



# Co-financing residential care for older people: models and equity implications\*

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## Introduction

The majority of frail older people in Europe are cared for at home; however, the majority of public and private expenditure is spent on residential care (Rodrigues et al., 2012). At an individual level, out-of-pocket payments (OPP) can represent a sizeable share of an individual's income (Muir, 2017). As an example, the lifelong costs borne by the median user in England are estimated to be £21,400, (c. €24,000) but they can be as much as four times this value for those in top deciles of care needs (Forder and Fernández, 2009). In most European countries, OPPs for residential care are income-related, but in some instances, assets or even relatives' financial resources may be taken into consideration for the calculation of OPPs. These OPPs have potential implications for equity both for access – whether residential care is affordable – and financing – who contributes the most – of residential care. There is currently limited systematic information being collected on OPPs (cf. Rodrigues et al., 2012; Muir, 2017), its equity and policy implications. This Policy Brief aims to partially fill that gap, by summarizing in a non-exhaustive manner information on OPPs for residential care in Europe to showcase diversity of funding systems for long-term care in Europe. While empirical studies on the distributional impact of residential care financing are limited, this policy brief also aims to summarize the evidence on the distributional implications arising from them where possible. In its final section, the Policy Brief will discuss how to overcome the general challenge in paying for long-term care, i.e. how to mitigate the unpredictability of care-related expenditures for citizens over the individual life-course.

**Keywords:**  
**Residential care,**  
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## Forms of user co-payments

To understand the mechanisms for financing residential care, it is necessary to recall their rootedness in social assistance schemes. This ‘last resort’ of social security is based on the subsidiarity principle, i.e. that statutory support is only granted if individual resources, the family or local community are exhausted. The rationale for the subsidiarity principle has generally been one of social fairness (i.e. ability to pay), to avoid moral hazard and to strengthen personal responsibility. In line with this principle, the use of residential care is subject to the payment of contributions or fees to the costs of residential care (i.e. out-of-pocket payments, OPP) by users or their families across Europe. Regarding the design of OPPs, three general types can be distinguished, with various combinations across welfare regimes. These types are: income-related OPPs, asset-based OPPs and OPPs based on (adult) children’s income.

### Income-related OPPs

**Income-related OPPs are the most common form of private contribution to the costs of residential care**

Income-related OPPs are the most common form of individual contribution to the costs of residential care (see Table 1), often requiring users to contribute either a percentage of their income/pension, or all but a pre-determined personal allowance, or until a cap. In Sweden, the complicated procedure of means-testing was abandoned by placing a cap on the OPPs, which is set at a rather low level so that most users are able to pay the contribution from their (pension) income without requiring social assistance – assets are furthermore excluded from the calculation of the OPPs. In total, OPPs cover no more than 5 to 10% of the total costs of residential care in Sweden as there is an individual monthly cap to user contributions of about €170 (cf. in the following: Cylus et al., 2018). Sweden is nonetheless an exception in the European context. In Finland, for example, the OPPs for residents of care homes represent 85% of their net income, with a minimum of approximately €100 per month left for personal use. In France, nursing home residents contribute with 90% of their income (including the attendance allowance or *Allocation Personnalisée d’Autonomie – APA*) to ‘hotel costs’ (i.e. board and lodging) in nursing homes, which may amount to up to €4,400 per month. In England, all users whose income exceeds around €27,000 per year, are considered to be ‘self-funders’ and are expected to contribute with all their income towards the costs of residential care, except for a Personal Expenses Allowance of about €120 per month. The Netherlands has a means-tested system for residential care as well, but the monthly cap for income-related OPPs was set at a more affordable €2,150 in 2012 (Tenand et al., 2020). In all countries, there are variations by region or municipality, regarding both costs and income-related user fees. One variable is, for instance, whether care-related allowances or benefits are counted as income. In Austria, the amount of the long-term care allowance

(*Pflegegeld*) between levels 4 (€690 per month) to 7 (€1,719),<sup>1</sup> besides the regular income (pension) of the resident, is directly used to cover the total costs. Only 20% of the pension and €45 from the long-term care allowance are kept by the resident. By contrast, a similar type of allowance in Italy (*Indennità di Accompagnamento*) is being suspended if the stay in a care home is partly or entirely funded from public budgets.

### Asset-based OPPs

**A major issue is whether assets are considered in means-testing and in the calculation of OPPs**

A major issue is whether assets (savings, investments and property) are considered in means-testing and, as a consequence, in the calculation of OPPs. If this is the case such as, for instance, in England or in Italy, use of residential care may be similar to an ‘inheritance tax’ with a marginal tax rate of 100%. There are various thresholds for a lower level of assets that is left for users and numerous regulations regarding in-vivo transfer of assets, for example, whether savings or property had recently been transferred intentionally to other family members (see Table 1). Italy is a special case as it has introduced a specific calculation base to calculate the ‘equivalent economic situation index’ (*Indicatore della Situazione Economica Equivalente – ISEE*) for households. OPPs (as well as other social assistance benefits) are dependent on this assessment that considers all forms of income, assets and the composition of the household.

**Austria waived the recourse on assets by 2018**

Austria had asset-based OPPs in place with regionally diverse thresholds above which assets would be considered, ranging from €4,000 to €13,000, which raised issues of equity between residents of different regions. This issue was eventually solved when the government waived the recourse on assets. As of 1 January 2018 the federal government prohibited the recourse to the assets of residents in care homes and compensated regional governments for the lost income by self-payers and residents that had contributed to care home costs from their assets.

**The ‘Fair Deal Scheme’ in Ireland results in cross-funding from richer to poorer residents**

To circumvent the risk of total exhaustion of assets, Ireland has implemented an asset-related OPP known as the ‘*Fair Deal Scheme*’. People moving into residential care must pay 80% of their ‘assessable income’ (i.e. regular income minus allowable deductions such as health costs) and in addition, if they own assets or property, another 7.5% per year of their assets above a threshold of €32,000, for a period of maximum 3 years. This time limit should ensure that, if residents need to stay in a care home for more than 3 years, their assets which could also be a farm or business run by a family successor, will not be further

1 Being assessed with care needs equivalent to level 4 or higher, on a scale from 1 to 7 with level seven describing the most severe care needs and thus the highest amount of the LTC allowance, has become the minimum threshold to qualify for a place in a care home in Austria over the past few years.

Table 1: OPP in residential care, selected countries

Country	Income-related OPP	Asset-related OPP	Comment
<b>Austria</b>	Yes, 80% of pension, plus long-term care allowance (except about €45)	No	Recourse to assets was waived in early 2018
<b>Finland</b>	Yes, 85% of pension, No minimum of about €100 pocket money	No	
<b>France</b>	Yes, 90% of pension and long-term care cash benefit (APA) for board and lodging	Yes	Recourse to first- and second-order heirs
<b>Germany</b>	Yes, flat-rate for care, plus fee for board and lodging and investment costs, about €110 pocket money	Yes, except €5,000 exempt assets	Recourse to children if above €100,000 gross income per year
<b>Italy</b>	Yes, for board and lodging according to means-test (individual ISEE)	Yes	Different rules between regions; no OPP if 100% invalidity and no assets
<b>Ireland</b>	80% of 'assessable income'	7.5% of assets per year (max. 3 years) above a threshold of €32,000	'Assessable income' means pension minus allowable deductions
<b>Netherlands</b>	Yes, capped at about €2,200 per month	No	Differences between municipalities
<b>Sweden</b>	Yes, but capped at about €220 per month	No	About 18% of residents pay no contribution due to low income
<b>UK (England)</b>	Yes, if assets over about €27,000 – full costs; below €14,000 – no charges; otherwise means-tested split	Yes	

Source: Authors' own compilation (see references). ISEE = Indicatore della Situazione Economica Equivalente; APA = Allocation Personnalisée d'Autonomie; OPP = Out-of-pocket payments.

curtailed (Robinson & O'Shea, 2010). However, the fact that the state still takes a financial interest in the estate has led in practice to a split of residents into 'Fair Deal' residents with no or rather low assets and 'self-payers' who try to protect their assets by disbursing their fees fully privately. As the OPPs of the latter are often higher than the 'Fair Deal' ones, this results in cross-funding from richer to poorer residents.

### **OPPs based on children's income or recourse to next of kin**

#### **OPPs with recourse to children's income are more seldom**

Finally, the implementation of the social assistance rationale also reflects the role of family values and related responsibilities in different countries. For instance, in Nordic countries, where the welfare system is focusing on the individual, rather than on the nuclear family, there is no recourse to partners or other family members foreseen to contribute to costs. By contrast, France takes a very strict approach to OPPs from other relatives. Residents contribute with 90% of their income, including attendance allowance (*Allocation Personnalisée d'Autonomie*), to costs of accommodation in nursing homes that may amount to up to €4,400 per month. If the resident's income is not sufficient to pay for the costs of care, social assistance may cover the difference, but only after a stringent means test, which includes the recourse to first- and second-order heirs, including grandchildren and in-laws who have to find an agreement on how to divide the charges among themselves. If family members are unable to come to an agreement, local authorities would step in to compensate the care home provider but may reclaim the amount paid from the estate (heritage) after the resident's death.

#### **Italy is characterised by various regional regulations**

In Italy, where 50% of nursing home costs are covered by the National Health System, the remaining costs for accommodation need to be covered by the resident based on his individual above-mentioned 'equivalent economic situation index' (*ISEE*). However, the income of other members of the household is not being considered, and if this is not sufficient, the local authority will step in (Brambilla & Crescentini, 2018).

In Austria, regional regulations demanding that next-of-kin pay for nursing home costs of their parents were stopped stepwise over the past decade, first in individual regions, then across the country altogether. This transition period had contributed to an increasing unpredictability of potential costs of long-term care for Austrian citizens. Also in Germany, regulations continued to puzzle families until a recent amendment specified that, as of January 2020, recourse on children would only take place if their gross income exceeds €100,000 per year (Bundesregierung, 2020).

## Equity implications of different models of OPPs

### Residential care entails redistribution from men to women

The distributional impact of the different OPP schemes described above can be assessed in relation to who is actually paying OPPs conditional on using residential care and who has access to residential care after paying OPPs. For example, in a study examining four OECD countries (England, Japan, Sweden and Germany), residential care was found to entail redistribution from men to women as a result of differences in health and higher life expectancy of women (Karlsson, 2007). More specifically, in each country analyzed, women unilaterally in each age category had a higher net present value compared to men (i.e. higher monetary value of benefits received minus contributions to the system). This is the result of women being more likely to be disabled and, conditional on level of severity of disability, to end up in a more costly care setting. Only part of this gender gap could be attributed to differences in income and consequently OPPs. Another comparative study highlighted that rules for OPP are also determined by needs (i.e. only those above a certain need qualify for lower OPPs) and therefore low-income individuals whose needs fall below the threshold of severity may not be able to access institutional care (Muir, 2017). In the following sections, we further outline the distributional impacts of various models constituting OPPs and financing residential care, taking into consideration the different methods of measuring distributional impact (see Box 1). Due to a lack of research on the distributional impact of children's contributions to parents' residential care, we focus on income-related and asset-related fees.

### Box 1: Methodological aspects of measuring distributional impact

In determining the distributional impact of different models, a distinction must be made between different ways to measure, as they influence the conclusions made on who benefits the most versus the least. Distributional impact can be analyzed based on the net benefit (i.e. subtracting the contribution from the value of benefits received), on the absolute amount paid, or percentage of income and/or assets paid. The percentage of unmet need under a certain system can also be used to determine the distributional impact, though it has not been as commonly used (Fernández & Forder, 2010). All of these measures are rooted in concepts of what constitutes fair OPPs and obtaining public assistance.

### Income-related OPPs

### Many lower-income individuals are not eligible for public support

As mentioned above, most countries use some degree of means-testing by income for residential care. Still, individuals with low income remain the most at risk and most exposed to the cost of care (Muir, 2017; Ilinca et al., 2017; Schmidt et al., 2014). A recent OECD study found that in many countries, income thresholds that dictate greater public support for long-term care costs are often set far below the relative income poverty line (approximately 50% of the median

equivalized disposable income after social transfers), meaning that many lower-income individuals are not eligible for greater public support. Means-testing by income often requires nursing home users to contribute nearly all of their income except for a pocket money allowance before receiving social assistance. Depending on the size of the pocket allowance, low-income individuals could be left with very little money after covering nursing home costs (Muir, 2017). For example, in Croatia, the pocket allowance amounts to about 3% of median income after costs are covered. Pocket allowances are slightly higher, between 9% and 15% of median income, in England, France and the Czech Republic. At the higher end of allowances in European countries, institutional care users with median income in Iceland and the Netherlands are left with about 25% to 50% of their income. Evidently, those with low incomes are most likely to spend down to the minimum allowance in a means-tested system for income.

**With a cap on contributions, all residents benefit in Sweden**

In a comprehensive system like the Swedish one where all individuals receive some type of benefit and a large majority of long-term care fees are covered by the state, medium- to high-income earners largely benefit out of having a cap on their contributions, while low-income individuals also benefit from either extremely reduced costs or no costs at all (Karlsson et al., 2007). The difference in net benefit received between men and women is extremely pronounced in this system, with women receiving about €16,750 more in terms of money's worth than men over the life span, reflecting higher intensity of needs for women as well as an income gap.

**In the Netherlands, residents with lower income are guaranteed access based on care needs**

As mentioned above, the Netherlands has a relatively means-tested system with a low cap set on income-related OPPs. Although financial barriers to residential care are thus limited, particularly for low-income individuals, eligibility is also based on need and availability of informal care (Hussem et al., 2016). As a result, lower-income individuals use a proportionally higher amount of residential care than richer individuals, even when controlling for need (Tenand et al., 2020), suggesting that a system without financial barriers and being based on care needs can result in residential care being more accessible for lower-income individuals.

While income-related fees are intended to ensure that individuals pay a proportional amount of their income, lower-income individuals are still the most at risk as they are most likely to be left with little pocket money after covering nursing home costs. This is particularly true when the pocket allowance is set at a low amount. Low caps on payments as well as high public support based on income appear to reduce this risk by decreasing barriers of access to lower-income individuals, though at the expense of increased public expenditure and lower fees for higher-income individuals who are considered able to afford long-term care. With lower financial barriers for all, the risk of moral hazard is higher,



suggesting that a needs-based assessment may be warranted to ensure that people with low income but high care needs are able to access residential care, as seen in the Netherlands.

### Asset-based OPPs

#### Should people needing residential care have to spend down their assets?

There is a strong argument about fairness of asset-based OPPs (Colombo et al., 2011) as individuals' ability to pay in old age is likely to be better captured by wealth. In the case of England, if income alone were to be used to cover residential care, less than 20% of home-owners would be able to afford care for more than 12 months (Mayhew et al., 2017). Conversely, if wealth were included in addition to income, this would extend the time that these individuals could afford to pay for care by more than five years, indicating a large difference in ability to pay when wealth is included. At the same time, it is argued that individuals that happen to need extensive residential care should not have to spend down their assets entirely and impoverish themselves in order to afford care. Furthermore, stringent asset-testing is likely to adversely impact people with assets that are lower in the income distribution more so than those with high income (Muir, 2017). Individuals with lower income yet owning assets may be required to pay more out of pocket for their residential care than individuals with higher income yet no assets. This is especially intensified when the asset threshold is placed at a relatively low level, such as in the case of England (about €27,000). In addition, those with higher income are more likely to be able to afford residential care fees out of their income without tapping into their assets, more so than lower-income individuals with assets (Hancock et al., 2007).

Asset-based OPPs hurt home-owners most, though the extent of impact depends on the person's income combined with any upper or lower boundaries set on asset contributions. As seen with the English system in 2007, where individuals with capital above the determined threshold paid the remainder of fees after a needs-dependent contribution from the National Health System (NHS), homeowners contributed on average 59% to their total costs of care compared to non-home-owners that contributed approximately 20% (Hancock et al., 2007). People with assets tend to be concentrated between middle- and higher-income individuals whose income is usually significant enough to cover the majority of nursing home fees without having to draw from assets. In England, 'self-funders' are quite spread out among the income distribution, with most concentrated in the higher income groups. This indicates, however, that some lower-income individuals are also asset-wealthy (Hancock et al., 2013). As a result, those with severe needs and income-poor individuals with some assets are most likely to exhaust their assets in paying for residential care. However, the percentage of people reporting unmet need in England is lower for lower-income groups in comparison to higher-income groups, suggesting that lower-



income groups are relatively better supported and able to access services they need in this means-tested system (Fernández & Forder, 2010).

To best understand how asset contributions to residential care impact certain groups of people, it is helpful to examine who benefits the most and least when reforms to requirements of asset contributions occur. Using the English system as an example, reforms to asset-based contributions would not largely impact higher-income groups, as these individuals are able to meet their care costs through their income alone without tapping into their assets (Hancock et al., 2007). In addition, wealthier individuals tend to have better health and therefore may be less likely to need residential care (OECD, 2003). Lower-income and middle-income individuals with housing assets would benefit the most from asset contribution reforms, as there is a sizable group within these income quintiles that is forced to draw from assets (Hancock et al., 2007).

**Distributional  
impacts of reforms to  
asset-based OPPs**

Defining ‘benefit’ as an increase in disposable income after covering care costs, these various reforms to the English financing system, as seen in Hancock et al. (2007), would have the following distributional impacts:

- Placing a lifetime limit on user contributions would benefit individuals in the highest income quintile and home-owners the most, reflecting the higher absolute OPPs paid by these individuals.
- Disregarding housing assets all together would benefit the middle quintiles most, reflecting the fact that most asset contributions come from middle-class individuals with housing assets whose income is insufficient to cover all costs.
- An increase in personal allowance expense – i.e. the amount one is able to keep after paying OPPs – would benefit the lowest three income quintiles the most and the highest quintile the least (Hancock, 2000), as many people in these lower incomes exhaust all income, save for the personal allowance expense.
- A lifetime cap of £100,000 on contributions to residential care would benefit the highest income quintile and home-owners the most, suggesting that mostly higher-income individuals and home-owners spend in excess of £100,000 on residential care. On the other hand, while individuals in the first four income quintiles do benefit from a cap on fees, the gains are below average compared to the highest income quintile, suggesting that less individuals in the lower income quintiles spend in excess of £100,000 compared to the highest quintile.

While asset-based contributions are intended to reflect an individual's ability-to-pay and are thus expected to impact wealthier individuals more, in reality, they appear to impact lower- and middle-income individuals with assets more so than high-income individuals. To limit asset-depletion of lower and middle-income individuals, the solution of a life-time cap was proposed by the Commission on Funding of Care and Support in England in 2011, in addition to raising the threshold of exempt assets (Gori et al., 2016). However, placing too high of a cap on fees still requires individuals to contribute significantly before reaching the cap, as evidenced by Hancock et al. (2007), and would more so benefit those that have substantial means to pay. This has also raised the argument for stronger pooling of risk to increase social protection and eliminate financial impoverishment for home-owners and those with high assets (Muir, 2017).

### **Distributing the costs of residential care across a wider population**

While many people can anticipate having to use residential care at some point in their life – e.g. as much as 75% of those surviving until the age of 65 in the case of England (Forder & Fernández, 2009) – a small minority are expected to face catastrophic costs. In addition, as previously seen in means-tested systems requiring income-related fees, those with low income are at risk of spending their entire income on residential care, save for the personal allowance. In systems requiring asset-based contributions, those with assets are at risk of spending down their assets in order to afford residential care. These risks, alongside aging populations putting pressure on the sustainability of long-term care financing, have led to the argument of distributing financing for residential care more evenly across and within generations, in order to protect individuals from having to pay catastrophic costs and be financially impoverished, whether through income- or asset-related contributions. Aside from financing measures that require residential care users to pay income-related or asset-related OPPs, alternatives have been used to finance residential care, which require contributions to the costs of care from other individuals than just those using residential care. These types of financing schemes redistribute costs from individuals requiring residential care to those not needing it, therefore spreading the risk of paying catastrophic costs upon needing residential care amongst the entire population and decreasing the costs to those that end up requiring residential care. Examples of this include social insurance contributions from the entire population, general taxation and long-term care insurance schemes that contribute to the high subsidization of residential care costs.

The example of the German Long-term Care Insurance (LTCI) may showcase this principle. Long-term care in Germany is financed through a compulsory long-term care insurance scheme, complemented by funding from general taxation. Employees mandated to contribute to the system and who are subsequently covered, contribute 3,05% of their income (3.3% for childless), shared between them and their employer. In return, and conditional upon requiring residential care, lump sums at several care grades (from €770 to €2.005) are paid but do not even cover the costs of nursing care. OPPs and social assistance are therefore still contributing significantly to total costs in care homes (Rothgang & Müller, 2018). Even though high-income earners or otherwise privately health-insured citizens can opt out of the public long-term care insurance, they need to adhere mandatorily to a private LTCI. Still, they contribute through general taxation to the social assistance benefits for residential care, and in case of residential care, they will contribute with larger OPPs. In addition, these OPPs have constantly risen over the past decade, as provisions of the LTCI are capped and do not even totally cover the costs for nursing in care homes (Rothgang & Müller, 2018). As a result, high-income earners experience a worse benefit-to-contribution ratio as they contribute to LTC funding through general taxation and do not profit from social assistance for residential care. Low-income earners benefit if they require residential care, but otherwise face disproportionately high contributions if they do not require services (Karlsson et al., 2007).

However, in spite of ever rising contributions and add-ons such as subsidized voluntary insurance and a collective provident fund, the basic problem of ever-rising contribution rates to the LTCI and rising OPPs has not yet been solved, neither has there been a compensation for the generally more advantaged risk structure for private LTCI providers. Suggestions to address the issues of coverage and fairness are therefore focusing on a comprehensive LTC insurance based on citizenship, with full coverage of nursing costs and a general cap on OPPs – all costs above a defined threshold would be funded by the citizen insurance (Rothgang & Domhoff, 2019). This approach would move the German system further towards the Swedish model of universal coverage, and it would take up an idea promoted by the ‘Commission on Funding of Care and Support’ (2011) in England that stipulated a system with a ‘life-long cap’ on individual social care expenditures to increase the predictability of this type of social risk over the life-course. Some scholars also argued that such a design could be complemented by a second tier (private) insurance to insure the remaining OPPs based on relatively affordable, age-related contributions (Kochskämper et al., 2019).

## Policy conclusions

### **The social assistance rationale is still prevalent in long-term care**

This brief and non-exhaustive overview shows that the social assistance rationale is still very much prevalent in the design of rules for OPPs for residential care in Europe, with sizeable contributions to the costs of care demanded from users or even their relatives. This stands in contrast with high-cost treatments in acute health care, which are mostly free at the point of usage, and could entail increased poverty risk for those who need residential care.

### **Basing access to residential care on need may decrease barriers of accessibility**

Despite income-related fees often being targeted to allow individuals to retain part of their income and subsequently some level of independence, the threshold set still often leaves lower-income individuals at risk of spending their entire income, save for the personal allowance. Raising the income threshold for financial assistance, increasing personal allowance amounts and basing access to residential care on need, as seen in the case of the Netherlands and Sweden, may decrease barriers of accessibility and affordability for lower-income individuals.

### **A lifelong cap on total OPPs paid by each individual could limit uncertainty**

The recourse to asset-based OPPs raises even more questions. At an individual level, most asset-based OPPs have no or very high ceilings on the total maximum that residents may pay. This could amount to a kind of ‘reverse lottery’, as it depends very much on unforeseeable circumstances whether people have to move to a care home. Still, and given the positive gradient between health and financial resources, there are possible regressive effects that will be at the centre of our further research. It is undisputed that regulations about asset-based OPPs are increasing uncertainty about savings and property, therefore also triggering conflicts on heritage and issues of intergenerational fairness. Moreover, simulations carried out in a number of studies highlight the potential for the poor targeting of any asset-based OPPs: income-rich individuals may not need residential care or be rich enough to pay from their income, while poorer and middle-class individuals may need to exhaust their life savings (Karlsson et al., 2007; Hancock et al., 2013; Hancock et al., 2007; Hancock, 2000; Muir, 2017). This could have implications for intergenerational transmission of (dis) advantages, particularly in countries with skewed income and wealth distributions. The possibility to impose a lifelong cap on the total OPPs paid by each individual could limit uncertainty and risk of catastrophic costs, as seen in Hancock et al. (2007), though should be cognizant of setting caps at a level that benefit lower- and middle-income individuals. Another means to protect the savings of income-poor individuals consists of increasing the exemption thresholds.

OPPs demanded from children are much less widespread and there is no information on their distributional effect. However, as less affluent families are more likely to need residential care (Schmidt et al., 2014), such intergenerational transfers may impose a higher financial burden on poorer households and thus impact social mobility.

In response to astronomical care costs experienced by relatively few requiring residential care, both through income- and asset-related fees, the solution of redistributing costs amongst the entire population has been raised. Though dependent on how they are implemented, long-term care insurance schemes, social contributions and increased financing through general taxation can alleviate costs to residential care users while diffusing the burden across the healthier, younger generations. Concomitantly, however, this raises issues of intergenerational fairness and equality.

**Redistributive mechanisms are needed to share the burden of financing more evenly between and within generations**

While residential care is indeed expensive, only a minority of older people at any given time need it, in particular as many countries are striving towards policies of 'ageing in place', de-institutionalisation and the extension of community-based care. This could be an argument for more redistributive financing mechanisms that focus on need, limit individual OPPs (like those in place in Sweden) and instead share the burden of financing more evenly across individuals with and without care needs as well as between and within generations.

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