, many older persons have to resort to private care providers, e.g. in means-tested systems like England and Spain. In other countries, users in institutional care are usually required to pay for board and lodging (e.g. in Germany, France, the Netherlands or Denmark). Estimated private expenditure for Switzerland corresponds to 1.5 times what is publicly spent, while estimates for Germany and England place that figure at 0.4 and 0.3 times public expenditure, respectively. For the Nordic countries private expenditure seems to be much lower in comparison (Huber et al. 2009). Depending on the design of the system, however, it can prove difficult to disentangle cash benefits used to pay for services from additional out-of-pocket payments for those services.



Unlike health care, out-of-pocket payments can be quite high in long-term care, namely in institutional care.

While for health care “social protection systems and private health insurance have managed to contain costs faced by private households” (Marin et al., 2009: 15), e.g. by exempting some groups from payment (low-income households, old-age pensioners), cost-sharing in long-term care is much higher. On the system level, in Finland e.g. 22% of total costs for long-term care were paid by the users, while for health services the

corresponding figure was only 4.2%. On the individual level, users of institutional care in Austria may be required to contribute to the costs with as much as 80% of their old-age pension, as well as their long-term care allowance and convertible assets. Therefore, even though the allocation of resources is severely tilted towards institutional care, users and families are still required to contribute heavily to finance it (Figure 5).

As a form of income protection, some countries have established caps on the co-payment amounts levied on users, or established minimum percentages of disposable income that users must be allowed to keep after paying for care (Glasby et al., 2010). User co-payments can nevertheless have an impact on the redistributive effect played by long-term care benefits. Most systems are progressive in the way revenues are raised (e.g. through payroll taxes); a progressivity that may be reinforced through the link between income and need for care (Fernandez et al., 2009: 13). However, depending on the design of co-payments, this redistributive effect may be weakened, i.e. individuals from the poorer quintiles may benefit the most from subsidised care (see below), but may also contribute the most, either in absolute terms or in percentage of their income.

Possible equality considerations of long-term care benefits

Low-income groups have a higher need for long-term care services, but co-payments may result in higher average payments in poorer income groups.

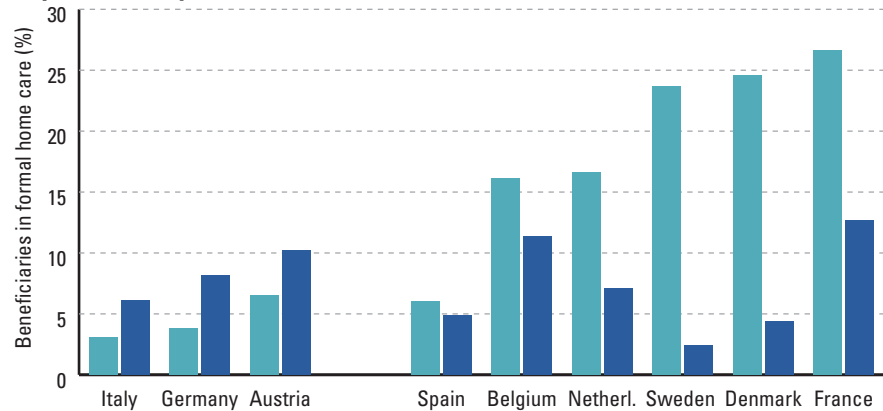
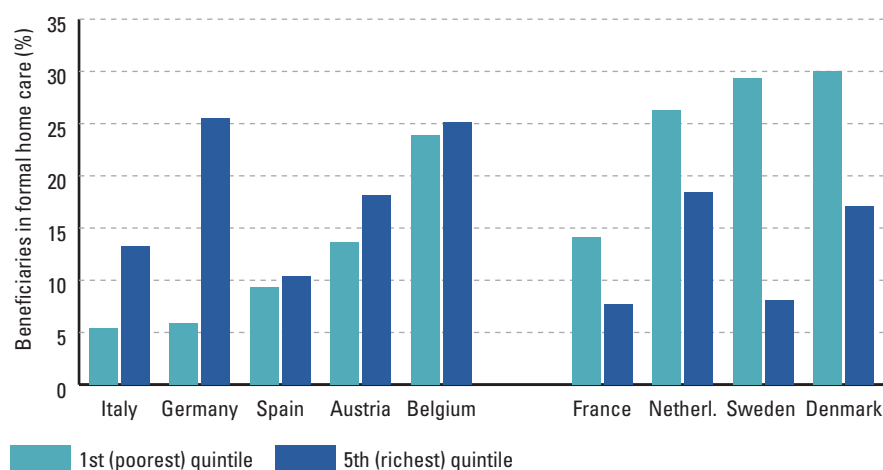
It is well worth to look at the income situation of long-term care users in different countries. Even in countries where user co-payments represent a fixed share of the user's income (and are proportionally distributed), payment structures can potentially be regressive. This is due to the fact that long-term care service use is skewed towards low-income groups (Klavus, 2010), i.e. users from low-income groups have a higher need for long-term care services and hence also pay for long-term care services more often, resulting in higher average payments in poorer income groups (see Glasby et al., 2010, on an example in Finland).

Users of professional home care⁴ were analysed considering equivalised gross household income, using data from the 2004 baseline Survey on Health, Ageing and Retirement in Europe (SHARE). The focus of the analysis dealt with two policy-related questions:

- To what extent is the use of formal home care services related to the capacity to pay, i.e. are people in high-income groups more likely to receive professional care at home than people in low-income groups?
- What are the differences between the eight European countries reviewed regarding the relationship between income and use of formal home care?

Figure 6:

Proportion of beneficiaries of formal home care within the poorest and the richest quintiles, respectively, in the countries studied (in percent).

Population 50 years and older

Population 65 years and older


Source:
Own calculations based on
SHARE 2004 baseline.

1st (poorest) quintile 5th (richest) quintile

The descriptive analysis in the eight countries⁵ studied (Austria, Belgium, Denmark, France, Germany, Italy, the Netherlands, and Sweden) suggests that three different groupings of countries can be distinguished with regard to home care users' characteristics. As shown in Figure 6, in Denmark and Sweden, the Netherlands and France the proportion of people aged 50+ in the poorest income quintile receiving home care is substantially larger than in the richest income quintile, which indicates that the system is in principle progressive – a characteristic that can be mitigated by the design of regressive co-payment structures (see above). In Sweden and Denmark differences in use between income groups increase further among elderly home care users (65+), whereas the gap decreases in the Netherlands and France among 65+ users. Conversely to the first cluster of countries, the second one (comprising Austria, Germany and Italy) displays a substantially larger proportion of richer people (in the highest two income quintiles) who benefit from formal home care than people in the poorest quintile. That might indicate less progressive systems of

formal home care than in the first group of countries. While the differences balance out in Austria in the 65+ age groups, the gap between income groups among the elderly becomes larger in Germany and Italy. In both of the latter countries considerably larger percentages of people in high-income groups receive professional care at home compared to the lowest two income quintiles (see Annex for more details). In Spain no clear pattern could be identified in both age groups (50+ and 65+) but a tendency towards a larger proportion of home care users in middle-income quintiles was found, which is also true for 65+ users in Belgium.

While these observations offer interesting preliminary insights into actual differences in use between income groups in different countries, results do not include information about the health status of formal home care users. Therefore, we will now turn to comparing the odds⁶ of receiving professional home care for the two richest income quintiles in each country with the odds for the two poorest quintiles. Health status and care needs are approximated by controlling for the number of limitations in Instrumental Activities of Daily Living (IADLs) such as preparing meals or doing housework.

Are high-income groups more likely to receive home care?

The most striking result when comparing the odds of different income groups is that in those countries that privilege provision of professional care services (be it home care or service housing) people from low-income quintiles have a higher chance of receiving formal home care, i.e. the systems seem to be more progressive. By contrast, in countries that rather provide cash for care benefits – or at least the option to receive cash rather than in-kind benefits – low-income groups do not stand an equally high (or higher) chance as high-income groups of receiving formal home care services, i.e. formal care systems may be less progressive.

People in the two poorest income quintiles in the Netherlands, Denmark and Sweden are more likely to receive formal home care services than people in the two richest income quintiles, i.e. the system seems to be progressive.

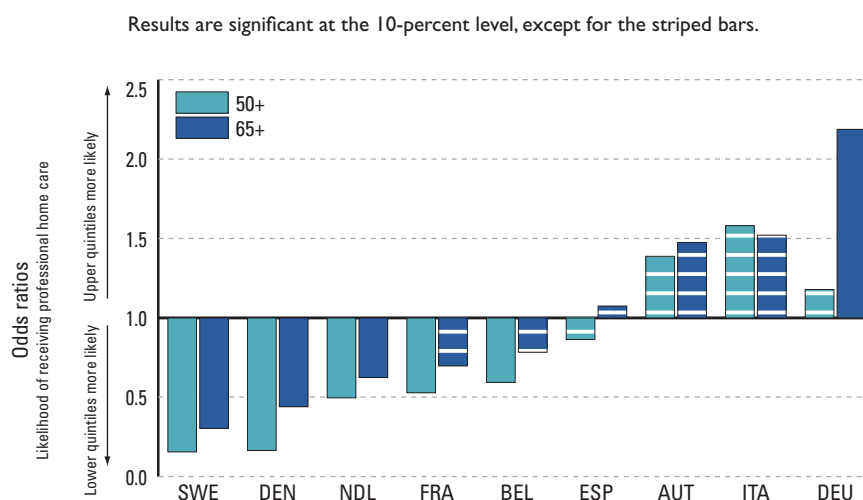
From this analysis we draw the conclusion that in the Netherlands, Sweden, and Denmark – where a large sector of formal home care and service housing exists (Huber et al., 2009) – as well as in Belgium and France, people from the two poorest quintiles are more likely to receive care in their own homes than people in the two richest quintiles (Figure 7). The progressivity in the odds of receiving home care persists also among older age groups (65+) in the Netherlands, Denmark and Sweden. Results turn non-significant for Belgium and France in the elderly age groups.

Figure 7:

Odds ratios of people aged 50+ and 65+ in the two richest income quintiles receiving formal long-term care at home (compared to the two poorest quintiles).

Notes: Odds ratios larger than 1.0 mean that the likelihood of receiving professional home care is higher for the two upper quintiles and odds ratios smaller than 1.0 mean that the likelihood of receiving formal home care is lower for the two upper quintiles.

Source: Own calculations based on SHARE 2004 baseline.



In Germany, by contrast, among elderly people 65+ the use of formal long-term care services at home is skewed towards high-income groups. In fact, the richest two income quintiles in Germany are more than twice as likely to receive formal home care as the two poorest income quintiles in the elderly age groups, pointing to a potentially regressive system of formal home care. Similarly, in Austria and Italy, no indications were found for a progressive structure of formal home care services. The values of odds ratios hint to the fact that high-income groups might be more likely than low-income groups to benefit from formal home care services in Austria and Italy, yet no valid conclusions can be drawn because results are not statistically significant. When including privately-paid providers in the analysis, results for people aged 50+ become statistically significant for Italy (see Annex) – meaning that high-income groups in Italy are more likely to benefit from (publicly funded and privately paid) formal home care services.

Relating these results to the designs of long-term care systems it is interesting to notice the large degree of flexibility in the use of (non means-tested) cash allowances for care in Austria and Italy (Huber et al., 2009), e.g. making it possible to pay for informal care, especially in low-income groups. In Austria high-income groups account for the largest group of formal home care users, yet 80 percent of the Austrian care allowances are directed to the two lowest income quartiles (Mühlberger et al., 2008), giving reason to assume that low-income groups mostly turn to the use of informal rather than formal care services. In line with the analysis above, a study on the German system of long-term care insurance also revealed that the influence of economic reasons often leads low-income

groups to opt for informal rather than formal care (Klie and Blinkert, 2002). In addition, information about the availability of alternatives to informal home care might not always be readily available to less well-off families.

For Spain no consistent and statistically significant results were found. Possibly, this is due to the fact that in Spain and other Southern European countries available care services are scarce and, hence, relatives often take on caring responsibilities (Huber et al., 2009).

Structures of formal home care services seem to be more progressive in countries where in-kind services for formal home care are provided (e.g. Sweden, Denmark, the Netherlands) than in countries where mostly cash benefits are used (e.g. Germany, Austria, Italy).

The results indicate that using cash benefits as opposed to in-kind benefits for long-term care may have differing redistributive effects. Public benefits do not usually cover all care needs and often require users to top-up subsidised care (see example of the Lower Austria region above). In such cases, when there is the option to take cash and use it to pay for an informal carer, this might be preferred in low-income groups. That is, top-ups will be less affordable for them and thus they rather use the cash benefit to pay a migrant carer or a family member, taking the cash benefit as a supplement to household income. For example, in Germany, when given a choice, 71% of people being cared for at home preferred to receive a benefit in the form of cash (over receiving in-kind benefits), and 16% opted for a combination of cash and in-kind home benefits⁷. In other countries, such as Sweden and Denmark, almost exclusive reliance on professional care services (in line with the “Nordic” model of social protection) allows for de facto targeting of low-income groups or of those more in need of care, and even in countries (like France and the Netherlands) that use cash allowances to some extent but where these come with a lot of strings attached, the redistributive effects seem to be much different from Germany, Austria and Italy. These arguments still need to be further tested, but they seem to match the empirical results presented here.

Conclusions

Despite concerns over the sustainability of long-term care systems, the fact remains that public resources devoted to this area of social policy are dwarfed by what is spent in other areas such as health or pensions. To some extent this is possible because families still provide a significant share of care in many countries, as only a minority of older people accesses professional care services. Not surprisingly, most Europeans thus believe that older people have to rely too much on their relatives for care and fear that in the future they will not be able to access care due to financial reasons (Eurobarometer, 2007). As shown in this Policy

Brief, the co-payments required from users and their families can be quite high, especially for institutional care. Similarly, most public resources are devoted to institutional care despite the fact that most people are cared for in their homes. Available data, however, indicate that an ageing population may not necessarily be associated with an increased need for institutional care. This strengthens the case for further differentiating formal care services, for better coordination between health and social care facilities and for developing home care, rather than continuing to finance relatively costlier nursing homes for the older population. Another policy option would be protection against long-term care through a compulsory insurance, a solution favoured by the large majority of people in the EU (Eurobarometer, 2007).

There is not a 'one size fits all model' when it comes to financing long-term care, with different systems (universal or means-tested) being associated with different trade-offs. The same holds true for the several options available to provide those in need of care with the means to secure the care they require, either through services or cash benefits. However, policy-makers should be aware of the potential inequalities associated with the different ways of financing and providing long-term care. Based on the preliminary results on formal home care presented here, it seems that in countries with a wide range of care services available (e.g. Denmark, Sweden) low-income groups are the ones most likely to receive formal care at home. In countries where cash for care allowances are handed out according to needs and a high degree of flexibility in use exists (e.g. Austria, Italy) it is the high-income groups that are more likely to benefit from formal home care services, whereas low-income groups might tend to use care allowances to pay informal carers instead. Being cared for at home is the preferred option of both users and their families in most countries (Eurobarometer, 2007), but should not be a question of affordability, or availability, of informal carers within the family. Therefore, it is recommendable that sufficient professional care services are available for users to be able to choose their preferred option.

Notes

- 1 It must be underlined that there is no objective and common definition of long-term care needs so that coverage and entitlements are also dependent on political decisions. Needs assessment tools thus differ between countries to the degree that, for instance, in the Austrian long-term care (LTC) allowance scheme about 17.8% of the old-age population is entitled to an attendance allowance, while in the German LTC insurance only about 10.5% of the old-age population receives benefits.
- 2 One should bear in mind that this is different from the percentage of older people.
- 3 The risk of needing care increases with age, so that the crude usage rate of institutional care is influenced by the age structure of the population, i.e. an older population may be more prone to need care. Comparing the usage of institutional care between two or more different points in time must therefore be made independently of the (potentially different) age structure of the population. Age-adjusted frequencies of usage are calculated by multiplying the usage rates of each age group (59-65, 70-74 etc.) in every individual year with the (constant) standard population of a specific year (in this case, 2005) for the respective age group. The sum of the age-adjusted frequencies is then divided by the total standard population (65+) to calculate age-adjusted usage rates.
- 4 A user of professional home care is defined as a person who received any of the following in his/her own home in the 12 months before the survey: (i) professional or paid nursing or personal care; (ii) professional or paid home help for domestic tasks that one could not perform oneself due to health problems; (iii) meals-on-wheels. Also, people who (iv) stayed in a nursing home temporarily in the 12 months before the survey are included, while permanent nursing home residents are not.
- 5 Greece and Switzerland were excluded from the analysis, as the sample sizes of home care users in these two countries were too small. Also, not sufficient information on formal home care use was given for Israel.
- 6 The parameters of binary-choice models are estimated by maximum likelihood techniques. To express likelihoods, odds ratios are used, which re-arrange probabilities in terms of the odds of $y=1$.
- 7 Source: Data from the German Federal Ministry of Health, retrieved from [http://www.bmg.bund.de/cln_169/nn_1169696/EN/Pflege/pflege__node.html?__nnn=true], accessed on 23rd August 2010.

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Annex

Table 1:

Proportion of people receiving home care in each quintile in respective age group (in percent)

Country	1 st quintile (poorest)		2 nd quintile		3 rd quintile		4 th quintile		5 th quintile (richest)	
	≥ 50	≥ 65	≥ 50	≥ 65	≥ 50	≥ 65	≥ 50	≥ 65	≥ 50	≥ 65
Austria	6.6	13.6	3.4	5.8	6.2	13.1	5.5	12.2	10.3	18.2
Germany	3.8	5.9	5.2	6.5	3.0	4.9	4.5	11.8	8.2	25.5
Sweden	23.7	29.4	9.4	11.6	4.4	8.9	1.5	3.4	2.4	8.1
Netherlands	16.6	26.3	14.3	23.0	13.2	26.2	7.6	15.9	7.1	18.4
Spain	6.0	9.3	9.9	11.6	10.4	15.3	8.6	13.8	4.9	10.4
Italy	3.0	5.4	4.1	5.9	5.3	8.6	4.6	7.2	6.1	13.2
France	26.8	14.2	21.3	13.0	19.3	10.6	10.0	5.5	12.7	7.7
Denmark	24.6	30.0	16.1	20.2	7.7	17.0	3.8	15.5	4.4	17.1
Belgium	16.1	23.9	24.3	32.4	17.3	24.5	13.4	24.1	11.4	25.1

Source:
Own calculations based on
SHARE 2004 baseline.

≥ 50...Age group 50 years and older ≥ 65...Age group 65 years and older

Table 2:

Estimation of the likelihood of receiving formal home care (excluding privately paid providers) of the highest two income quintiles (compared to the lowest two income quintiles), controlling for the number of limitations in instrumental activities of daily living (IADLs)

Country	≥ 50 years			≥ 65 years		
	Odds ratio	Adj. R ²	N	Odds ratio	Adj. R ²	N
Austria	1.388	0.214	1490	1.475	0.192	707
Germany	1.179	0.151	1837	2.187***	0.142	799
Sweden	0.157***	0.246	2071	0.305***	0.2	938
Netherlands	0.497***	0.113	1861	0.625*	0.093	723
Spain	0.864	0.119	1416	1.075	0.116	751
Italy	1.581	0.155	1615	1.521	0.145	737
France	0.529***	0.109	1389	0.698	0.122	602
Denmark	0.166***	0.221	1326	0.441**	0.168	564
Belgium	0.594***	0.106	2454	0.784	0.104	1017

Source:
Own calculations based on
SHARE 2004 baseline.

Significance levels: * p ≤ .10 ** p ≤ .05, *** p ≤ .01

Table 3:

Estimation of the likelihood of receiving formal home care (including privately paid providers) of the highest two income quintiles (compared to the lowest two income quintiles), controlling for the number of limitations in instrumental activities of daily living (IADLs)

Country	≥ 50 years			≥ 65 years		
	<i>Odds ratio</i>	<i>Adj. R²</i>	<i>N</i>	<i>Odds ratio</i>	<i>Adj. R²</i>	<i>N</i>
Austria	1.408	0.1904	1492	1.494	0.1666	709
Germany	1.179	0.1509	1837	2.187***	0.1421	799
Sweden	0.156***	0.2135	2077	0.306***	0.1651	942
Netherlands	0.537***	0.0751	1869	0.658*	0.0490	731
Spain	0.848	0.1167	1418	1.047	0.1122	753
Italy	1.656*	0.1339	1615	1.607	0.1207	737
France	0.527***	0.1002	1393	0.717	0.1093	604
Denmark	0.201***	0.1811	1335	0.579*	0.1141	571
Belgium	0.595***	0.1059	2456	0.784	0.1039	1017

Source:
Own calculations based on
SHARE 2004 baseline.

Significance levels: * $p \leq .10$ ** $p \leq .05$, *** $p \leq .01$



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<http://www.euro.centre.org>

European Centre
for Social Welfare
Policy and Research

Berggasse 17
A – 1090 Vienna

Tel: +43 / 1 / 319 45 05 - 0
Fax: +43 / 1 / 319 45 05 - 19
Email: ec@euro.centre.org

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